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Doctors with Africa

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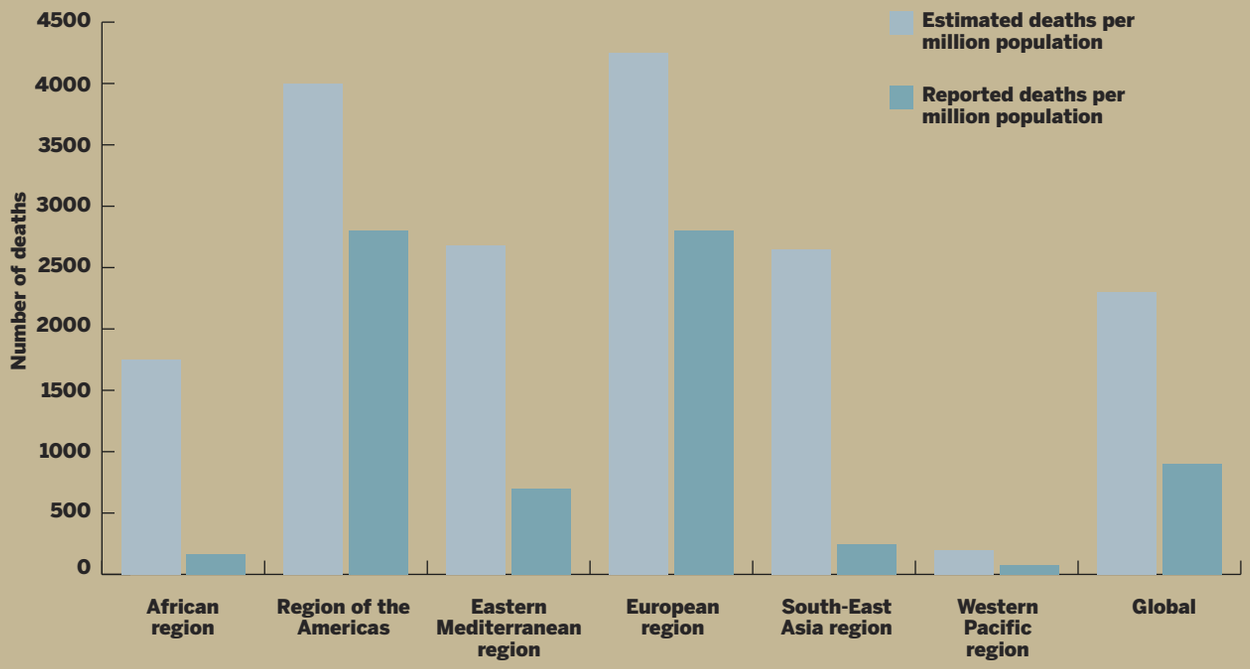
No Doctors, No Nurses, No Health Workers = Impossible Healthcare

NEWS

Cumulative mortality data from COVID-19 in the world

In Europe and America, cumulative mortality levels from COVID-19 were ten times higher than in the majority of countries in Asia and Oceania (Western Pacific Region).
Figure 1 shows the cumulative mortality data (all deaths from the beginning of the pandemic to May 31, 2022) per million population, in the six WHO Regions (see **Figure 2**). The red bars show the reported cases of death, and the light blue bars, the estimated cases of death.

FIGURA 1 / EXTIMATED AND REPORTED CUMULATIVE DEATHS FROM COVID-19, GLOBALLY AND BY WHO REGION, AS OF MAY 31, 2022



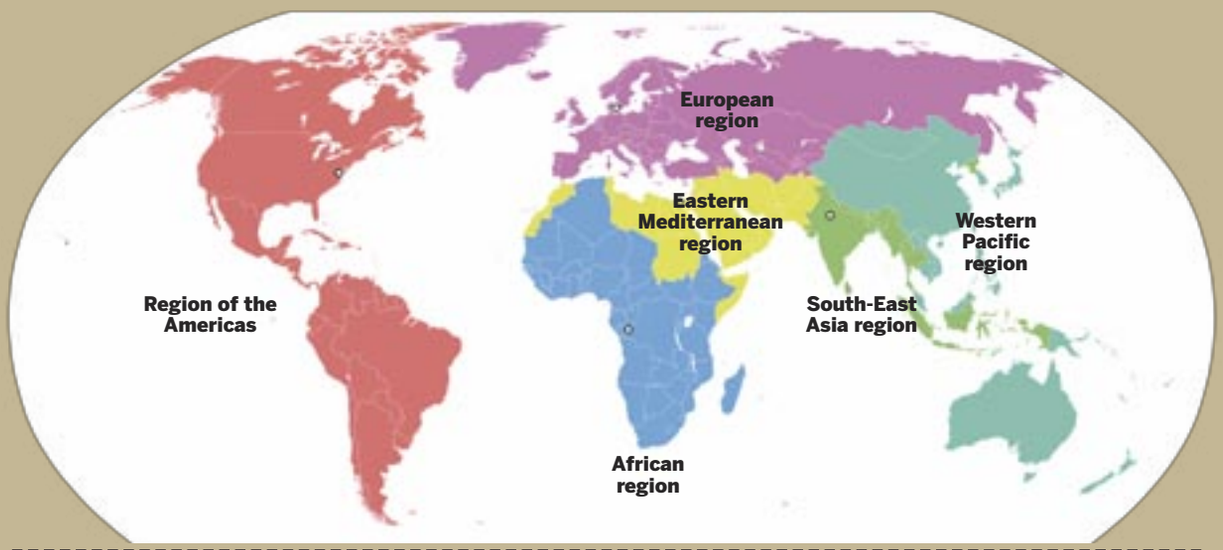


FIGURE 2 / WHO'S SIX REGIONS

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No Doctors, No Nurses, No Health Workers = Impossible Healthcare
A major crisis is shaking up the world's health systems: a shortage of doctors, nurses, and health workers. Planning and support policies are not yet adequate. Human resources are the cornerstones of health and care. Without them, there is no future.
This is why Doctors With Africa CUAMM is working ceaselessly to bolster and train human resources in Africa and Italy.

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PEOPLE-CENTERED

We aim to give young African students skills and training because we read in their eyes the best future for Africa. Growing and supporting new health workers in Africa means contributing to the future, not only of healthcare but of an entire continent.

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

We so often hear them called human capital, but at CUAMM we prefer to call them just "people." It's people who have always made the difference and in whom we will keep on investing in Italy and Africa alike.
There is a good reason that this issue of *Health and Development* is all about human resources in health and their shortage in a situation of crisis on an international scope that is even more severe in African countries. It is also the reason that the focus of the CUAMM's "Mothers and Children First" program, whose third phase has been launched, is "People and Skills." This program involves 8 countries and 14 hospitals and was conceived to support the care of mothers and children in their first 1,000 days of life while also supporting the development of human resources and the skills of health workers, which are the engine driving health systems that work and are sustainable over time.
This is also why some of our medium-term efforts are focused on training health workers in Africa, especially young people. This is to say that people are both the focus and key players in the cooperation we have been building for over 70 years.

The great commitment we are working on now involves mobilizing to make Africa truly central with its needs and those of its people. We start from a vision, which we always translate into planning, engagement, and action in the field as well as opportunities to meet with people. In the coming months alone, there will be over 200 events on awareness-raising on these topics, which we will organize throughout Italy, bringing us to *African Day*, which was celebrated last May 25, until our next *Annual Meeting* in Milan on November 4, 2023. This will be the most important event of the year. We will gather to share the point on the path we are on and our upcoming destinations, along with the people who support and make up CUAMM every day, in Italy and Africa.
One of the specific objectives of this intensive action of sharing is to involve as many people as possible in our next challenge: training 10,000 new health workers in Africa. This is a challenge that looks to the present and even more to the future at this time in history when health care is suffering a shortage of personnel and health systems are at risk of failing. The data that tells of the shortage is alarming and the accounts of doctors, nurses, and workers who do not quit or move to other countries describe difficult working conditions, psychological strain, the lack of practical support and recognition (as we can read in the article on page 4 gives an unsparing portrait of this situation).
In Africa, the problem has become even more extreme, adding to the structural difficulties of the local health systems: Africa has 24% of the global disease burden with only 3% of the global health human resources, as described in one of the following articles (pg. 13). This is a reason that this issue is so important to us because it is to do with inequality and working to reduce it through long-term interventions, field research, and training people.

At CUAMM, we want, as always, to give space to all people who contribute, each in their own way, to building health in Africa in the most remote places and in conditions that would be reductive to call just complex. We especially want to give space to the many young students in whose eyes we see a better future for the continent. These young men and women follow a dream with determination and stubborn tenacity. Just like Gordon did. He's a South Sudanese midwife whose story is that of an entire country that is looking ahead and building its story through its difficulties. This is a story of war, loss, and difficulties as well as commitment and faith in the future as individuals and as communities.
Training a health workforce in low- and middle-income countries can truly make the difference and in the mid to long-term could turn the tide, symbolically and tangibly, for young Africans. Young Italian residents can open new prospects by choosing to take part in the JPO –Junior Project Officer program, which CUAMM has organized for over 20 years. In this issue, an article considers the recent publication of a peer review on the lasting value that the experience has for young doctors.
This theme – people and their skills – will continue in our next Annual Meeting in Milan on November 4 to which you are all warmly invited.

DIALOGUE

THE END OF CARE WORK

The work of giving care has turned into a service-based job where patients are the recipients of a set of services – diagnostic, therapeutic, support – that are hyper-fragmented and provided by "anyone" with the goal of achieving the maximum output with the minimum input.

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

In the second issue of *Health and Development* (then "CUAMM News"), in 1989, it was something of a "scoop" when we reported a document from the World Bank that suggested how developing countries should finance their health systems.[1] An anonymous, seemingly technical document – brought to light by Maurizio Murru's intuition – soon proved to be a cornerstone of global health policies for decades to come.

It gave a simple, yet ruthless recipe for countries that depended on the World Bank because of their debt to it: drastically cut public spending, especially health spending, make public services for pay, foster the privatization of health services, promote private insurance, and decentralize the level of health government to provinces or districts.

The World Bank, true to the dominant liberal ideology, sent two clear, solemn messages with this recipe: 1. States should not be interested in the health of their citizens; 2. A lot of money can be made off of health and especially illness, which is why the market should handle it.

From the 1980s on, with every debt crisis, states dealt heavy blows to their public health systems because, as Naomi Klein has described in many different situations, "Those opposed to the welfare state never waste a good crisis."

A new "good crisis" started in 2008, caused by U.S. banks' speculative policies on real estate mortgages, spreading quickly to the rest of the world and sparking a severe global economic crisis. This recession brought European countries to their knees, already weakened by unfavorable global competition that had also heavily indebted them. The countries most affected were Portugal, Italy, Ireland, Greece, and Spain (the origin of the odd acronym PIIGS). The recipe that the "Troika" (the European Central Bank, the International Monetary Fund, and the European Union) concocted to deal with the crisis was much like the one adopted two decades earlier by the World Bank for developing countries: austerity policies, public spending reduction, cuts to health and education, and privatization of public goods. The social costs of this recipe were, predictably, extremely high, including the rise of unemployment, poverty, and social inequality added to the difficulty of accessing health services, reduced public health supply, and increased co-pays.[2]

Unlike in other countries, the Troika did not intervene in Italy. The letter from the European Central Bank (August 2011, signed by Trichet and Draghi) sufficed, ordering the Italian government to cut public spending and favor privatization. The decisive blow to our national health system was stopping personnel recruitment, which led to the loss of 50,000 employees over ten years, including doctors and nurses. This led to the reduction of the public health supply and the heavy recourse to the private sector, terrible inequality in access between those made to wait months to see a doctor (or to do without) and those who pay to cut to the front all lines. But the attack on the human capital of the national health service had an even more serious consequence: the "work of giving care" in which health workers always worked in a specific field, knew each other, and worked together to give patients effective care – became a "service-based job" where patients are the recipient of a series of services – diagnostic, therapeutic, support – that are hyper-fragmented and provided by "anyone" with the goal of achieving the maximum output with the minimum input.

Health managed by the market damages people's health – especially that of the most vulnerable and poorest – and the field becomes unattractive for health workers, who are overworked, exploited, and underpaid. In Italy and in the entire world, this is why there is a shortage of doctors and nurses (according to the Lancet, the global shortage of nurses before the pandemic was estimated at 6 million and might reach 13 million in coming years due to the increase in demand for health care and the low personnel recruitment[3]).

NOTES

1 The World Bank. *Financing Health Services in Developing Countries, An Agenda for Reforms*. Washington DC, USA, 1987.

2 https://www.saluteinternazionale.info/2014/10/ttip-e-dintorni-il-liberismo-in-sanita-per-chi-suona-la-campana/

3 Editorial, *The future of nursing: lessons from a pandemic*, Lancet, 2023; 401:1545 (May 13, 2023).

"HIDDEN" HUMAN RESOURCES

Building health in Africa is not up to just a few people. Alongside the daily efforts of doctors, nurses, and health workers, other professional figures' support is essential for the health system to function. These include Community Health Workers, drivers, and local activists. Most are young men and women who do not necessarily have a health background but are equipped to bring health to the most remote communities.

For example, Nutrition Officers in Uganda who support the local population through information and awareness-raising on the proper nutrition for children.

NICOLA BERTI

FORUM

HUMAN RESOURCES IN HEALTH: A KEY ASSET AT RISK

Chronic underfunding, privatizing services, and political indifference, worsened by the pandemic wave of Covid-19, and the growing shortage of human resources: these are just a few of the problems that assailing health systems worldwide. This crisis in the shortfall of workers has more than one disruptive aspect, between massive hospital admissions, professional migrations, and growing inequality.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

Health systems in Italy and Africa are at a critical crossroads in their histories. Having come out of the Covid-19 epidemic depleted, they are chronically underfunded and are suffering from the privatization of services and political indifference. The most salient feature of this confused situation is the deep crisis in human resources: there are lack of health workers, the givers of care. This phenomenon is complicated due to the different levels of data availability, low adherence to international standards, and the application of different models for simulation and forecasting staff. Keeping all this in mind, let's consider some of the problem's crucial aspects.

STOCK

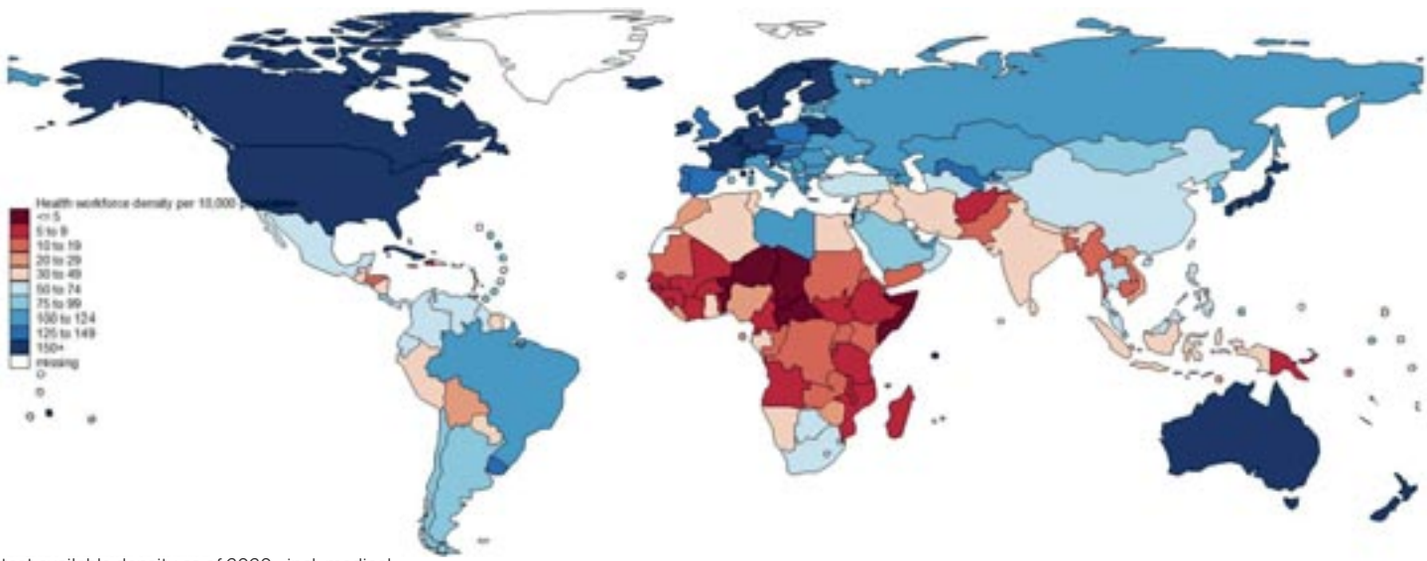
In 2020, the workforce stock employed in the health sector was 29.1 million nurses, 12.7 million doctors, 3.7 million pharmacists, 2.5 million dentists, 2.2 million midwives, and 14.9 million additional occupations, accounting for 65.1 million employed health workers. Since 2013, this stock has increased 29% globally.[1]

DISTRIBUTION

The global health workforce is distributed unequally. High-income countries have a health worker density per 100,000 people that is 6.5 times more than that of low-income countries (see **Figure 1**). Overall, about a fifth of the world population, the high-income part, absorbs 50% of available health workers.

Italy. According to the OECD's *Health at a Glance*, there is an average in Europe of 4 doctors and 8.3 nurses per 1,000 people. Italy is in keeping with the average in doctors but has a severe shortfall of nurses with 6.3 per 1,000, especially locally. The ratio between nurses and doctors is 1.2, one of the lowest in Europe.[2] In recent years, the number of staff with permanent contracts in the National Health Service has dropped precipitously.

FIGURE 1 / HEALTH WORKFORCE DENSITY PER 10,000 POPULATION IN 2020



* Latest available density as of 2020 - incl. medical doctors, nursing personnel, midwifery personnel, dentists, pharmacists

An analysis of the "National Health Service Staff" conducted by the National Agency for Regional Health Services shows a fluctuating trend.[3] On December 31, 2018, it was less than in 2012 by about 25,000 workers (41,400 less than in 2008). In 2020-2021, due in part to the effect of the Covid-19 epidemic, there was an increase in personnel, leading to the number of workers in service in 2021 comparable to that of 2012.

Sub-Saharan Africa. A recent WHO study of 47 countries in sub-Saharan Africa, there are an average of 1.55 qualified health professionals for every 1,000 people with high inequality between urban and rural areas. Fragile countries in conflict, like South Sudan, have an average density of 0.3 health workers per 1,000 people.[4] Seychelles, Mauritius, Namibia, and South Africa are the only countries with health worker densities above the minimum threshold of 4.45 x 1,000 population needed to meet the *Universal Health Coverage* goals.

2030 FORECASTS AND THE GAP

Given the current situation of health worker stock production, 2030 forecasts suggest a conservative growth rate of 2.7% annually (with a 0.9% growth in the world population) which would be an increase of 19 million net jobs, bringing the health workforce to 84 million workers. The gap, based on personnel needs determined by WHO,[5] would be around 10.2 million professionals, primarily nurses, which is large enough to be considered a "Global Health Emergency."[6] This number is likely an underestimate that only considers health personnel in the public sector. According to the *Burden of Diseases* study group, if the goal is to achieve 80% universal health coverage (UHC), the human resources gap would be much larger, closer to several dozens of millions of workers.[7]

Based on an analysis by CREA in **Italy**, to align with the other European countries, there is a shortfall of 30,000 doctors and 250,000 nurses.[8] Mountain areas, isolated villages, the most populous regions, and primary care suffer the greatest shortages, and the personnel crisis is most keenly felt in the hospitals. The most affected medical specialties are urgent-emergency medicine, anesthesia, pediatrics, internal medicine and surgery, and all the specialized diagnostic services.[9] The shortage is clear today in competitions with no applicants, the use of "pay-per-use doctors," voluntary resignations, and the closure of essential health services.

Sub-Saharan Africa. In 2030, considering rapid population growth and the shortage of workers, Africa could account for 52% of the global shortage (in 2013, it accounted for a third of it). Sixty-five percent of the workforce shortage would be in 55 countries, mostly in Africa, which WHO put on a red list for active international recruitment.[10] The shortage of nursing staff is especially acute. Some 5.78 million nurses are needed by 2030, but without additional investments and maintaining the current capacity for production and use, only 47% of the demand could be met. [11]

PROFESSIONAL MIGRATION MARKET FORCES, PERSONAL REASONS, AND THE PARADOX OF UNEMPLOYMENT

Aside from reasons related to the lack of or inadequate planning of health personnel (the gap between need and graduates, the turnover problem, the retirement wave, and so on), other major causes of the existing gap and professional migration are the work conditions and compensation. **In Italy**, according to CREA as well, the nursing profession has poor attractiveness. Only 1% of students choose this degree program compared to an average of 3% in other EU countries. Factors include low compensation (40% less than the average of northern European countries), inadequate university training, especially in terms of clinical specialization, stressful work paces, and very limited professional career opportunities. According to the OECD database, almost 180,000 Italian health professionals chose to work abroad between 2000 and 2022.[12] England, Switzerland, Germany, Spain, and Belgium are the countries most attractive to nurses. This phenomenon is partially offset by hiring foreign professionals, which accounted for about 6% of the entire workforce in 2018–19 with an upward trend.[13] Meanwhile, to cover the gaps in the workforce, all players, both public employers like the Regions (e.g. Sardinia, Emilia Romagna, Calabria, etc.), and private ones, such as health companies, the temporary employment companies, and cooperatives are increasingly actively recruiting doctors and nurses from non-European countries, such as Argentina, Brazil, Tunisia, Moldova, the Philippines, and India. The Ministry of Health seems to take the same approach. [14]

In Africa, though the production of health personnel has increased significantly based on developing a university network (with almost 200 universities) and training schools for health workers (2,300 nursing and midwifery schools), there is migration within and outside the continent. African health professionals migrate to countries in Africa with higher wages such as South Africa, Namibia, and Botswana. The gross annual salary of a nurse in Namibia is about USD 50,000 compared to an average in Africa of USD 10,000, and USD 2,196 in the Democratic Republic of Congo.[15] There is also emigration to Western countries (e.g. UK, USA, Australia, Canada, France, and Belgium) whose systems increasingly depend on employees from abroad. In the UK, one-sixth of health workers employed in the NHS have a foreign passport; 15,000 employees come from Nigeria alone.[16] According to a systematic review of low-income countries, covering the last 50 years, people emigrate or intend to do so not only for market reasons but increasingly for personal reasons such as safety, professional satisfaction, quality of life, and family reunification.[17]

Lastly, the paradox of unemployment in health care is noteworthy. In Kenya, there are 5,000 unemployed doctors, and thousands of unemployed nurses from Ethiopia, Ghana, the Democratic Republic of the Congo, Malawi, and even South Africa.[18] The issue is not, as incorrectly suggested, due to excess supply but to restrictive public policies. This supposed surplus

of personnel is tied to rigid budgetary policies, often imposed by financial entities (IMF, WB) that prevent the public administration from absorbing these resources despite the health systems' clear needs.[19]

FUTURE STRATEGIES

The correlation between human resources, actual coverage, and mortality has been long clear.[20] The WHO has made clear suggestions to avoid the collapse of health systems after the Covid-19 epidemic.[21] The mix of suggested actions includes investments in basic and continuing education based on the people's health needs; adequate fiscal, contractual and regulatory spaces for the recruitment and long-term stabilization of health personnel; monetary and other incentives to support allocating personnel to less accessible geographical areas; developing new care models based on task shifting, interprofessional teams, integrating local hospitals, moving to digitization and new technologies. It is still to be seen how much this structural reform agenda will be done by governments and should undergo careful public scrutiny.

Internationally, we need a stronger commitment from the Global North, multilateral agencies, and large funders to train the health workforce in low- and middle-income countries. Global initiatives are already underway, such as the *WHO Roadmap for Building the Public Health and Emergency Workforce, Community Health Workers Delivering Primary Health Care: Opportunities and Challenges*, and various efforts led by the countries that need support. The poaching of healthcare personnel abroad is unethical. The Global Code of Practice on the International Recruitment of Health Personnel is clear: we must take into account the rights, obligations, and expectations of source countries, destination countries, and migrant health personnel; it is essential to share decisions with local authorities and professional associations; we must recognize the reciprocity of interests and the commitment to concretely support the development of human resources, in the medium to long term in countries with low resources. This means truly helping people where they live.

NOTES

1 Boniol M, Kunjumen T, Nair TS, et al. The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage? BMJ Global Health 2022;7:e009316. doi:10.1136/bmjgh-2022-009316

2 OECD/European Union (2022), Health at a Glance: Europe 2022: State of Health in the EU Cycle, OECD Publishing, Paris, https://doi.org/10.1787/507433b0-en.

3 The National Health Service Staff studies, March 2023, National Agency for Regional Health Services https://www.agenas.gov.it/comunicazione/primo-piano/2147-il-personale-del-servizio-sanitario-nazionale

4 Ahmat A, Okoroafor SC, Kazanga I, et al. The health workforce status in the WHO African Region: findings of a cross-sectional study. BMJ Global Health 2022;7:e008317. doi:10.1136/bmjgh-2021-008317

5 WHO. Health workforce requirements for universal health coverage and the Sustainable Development Goals. (Human Resources for Health Observer, 17). https://apps.who.int/iris/ handle/10665/250330

6 Recover to rebuilt. The shortage of nurse is a global health emergency. International Council of Nurses, 2023

7 Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet 2022; 399: 2129–54

8 *Senza riforme e crescita, SSN sull'orlo della crisi*, 18th Health Report, CREA, 2023. According to most conservative estimates by the Court of Auditors and FNOPI, 65,000 nurses would be needed.

9 Medical Specialist Shortage Map, Region by Region Studio Anaao Assomed 2019.

10 WHO health workforce support and safeguards list 2023 8 March 2023, Technical document https://www.who.int/publications/i/item/9789240069787

11 The Nursing and Midwifery Workforce in the African Region: optimizing and accelerating investments for resilient health systems, WHO African Region, 2023

12 La grande fuga di medici e infermieri in Italia. *Quotidiano Sanità*, March 7, 2023.

13 *Operatori sanitari stranieri e COVID-19 nell'UE: gli 'invisibili' diventano 'visibili'?* Senyo Dotsey, Quaderni del CNEL -n. October 16, 2021

14 Schillaci: "Con il Pnrr soldi al personale, infermieri dall'India per i buchi in corsia", *Repubblica* June 2, 2023

15 Analysis of nursing and midwifery labour market outcomes, WHO African Region, 2023.

16 NHS staff from overseas: statistics https://commonslibrary.parliament.uk/research-briefings/cbp-7783/

17 Toyin-Thomas P, Ikhurionan P, Omoyibo EE, et al. Drivers of health workers' migration, intention to migrate and non-migration from low/middle-income countries, 1970-2022: a systematic review. BMJ Global Health 2023;8:e012338. doi:10.1136/ bmjgh-2023-012338

18 https://nation.africa/kenya/news/the-frustrations-of-kenya-s-jobless-doctors-4111842

19 Health worker unemployment in LMICs with shortage: a policy brief prepared for the 2nd review of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel, WHO, 2019

20 Speybroeck N, Kinfu Y, Dal Poz MR. Reassessing the relationship between human resources for health, intervention coverage and health outcomes. Geneva: World Health Organization, 2006.

21 Ticking time bomb: Without immediate action, health and care workforce gaps in the European Region could spell disaster, WHO Europe, 2022.

FORUM

YOUNG DOCTORS IN A SYSTEM IN CRISIS

The national health system is in a persistent crisis of facilities and personnel. It is urgent to act with planning policies that ensure adequate resources in terms of health personnel, which are pivotal to a system for health care that is fair, local, and focused on primary care, returning general medicine doctors to a central role.

TEXT BY / ANNALISA NAPOLI / PHYSICIAN AND PRESIDENT OF THE ITALIAN SECRETARIAT OF YOUNG DOCTORS

FRAGILE HEALTH CARE

Worlds and contexts that may seem light years apart share a common denominator though expressed in different forms and formulas: the central role of human resources. The fragility of health systems is known to be closely connected to the shortage of workers, their training, and the adequate development of networks and effective allocating of resources within them. Both in developing countries and in Italy, it is *people* who truly make the difference, providing care and support to individuals and populations. It is people who do research to study causes and evaluate interventions. They dialogue with the communities to ensure continuity between emergency and development that is more *resilient* than ever, even under the impact of change.
The debate currently underway in this historical period no less complex than during the pandemic is focused primarily on two closely linked factors: the worsening crisis of the Italian National Health Service – which is intended to be public, equal, and universal by definition – and the increasingly urgent need to adopt planning policies that bring in adequate resources for health personnel, the pivotal strength of the system.

REORGANIZING THE NATIONAL HEALTH SYSTEM

A post-emergency follow-up is needed to reorganize and put the system into motion after years of no or scant far-sighted planning. This cannot fail to consider the new, growing health needs of the people, which became more starkly evident during the pandemic, in order to study and correct the factors at the basis of the National Health Service's chronic problems.
Italy's new health needs should be understood and assessed in the wider, more complex landscape of the changed and still shifting national social-health situation.
There has long been a progressive increase in life expectancy coupled with a rise in chronic disease and multi-morbidities.
Increasing the number of resources to be used – structural resources and, importantly, human resources – should be joined with a qualitative reassessment of the entire health system.
A few important steps have been taken towards reforming the specialist medical system, which is one of the most critical areas, moving in the direction of greater investment in resources. For several years, because of the allocation of significant resources both to funding specialist training contracts and scholarships in general medicine, the "training bottleneck" had been loosened. It had been holding back thousands of young doctors who were unable to access post-degree training.

THE CORE IMPORTANCE OF TRAINING

An additional effort in terms of planning has been made recently to evaluate and define the National Health Service's quantitative and qualitative needs in terms of professionals.
There are still unresolved critical issues in university training. True, adequate reform has yet to be made to the pre- and post-degree training system. It still stops short at emergency provisions to make up for shortages by adding medical residents starting from the early years of the program. Training should be rethought and recalibrated to fit the changed health contexts, protecting its value and quality, and correcting its inadequacies and existing problems. The attractiveness of the public health service must be boosted, especially for its branches that have been most gutted by the flight of health personnel, both to the private sector and abroad. This siphoning-off has become a now chronic symptom of the structural inadequacy that has seen the main sacrifice in the emergency and urgent care sector, It is clear from the early stage of entering into specialization programs, as a result of poor protections, little incentives, and episodes of aggression having become frequent.

NEW DOCTORS AND REFORMS FOR LOCAL HEALTHCARE

Comparable problems persist in the specific training in general medicine. Considerable effort has been made by the institutions and the regions, including using funds made available by the Recovery Plan, to increase the number of scholarships to make up for the shortfalls caused by the wave of retirements already underway. Local health is facing yet another trial. This is also a problem of numbers, and increasingly so. The critical factor of personnel is closely tied to creating community homes and ap-

plying and implementing new models of local health care, as per the Ministerial Decree 77. The number of family doctors is dropping at an alarming rate. This problem is now clear in all regions and the numbers are significant. There is a shortage of almost 2,900 family doctors and another 3,400 will be lost by 2025. Retirement waves, uneven, fluctuating generational handovers, the profession's low attractiveness, planning failures, and the growing complexity of health needs and work management.

Critical problems that have been clear for years emerged dramatically during the pandemic, which exposed the fault lines in local care and the need to reform planning, which cannot be put off any longer. The Recovery Plan, and the accompanying Ministerial Decree 77/2022, require institutions to take tangible action in this direction. Yet, this change is still a considerable way from being implemented, even though a substantial part of the Recovery Plan's resources is devoted to developing a network of local services.

Based on the definition of the Mission 6 Health Plan, Community Houses, and Community Hospitals make up the "places of care" in charge of health care close to home, based on a multidisciplinary approach that includes social aspects and social-health integration. The hope is that they will be a model that is not merely structural and can truly respond to the growing health needs of the people in the context of a health service where there is an increasing number of chronic diseases, a shortage of personnel, and poor integration between hospitals and the local area with a resulting overburdening of the emergency rooms. The Community Houses project involves a total reform of the local health service starting from training doctors in general medicine.

It takes at least ten years to train a family doctor with a quality training program focused on a core curriculum that is consistent throughout the country. It is to consider specific skills needed, including digital ones, which is a central aspect of the Reform Plan.

Local medicine is needed to meet patient needs, focusing on the daily practice of promoting health care and nearby medicine, close to patients and their worlds, including in family and social terms. It needs to shift from a hospital-centric model to a proactive, interdisciplinary care model that pivots on primary care with the general medical doctor in the role of director.

It is fundamental that the generational handover underway become a chance to move beyond old systems and build new ones through an ongoing dialogue between health professionals and institutions, protecting the public health service, and, importantly, the right to health as guaranteed by article 32 of the Italian constitution, to be made central to any analysis of health and the political and health care agenda.

BIBLIOGRAPHY

https://www.saluteinternazionale.info/2023/06/in-difesa-del-ssn-e-del-welfare-territoriale/

FORUM

"PREPARING FOR DISASTER SAVES LIVES"

Africa is facing a series of significant challenges including demographic, economic, socio-political, and climate changes. Africa needs to take on this complicated situation through a process that centers on training professional health workers, to build resilient communities and health systems to respond to the disasters caused by environmental risks and human causes.

TEXT BY / VALENTINA ISIDORIS, ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

A COMPLICATED SITUATION

In the last twenty years, Africa has been going through a series of demographic, economic, and socio-political changes that make the situation in its countries so unstable that it is difficult to ensure the people the security and public services of primary importance.[1] Increasingly frequent environmental disasters are added to the situation. Though Africa as a continent contributes only 3% to global emissions, it is the area most exposed to the negative effects of climate change.[2] According to the report *"State of the Climate in Africa 2021"*, climate change in Africa is reflected in a constant increase in temperature and increasing natural disasters:[3] heavy rains, floods, tropical cyclones, droughts, fires, and heat waves are among the disasters that are cyclically affecting African regions, obstructing positive development and creating thousands of "climate refugees."[4] In places like the Horn of Africa and certain provinces in Angola, extreme drought has reached critical levels and the people have been forced to flee to neighboring countries due to hunger and the lack of water sources.

Another problem that Africa is facing is the spread of conflicts and political violence, worsening the situation of already fragile countries. For example, the conflict in Ethiopia has been defined as one of the "deadliest in 2022" which has led to over 600,000 civilian deaths and 2 million displaced people in the Tigray and surrounding regions.[5] The very recent conflict between Sudan's top military leaders plunged the already beleaguered country into chaos yet again, forcing more than 2 million people to flee.

The situation is made even more dire because many African countries have to face more than one of these crises at the same time. For example, Mozambique was struck in 2019 by two tropical cyclones (Idai and Kenneth), and since 2020 has been undergoing a severe humanitarian crisis in the Capo Delgado area, where "internal displaced people" have fled Islamic terrorism.

PREPAREDNESS SAVES LIVES

In a complex situation like that in Africa, health personnel play an essential role in building resilient communities and health systems to respond to the disasters caused by environmental risks and human causes.[6] This is why all health professionals must be suitably prepared and equipped to work effectively during emergencies, especially in limited-resource settings.

Recent studies, however, show how the long-standing shortage of human resources in many African countries and inadequate training capacities are still serious obstacles to the growth and development of health personnel in response to the needs of the people, including during emergencies, due to delays and complications in both response and recovery phases.[7][8]

This is despite the people's desire to be trained and improve their education.[9][10] CUAMM has seen this directly in the countries afflicted by emergencies, both in the spontaneous mobilization of health workers and others, including community health workers and young activists eager to be helpful during an emergency. In Mozambique, after Cyclone Idai passed, it took just a few days to form teams of volunteers working to respond to the most pressing needs, such as wound care and educating the people about the risk of epidemics, using human resources already on site and involved in community programs for HIV prevention and care.[11]

From experience gained in the field and from the evidence seen on a global scale, there is an increasingly clear need for preparation to manage crisis situations, especially in low-resource settings like in Africa. this process needs to center on training of health professionals and their preparedness to manage crises within the health units and to integrate their work with community-level responses.[6]

JUST IN TIME IN LOW RESOURCE SETTINGS

Starting from these considerations, *"Just in Time in Low Resource Settings"*[12] was launched, a training developed by Doctors with Africa CUAMM with the Research Center in Emergency and Disaster Medicine (CRIMEDIM) of the University of Piedmont "Orientale."[13] Organized in accessible online modules on an e-learning platform, the course was created with the goal of training participants in the basic principles of disaster medicine and public health emergencies and to teach standard operating procedures before (preparedness), during (response), and after (mitigation) a disaster.

The course is currently offered in sub-Saharan African countries. Its intended targets have responded with immediate interest.

From March to May 2023, more than 500 people completed all the modules of the training and passed the final test, earning a digital participation certificate. The data collected about the types of professions of those who registered is interesting: 31% are doctors, followed by nurses (13%) and students of medicine and health professions (12%). The remaining 44% are from other professional categories involved in the local health system including public health experts, environmental health officers, humanitarian activists and coordinators, nutritionists, community health officers, clinical officers, and risk communication officers. It is noteworthy that the course attracted the interest not only of those working in health but also of other professionals who work in close contact with countries' communities and health systems.

Though the course originated as an experiment, it had considerable success, confirming the high interest in emergency management and the importance of training at the basis of CUAMM's training plan. Ninety-eight percent of those who answered the evaluation questionnaire felt that *"Just in Time in Low Resource Settings"* was interesting and useful for their educational and working background.

BUILDING FOUNDATIONS FOR RESILIENT SYSTEMS

Starting from the needs of a local area, responding to the needs of the people, and trying together to find the best responses that lead to concrete solutions – this is the approach that Doctors with Africa CUAMM would like to maintain in the realm of emergency management, starting from the continued development of training African professionals.

According to the WHO 2030 Agenda for human resources employed in the health sector, giving more resources and energy to training health Professionals would reduce risks to the health of the most vulnerable groups and improve the confidence of health workers to respond effectively to disasters: from being able to come "prepared" and quickly respond to a crisis as it happens, to the capacity to absorb the crisis, adapt, and change.[6]

In order to achieve this, investments must be made in quality, long-term training that can be easily accessed in online/offline modes, and which can adapt to the African context to bolster the skills of professionals and the local communities in order to build the foundations for rapid, efficient, and immediate responses to emergencies.[14]

To these ends, CUAMM will continue to focus its efforts on working in the field and strengthening the ability to adapt so that at the end of an emergency, the lessons learned solidify and lead to creating resilient communities and health systems.

NOTES

1 World Bank, *What is a fragile state?*, 2015 https://blogs.worldbank.org/developmenttalk/what-fragile-state
2 IPCC, *Climate Change 2022: Impacts, Adaptation and Vulnerability*, 2022 https://www.ipcc.ch/report/ar6/wg2/downloads/report/IPCC_AR6_WGII_FullReport.pdf
3 WMO, *State of the Climate in Africa*, 2021 https://public.wmo.int/en/our-mandate/climate/wmo-statement-state-of-global-climate/Africa
4 UNHCR, *Climate change and disaster displacement*, https://www.unhcr.org/what-we-do/build-better-futures/environment-disasters-and-climate-change/climate-change-and
5 International Crisis Group, *Crisis Watch Digest Ethiopia, War in Sudan*, 2023 https://www.crisisgroup.org/
6 WHO, *Global strategy on human resources for health: Workforce 2030*, https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf
7 The Lancet, *Human resources for health-investing in action*, 2016 https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30246-X.pdf
8 IFRC, *World Disasters Report 2020*, https://www.ifrc.org/document/world-disasters-report-2020
9 NCBI, *Knowledge of and Attitude Toward Disaster Preparedness Among Secondary School Students in the Western Region of Saudi Arabia*, 2023 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9937084/
10 BMC Emergency Medicine, *Emergency and disaster management training; knowledge and attitude of Yemeni health professionals- a cross-sectional study*, 2018 https://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-018-0174-5
11 The Lancet HIV, *HIV continuity of care after Cyclone Idai in Mozambique, 2020* https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30045-X/fulltext
12 Doctors with Africa CUAMM: https://doctorswithafrica.org/en/whats-new/news/just-in-time-in-low-resource-settings/
13 CRIMEDIM: https://crimedim.uniupo.it/
14 NCBI, *Nurses in Disaster Preparedness and Public Health Emergency Response*, https://www.ncbi.nlm.nih.gov/books/NBK573904/

EXPERIENCES FROM THE FIELD

HUMAN RESOURCES IN HEALTH: THE CASE OF TANZANIA

In sub-Saharan Africa, the shortage of doctors and health workers is a major problem, converging with fragile health systems and the scarcity of economic resources and trained personnel. The case of Tanzania offers a snapshot of the complexity of these issues, including results achieved and ongoing challenges.

TEXT BY / PAOLO BELARDI / DOCTORS WITH AFRICA CUAMM

SUB-SAHARAN AFRICA WITHOUT HEALTH PERSONNEL

Forecasts for 2030 about the shortage of health personnel speak loud and clear: they estimate a shortage of 10.2 million professionals, nurses first and foremost, to close the existing gap between personnel needs, as determined by WHO and their actual availability. This fact is even more dire in Africa which has 24% of the global disease burden with only 3% of the global health human resources. Africa alone has 36 of the 57 countries in the world that suffer from this shortage. Why is this? Rapid demographic growth, "brain drain" to higher income countries, and inadequate number of trained personnel yearly, and uneven distribution geographically, due to internal migration from rural to urban areas.

THE CASE OF TANZANIA

Tanzania lacks human resources in health care because of the low number trained professionals, difficulty in retaining qualified personnel, and inequitable distribution of resources. While 75% of the population resides in rural areas, only 55% of the nursing staff and 31% of the medical staff work in those areas. Significantly, one of the causes of the loss of human resources in health is due to transfers to other countries is because the health system's scarce capacity to absorb them.

Due to 1990s reforms in the country, a policy was adopted that decentralized the health system, giving more autonomy to the districts, including in managing human resources. This has led to increased demand for health professionals on a district level, which was partly met by accrediting private training institutions and making greater investments in public institutions. Up in the late 1990s, *Muhimbili University* (Dar es Salaam) could enroll 50 future doctors per year; in 2010, 200 enrolled/year.

TRAINING AND RECRUITMENT OF HUMAN RESOURCES

In the area of training, the efforts made and goals achieved are undeniable but they have not translated in improved recruiting; in 2012, there were 0.3 doctors, nurses, and midwives per every 1,000 inhabitants as opposed to the 2.28 per 1,000 recommended internationally. In this situation, the lack of expertise in managing and planning human resources has played a critical role. Another major obstacle has been the complex, costly, and overly bureaucratic recruitment system. The Ministry of the Economy and Finance approves the annual budget for vacancies for health personnel without taking district assessments into account. This means that every year the number of vacancies is lower than actual needs and the number of doctors graduated. We also see the brain drain issue on the one hand the shifting of resources to the private sector on the other. Since 2006, the government has established a system to connect training institutions with health facilities, founding its Human Resources for Health Information System (HRHIS).

IMPROVING PROCESSES BEYOND THE CHALLENGES

These challenges are exemplified in an analysis of the distribution of human resources in the field of maternal childbirth care. The most recent national survey shows that three-fourths of Tanzania's health facilities provide care for physiological childbirth and at 11% delivery by Cesarean section is possible. However, only 28% of the facilities that provide physiological childbirth care have a *provider on call* 24/24 and only 30% of these have *Basic Emergency Obstetric Care (BEmONC) or Comprehensive Emergency Obstetric Care (CEmOC)* guidelines. Eighty-seven percent of these facilities have a complete birthing kit, which drops for those working in dispensaries.

The issue of training, managing, and planning human resources is key for health system performance at all levels. This is why Doctors with Africa CUAMM has also launched in Tanzania the phase of the "Mothers and Children First" program called "People and Skills". The program shows the ineluctable need to work systematically and with an integrated approach to people in all the professional and training steps that involve them, in order to build virtuous processes and long-term changes that will benefit the entire health system.

EXPERIENCES FROM THE FIELD

"BOMA HEALTH INITIATIVE" IN SOUTH SUDAN

The objective of the *Boma Health Initiative*: create a community health system to face the care and health needs of a fragile country without resources like South Sudan. Its implementation has moved forward through structural problems and future prospects to work towards, always centered on human resources – *the Boma Health Workers*.

TEXT BY / CHIARA SCANAGATTA / DOCTORS WITH AFRICA CUAMM

A HEALTH SYSTEM TO STRENGTHEN

South Sudan has one of the highest rates of maternal mortality in the world (789/100,000 live births), far above the maximum set as a sustainable development goal for 2030 (140/100,000). It is also one of the 12 countries with neonatal mortality above 30/1000 live births[1]. It lacks a health facility network able to provide emergency obstetric care. The government does not have the resources to make up for those shortfalls. It depends completely on its international partners, whose interventions, however, are often uncoordinated and limited in time and space, primarily for emergencies and lacking a planning vision.

Interventions of these kinds are particularly ill-suited to make up for the shortage of dedicated, prepared human resources. Only 15% of women give birth in the presence of qualified personnel with an average of 3.5 health professionals (doctors, nurses, and midwives) for every 10,000 population. South Sudan has little chance of reaching the ratio goal of 23 by 2030[2], lacking long-term investments in professional training. The few qualified personnel are concentrated in the capital, preferring jobs in the private sector. Those who work in the rural government facilities lack skills and knowledge and are often little incentivized, underpaid, and not very present. This all has consequences on the services, which are discontinuous and deficient, and on-demand for them. The people are reluctant and discouraged from going to the health units and centers, which are often closed and do not meet patients' needs.

During the war years, with health care limited to the humanitarian sphere, NGOs trained different kinds of community health workers through very "hands-on" training courses. they then became the system's main workforce and also staffed health units and centers and sometimes hospitals. The South Sudanese Ministry of Health has begun to address the problem by aiming to replace community health workers with qualified personnel at the health facility level. The Ministry has abolished training courses, focusing on Health Sciences Institutes and qualifying courses of study, such as the diploma in midwifery or nursing. In addition, its human resource policy launched in 2019 limited these figures' presence in standard teams by level of care and disincentivized them by offering significantly lower compensation than in the past. It also set up an alternative placement for them within the system, creating a new policy for forming a community health system.

BOMA HEALTH INITIATIVE: FOR A COMMUNITY HEALTH SYSTEM

Creating a community health system is considered a key step to promoting access to basic health services by involving the people in supporting health starting on the family and village levels, or the BOMA, South Sudan's smallest administrative unit. This system's operational branch are the *Boma Health Workers*, paid village health workers, responsible for diagnosing and treating uncomplicated malaria/diarrhea/pneumonia in children under 5, educating the public about major health and nutritional issues, identifying and referring pregnant women and children under 2 who are not immunized or who have not yet completed the vaccination cycle. It was suggested that natural candidates for this role are those who, at the time of the policy's publication, were community health workers at government health facilities and hospitals or for one of the many NGOs in the country.

The Boma Health Initiative was launched as a way to reduce the gap between the population and basic preventive and treatment services, streamline access to health facilities, improve the quality of the care provided by the formal health system, encourage the replacement of auxiliary/unqualified personnel with professionals, ensure the acceptability of proposed reforms in formal health services, and bring all the community figures in the area under the aegis of the Ministry.

Reaching these objectives is proving more difficult and complex than imagined. Among the causes are the long time it takes to develop a sufficiently qualified workforce to replace the widespread presence of the formal health network of Community Health Workers and the high costs of implementing the *Boma Health Initiative* on a national scale, with resulting difficulties for the *Boma Health Workers* to give adequate coverage, poor levels of regulation, and a wide margin of action left to traditional figures. Additionally, when the B*oma Health Workers*

were chosen, the Community Health Workers were still supporting the work of health facilities and hospitals, which meant that Boma Health Workers were chosen from the area's population without previous experience and lacking any basic training with enormous gaps in training and skills. This is a still significant weak point considering the complexity and many-faceted nature of the tasks given them and that *Boma Health Workers* are involved in every new initiative concerning the health sector.

CONTINUITY OF CARE AND TRAINING

Since the *Boma Health Initiative* was launched, there has been a notable, ongoing decline in outpatient visits at peripheral health facilities. This might mean that the Boma Health Workers are successfully serving as filters for the patient flow to the health units and centers and/or that their efforts on the side of health education are promoting good habits to reduce the incidence of the most common childhood diseases. However, there is a question of whether *Boma Health Workers* are intercepting the same people who, without them, would have come to the health facilities, still leaving the most remote areas uncovered.

Furthermore, the funding of the *Boma Health Initiative* itself has taken resources from the health system, with 25% of the governmental facilities and all the state hospitals no longer receiving any external support since 2022, meaning they can no longer ensure continuous operation.

South Sudan's government has focused a great deal on the *Boma Health Initiative*. It can be considered one of the components of the health system. It might prove useful to improving the health of the population if only in terms of continuity of care between several levels, if supported by substantial investments including in training qualified health personnel, for whom the *Boma Health Workers* are meant to complement, not replace.

Boma Health Workers need to be trained and adequately supported to do the work assigned to them and avoid constant turnover and loss of experience, acquired knowledge, and relationships with the people. Their task must be commensurate with their skills, their number, the areas to be covered, and any increase in their duties must be balanced by a proportional increase in support.

NOTES

1 The sections refer to the Reproductive Health Policy 2020-2030 and the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH and N) Strategic Plan 2020-2024 of the South Sudanese Ministry of Health

2 Comprehensive Report and A Strategy for the Tracking, Deployment, and Retention of Human Resources for Health, with a specific focus on mapping those trained under the Strengthening Midwifery Services (SMSII Project), Ministry of Health, Government of South Sudan, Canada and Sweden cooperation, UNFPA (June 2018)

DESTINATION: CARE

From the villages and the most remote parts of Sierra Leone – where there are often a lack of infrastructure and basic connections – to the places of care. This is one of the pathways to health in sub-Saharan Africa.

Drivers and workers often use makeshift vehicles to bring patients to hospitals and clinics to receive care. This essential contribution is made by those who can offer better access and coverage for primary care at the furthest outposts.

NICOLA BERTI

REVIEW

ITALIAN JPO RESIDENTS IN AFRICA

Six months of specialization in Sub-Saharan Africa with the JPO Junior Project Officer project. This professional and personal training experience inspires new perspectives on global health, as shown by a survey given to the residents involved over the years.

TEXT BY / CHIARA DI BENEDETTO / DOCTORS WITH AFRICA CUAMM

A GROWING PROJECT

For over 20 years, the JPO – Junior Project Officer project, supported by Doctors with Africa CUAMM, has involved residents specializing in medicine from Italian universities in a training period in the sub-Saharan African countries where CUAMM is active.
It involves months of clinical practice, training, and research in the field where young doctors come face to face with very different worlds from where they are used to working. Structural problems, lack of resources, and social and cultural difficulties are among some of the challenges to be managed during this experience.

Between 2002 and 2020, over 240 residents participated in the project, with a constant growth of applications received and departures; in the first five years of the project, there were seven applications and four departures, which now have grown to 56 applications received and 27 departures in the project's last five years. Out of the 43 faculties of medicine in Italy, 37 have been involved in the JPO project and sent residents. In many instances, they also activated partnership agreements with Doctors with Africa CUAMM, showing the need for internationalization and openness towards low-resource countries.
There are two special qualities of the JPO project compared to similar programs: its six-month duration, which lets residents adapt to the setting and come into real contact with the issues of global health; that it takes place in countries where the relationships between institutions and health worlds are well-established. These factors allow for a well-organized approach, situated in specific settings with collaborations between all those involved.

EVALUATING EXPERIENCES

In March 2023, the BMC Medical Education published the article "International medical electives in Sub-Saharan Africa: experiences from a 19-year NGO-driven initiative"[1], reporting the results of an assessment survey of young residents in the JPO project, with 65% of the responses collected, primarily from residents who went between 2016 and 2020. Most of the questionnaires (54%) were completed by residents who went as JPO in the last five years of the study's period, with a prevalence of women and residents in pediatrics, public health, and internal medicine. The hospitals of Wolisso, Tosamaganga, and Beira were those that hosted the most residents.

The results of the survey give an interesting snapshot of the project and highlight some partly predictable aspects, including for Italian residents, there are many challenges in training and practicing in the African context in practical, psychological, and cultural terms; the personal and professional growth they gain from it is reported as significant (93% and 80% of the respondents gave these responses, respectively) and often have tangible effects on their professional futures.

Of the respondents, 27% said that the JPO experience had an impact on their career choices: an additional period spent in a medical setting in Africa (29%), the intention to have similar experiences in low-income countries (33%), and still active contact with the African setting (50%) and Doctors with Africa CUAMM (91%). Additionally, they reported acquiring greater autonomy (79%) and resilience in adapting to and managing complex situations (77%).

Naturally, difficult aspects of the experience in Africa also emerged: about 64% noted problems related to the lack of equipment – from devices to medicine – and different ways of working (57%) and exposure to situations for which they did not feel technically prepared (56%) or psychologically prepared (39%). In addition, many of the residents received or perceived medium-low recognition of the JPO experience by their home universities, which is an important point to explore further.
Generally, the JPO project was a significant part of the space for growth in innovative medical training aware of global health issues. Mainstream medical training is almost exclusively focused on clinical aspects with a local range of action. In our times, we need a broader vision and complex tools, a multidisciplinary approach oriented to global health as a practice and as a goal.

NOTES

1 Quaglio et al., International medical electives in Sub-Saharan Africa: experiences from a 19-year NGO-driven initiative, in BMC Medical Education, March 2023.

REVIEW

HEALTH WITHOUT NURSES

They are too few in number, put under too much pressure, and given too little social and economic recognition of their profession's value. Nurses are the pillars of people's health and care and they are in a dire situation. Improving it means giving new strength to health systems and helping build universal health coverage.

TEXT BY / CHIARA DI BENEDETTO / DOCTORS WITH AFRICA CUAMM

NURSES: AN ESSENTIAL RESOURCE

May 12, 2023, was International Nurses Day and a chance to consider the situation of nursing care – with its many, persistent critical areas and its future prospects.
The world's nursing personnel includes 27.9 million professionals, about 59% of health workers. They are significant both in numbers and qualitatively, considering their role in care and health in hospitals, long-term care facilities, and in the community. This is true both in ordinary and extraordinary situations, such as during the Covid 19 pandemic where nurses made the difference in varied settings. These ranged from managing mobile clinics in Botswana to reach rural areas and intensive care to their support in the research and development of vaccines and drug therapies in the United Kingdom.
This went beyond the rhetoric about "hero nurses" that never translated into better protections and guarantees – increased salaries, better contractual conditions, logistical and psychological support, training – nor a recognition of the scientific and management contribution they make to the health system.

SNAPSHOT OF A CRISIS

In 2020, WHO warned that there was a shortfall of 5.9 million nurses worldwide, almost a quarter of the current workforce, which is 28 million people. The greatest shortage was in the lower-middle income areas of Africa, Latin America, Southeast Asia, and the Eastern Mediterranean. This shortage seems set to grow due to the increase in demand, mass resignations, and low replacement rates. In Italy alone, there is a shortage of 65,000 nurses with a ratio of 1.6 nurses per doctor as opposed to 3 as suggested by international standards.
Many studies have given a snapshot of the group's professional and personal challenges. an article in *The Lancet Regional Health Western Pacific* reported a shortfall of nearly 140,000 nurses in China, showing that 34% of them considered themselves to be burned out and 56% showed symptoms of depression during the pandemic. A 2022 survey in Belgium showed that 44% of nurses would like to leave their jobs. Around the world, nurses have gone on strike against low wages and unsafe working conditions, with a great variety of outcomes: from improved agreements achieved in Germany to a ban on strikes by health workers in Zimbabwe.

FUTURE PROSPECTS

The year 2020 was the *International Year of the Nurse and the Midwife*, marking the 200th anniversary of the birth of Florence Nightingale, a pioneer of modern nursing care, to highlight the importance of the role of nursing staff.
For the occasion, WHO, ICN (International Council of Nurses), and Nursing Now published the State of Nursing in the World Report including general guidelines to address the shortage of nursing staff and how to proceed in the future. Some of these suggestions specifically stress:

- The need to invest in high-level nurse training, responding to the global and local health needs, in step with technological innovation and able to understand current health and social needs;
- The goal of training at least 6 million new nurses by 2030, especially in middle- and low-income countries to make up for the shortages and make the local health systems more resilient. This includes the goal of rebalancing the migration flows that transfer nurses from developing countries to high-income countries with health systems that can absorb them;
- Enhancing the role and involvement of nurses on the decision-making, policy-making, and scientific levels, recognizing the skills and work in the field of these health professionals.

BIBLIOGRAPHY

1 State of the world's nursing - 2020
https://www.who.int/publications/i/item/9789240003279
2 Health at a glance - 2022
https://www.oecd.org/health/health-at-a-glance-europe/
3 The Future of Nursing: lessons from a Pandemic
Lancet, 2023; 401:1545 (May 13, 2023)
4 Financial Times
https://www.ft.com/content/402df6ca-5098-40ca-9cc8-bae331c39398
Jamie Smyth in New York and Sarah Neville in London JUNE 2 2022
5 Sanità 24 – *Il Sole 24 Ore*, December 8, 2022, edited by FNOPI
https://www.sanita24.ilsole24ore.com/art/europa-e-mondo/2022-12-08/ocse-2022-ruolo-chiave-infermieri-nell-assistenza-ma-sono-pochi-e-pandemia-ha-aggravato-carenze-italia-coda-classifica-38-paesi-ocse-numero-organici-retribuzioni-e-formazione-151252.php?uuid=AE539cNC

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:
  - 21 hospitals;
  - 95 local districts (with activities focused on public health, maternal and infant health care, training, and the fight against HIV/AIDS, tuberculosis and malaria);
  - 761 health facilities;
  - 4 nursing schools (in Lui, South Sudan; Matany, Uganda; and Wolisso, Ethiopia);
  - 1 university (in Beira, Mozambique);
- **3,459 health workers**, including 256 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
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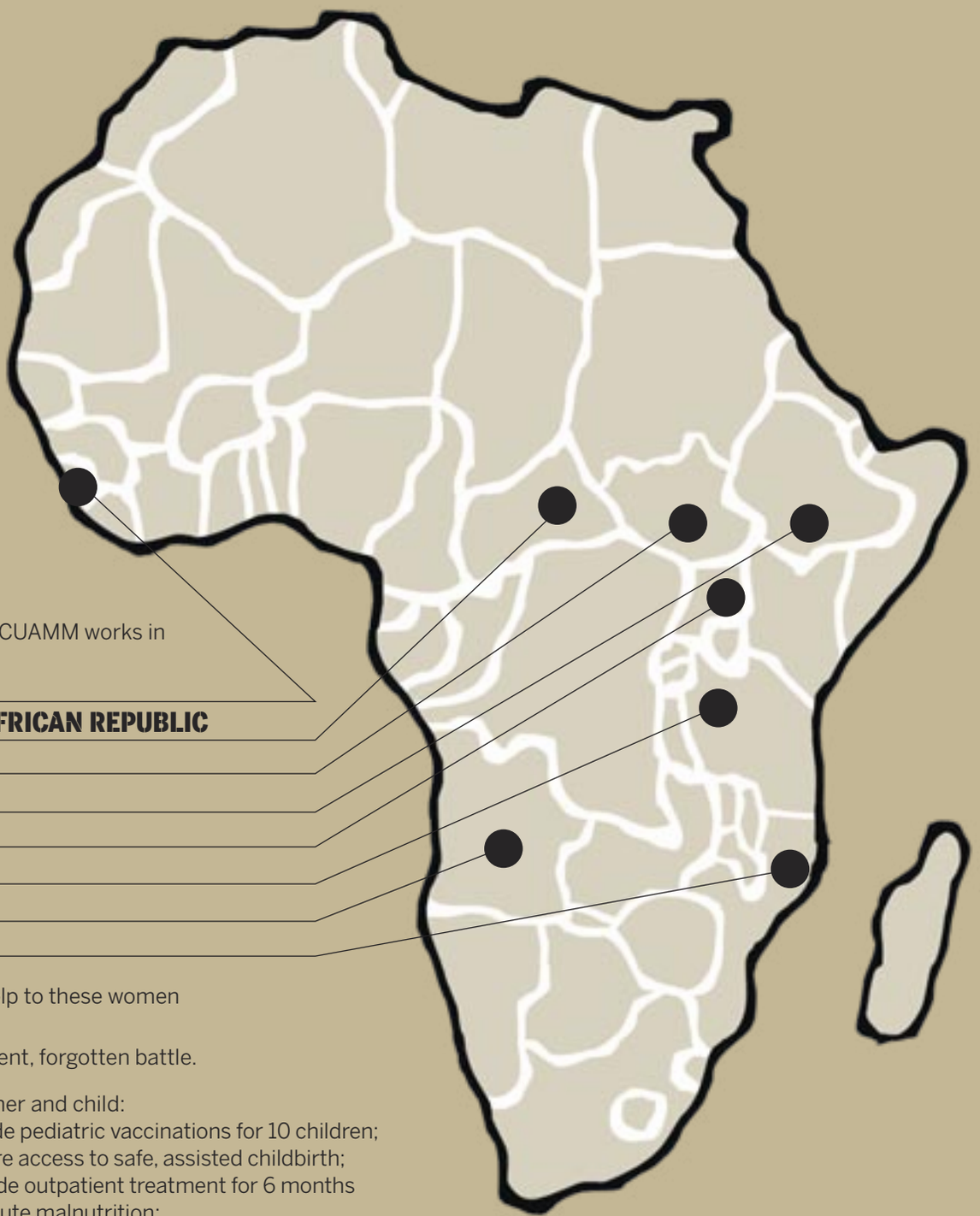
AFRICA'S NEEDS

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.

Help care for a mother and child:

- 10 euros to provide pediatric vaccinations for 10 children;
- 40 euros to ensure access to safe, assisted childbirth;
- 60 euros to provide outpatient treatment for 6 months for a child with acute malnutrition;
- 80 euros to support a professional training course for a midwife
- 100 euros to support a professional training course for a local doctor (continuous training)

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"We so often hear them called human capital, but at CUAMM we prefer to call them just 'people.' It's people who have always made the difference and in whom we will keep on investing in Italy and Africa alike."

don Dante Carraro