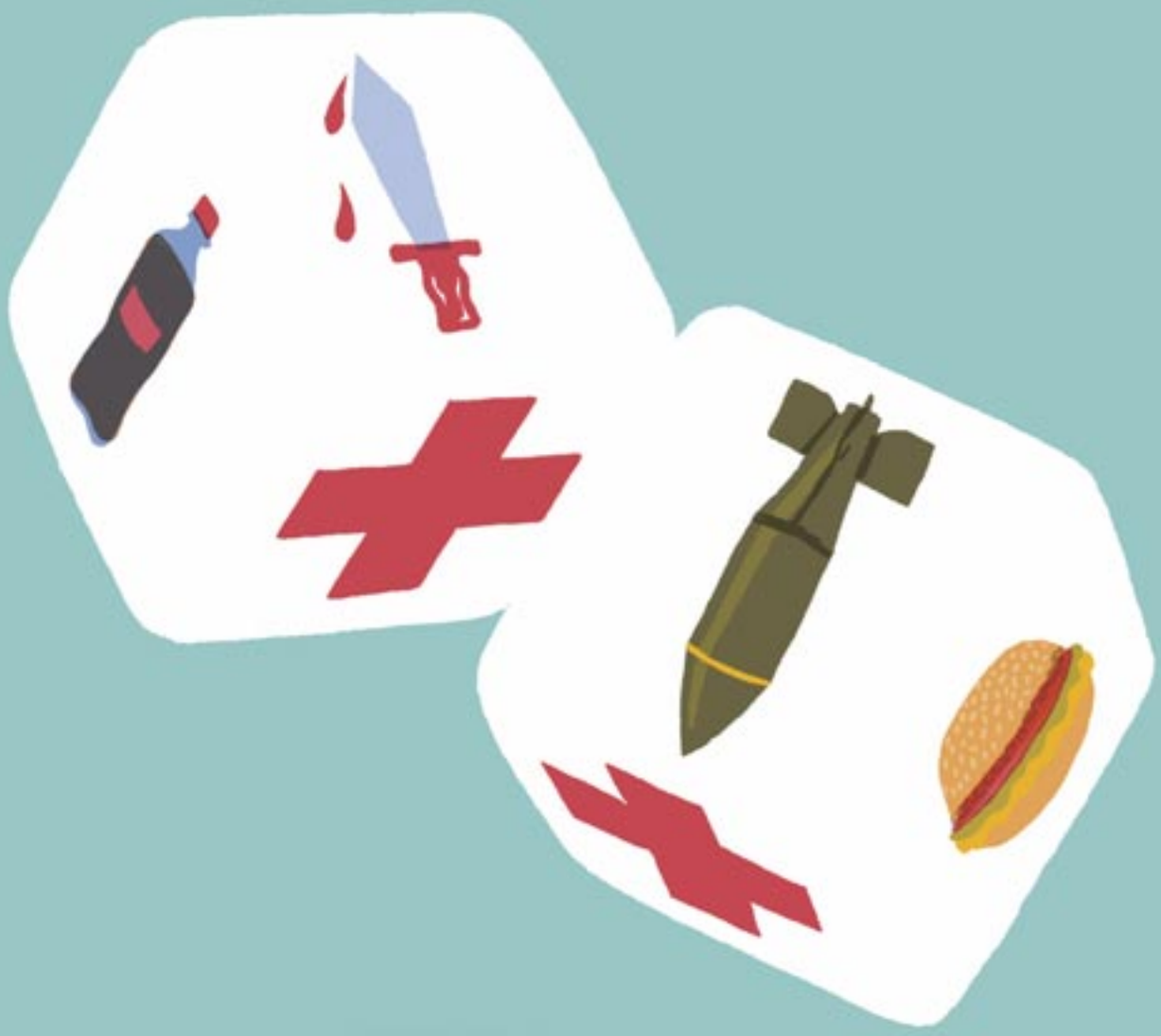
MEDICI CON L'AFRICA
CUAMM
Doctors with Africa

HEALTH AND DEVELOPMENT

Magazine on
International Development
and Health Policy
February 2024 — No. **88**

Health in the Balance

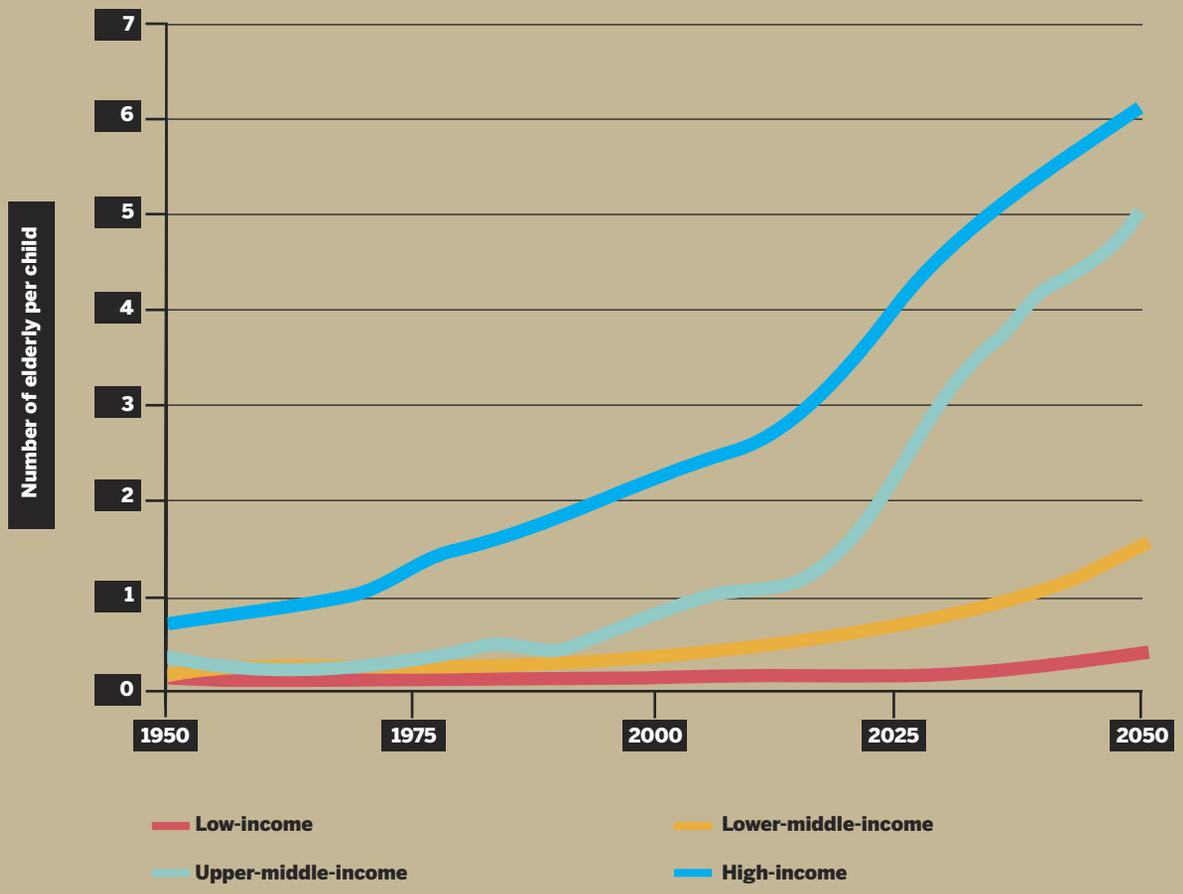


NEWS

Higher-income countries are aging rapidly, while lower-income countries are still young.

The world as a whole is aging rapidly. Globally, there are already more people over the age of 65 than children under the age of 5. By 2050, there will be twice as many people over 65 as children under 5, and the number will surpass young people between 15 and 24.

FIGURE 1 / NUMBER OF ELDERLY (65 YEARS AND OLDER) PER CHILD (UNDER 5 YEARS) BY COUNTRY INCOME GROUPS, 1950-2050



Source: World Bank 2023. *World Development Report 2023: Migrants, Refugees, and Societies*. Washington, DC: World Bank. WDR 2023 team calculations, based on the medium fertility scenario of World Population Prospects 2022 applied to country income groups. (From Neodemos)

EDITOR

Gavino Maciocco

EDITORIAL STAFF

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

EDITOR-IN-CHIEF

Anna Talami

A PUBLICATION OF

Doctors with Africa CUAMM

ADMINISTRATION

Via S. Francesco, 126 - 35121 Padua
t +39 049 8751279-8751649
f +39 049 8754738
e-mail cuamm@cuamm.org

EDITORIAL COORDINATION

Chiara Di Benedetto

COVER ILLUSTRATION

Lorenzo Gritti

LAYOUT AND PRINTING

Publistampa, Via Pennella, 70 - 38057 Pergine Valsugana (Trento)

COPYRIGHT

Doctors with Africa CUAMM, Via S. Francesco, 126 - 35121 Padua. Articles and materials contained in this publication can be reproduced in whole or in part provided that the source is cited.

REGISTRATION AND AUTHORIZATION

Law Courts of Padua no. 1129 on 6 May 1989 and on 11 September 1999. *Health and Development* is a triannual magazine on international development and health policy.

DISPATCH

Poste italiane s.p.a. - Spedizione in Abbonamento Postale - D.L. 353/2003 (convertito in Legge 27/02/2004 n° 46) art. 1, comma 1, NE/PD

TRANSLATION

Miriam Hurley

With the support of

Fondazione
Cassa di Risparmio di Padova e Rovigo

Cover illustration

Health in the Balance

People's health and the sustainability of health systems in low-resource countries are continuously challenged and weakened by different factors, including armed conflict, gender-based violence, and the growing spread of chronic non-communicable diseases. The balance of health depends on very many factors that must be considered and managed with an integrated approach.

MIX
Paper from responsible sources
FSC® C009263
FSC www.fsc.org

CONTENTS

DIALOGUE

FORUM

EXPERIENCES FROM THE FIELD

REVIEW

DIALOGUE

HEALTH IN THE BALANCE

Wars, economic and political crises, and instability have put the right to health to a severe test, with repercussions on individuals and communities. This is why CUAMM continues to focus on the most vulnerable people so that, in these turbulent times, they may also have that state of physical, mental, and social well-being that we call health.

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

We started the year 2024 among the suffering of wars and the deep wounds that the ongoing massacres of innocent people bring: men, women, and children are losing their lives in inhumane ways and experiencing unfathomable suffering in Gaza, Ukraine, and in the forgotten conflict in the Tigray and in war-torn Yemen. We have seen such situations too many times and are continuing to see them in our Africa.
Behind these deaths, there are equal numbers of situations of hardship, which are amplified in places of war. Health facilities become military targets, childbirth assistance and services for mothers and children are disrupted, and care for the chronically ill loses priority while violence, including gender-based violence, escalates.

We are too familiar with this reckoning when the burden of conflicts, economic and political crises, and social instability undermines all personal or community balance. Where there are these kinds of burdens, there is an enormous price to pay for health. Life trajectories are shattered and the identities of individuals and groups are torn apart. Health is compromised for generations to come. The connection is clear – where there is no respect for human beings, there is also no respect for fundamental aspects of the human condition such as health.

This ongoing deep global division puts health at risk and is why we have decided to focus this issue of the magazine on the major challenges facing those who work, as we do, in fragile contexts. It is fundamental to provide care and services for those suffering from chronic diseases (NCDs). These diseases kill 41 million people every year, accounting for 74% of deaths globally, and 77% of total deaths are in low- and middle-income countries (WHO, 2023). In these countries afflicted by conflicts and humanitarian emergencies, the treatment of chronic diseases that require continuity of care and constant monitoring is often the first to be interrupted, with emergency and urgent diseases taking their place. We experienced this firsthand on the CUAMM mission to the reception centers for Ukrainian refugees in Moldova (p. 17): in the outpatient day clinic that we managed, we mainly treated people with health problems not directly related to the conflict, proving how significant this healthcare problem is even in emergency contexts.

While keeping our attention on critical and conflict settings, we wanted to delve specifically into the problem of gender-based violence (GBV), which becomes even more dire in the absence of stability. This is confirmed in the article by Orsi et. al. Pg. 14), which considers the problem starting from WHO estimates that in countries with limited resources and conflicts, the prevalence of women who have been victims of violence in the last 12 months and during their lives is 22% and 37%, respectively (WHO, 2018); and in the article by Putoto (p. 4) delineating the situation, risk factors and strategies to combat this global phenomenon.
This issue also touches on other topics that we encounter more and more often, such as mental health as a decisive factor in individual well-being. We are introducing the mobile clinic with which CUAMM Bari provides health services to migrants in the Foggiano area, joining basic medical with mental health and psychological-social services.
Our attention to the most vulnerable groups and every person continues to stay true to the principles of the Universal Declaration of Human Rights of 1948 and the International Covenant on Economic, Social, and Cultural Rights of 1966, which are still relevant today. Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity; and health is a human right.
As health professionals, we will keep on fighting for health to be a right for everyone, including in these turbulent times.

DIALOGUE

ONLY AFRICA WILL SAVE US

While Italy and the rest of Europe are aging and seem to be losing the future orientation of their history in the 20th century, Africa is alive with energy and resources that will define future global scenarios. Despite its many problems, Africa is now a key player with which to forge new relationships.

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

Disgust and indignation, but not surprise, in the reaction to the suggestion from the German party AfD (*Alternative für Deutschland*) to deport all immigrants from Germany both undocumented ones and documented residents, and even those who have German citizenship. It was not a surprise because AfD is a hard-right neo-Nazi party with well-known racist, Islamophobic, anti-Semitic, xenophobic, and Identitarian leanings. AfD took 10% at the federal elections in 2021 and 83 deputies, and in some East German Lenders, it even reached over 20%. At the 2019 European elections, AfD won 11 seats and joined the parliamentary group "Identity and Democracy," of which Italian party the League is also a part.

Another distasteful idea was Boris Johnson's decision to make an agreement with Rwanda to deport the "illegals" there. The first flight was scheduled to depart in June 2022 but was canceled after the European Court of Human Rights intervened. The latest ruling by the Supreme Court – the UK's highest court – established that the deportation plan (which has already cost £140m) is illegal. No asylum seekers have been sent to Rwanda.

Italy has also recently chosen the path of deporting "illegals" to Albania. For that matter, two of the parties in the incumbent government have also espoused racist and xenophobic ideas similar to those of the AfD. Once they came into power, they tried to assume a patina of respectability (e.g., Mattei Plan). However, Italy's immigration policies continue to be closed and labyrinthine, made even harsher after the Cutro Decree. There is no reception or integration, longer periods of detention in the infamous detainment centers, and – finally, the cherry on the cake – deportation to Albania (costing €673 million over ten years).

This Albania project is futile and costly – if it is even lawful at all – because asylum recognition procedures and periods of detention of migrants are shifted to the other side of the Adriatic, and then they all return to Italy to be either received or returned to their country of origin (a rare event, less than 1% of "illegals" per year). But with an eye on European elections, the project has to be shouted about. Meanwhile, a piece of information is regularly ignored that demographers and economists have been tirelessly pointing out for decades: Italy is heading towards a relentless demographic decline with catastrophic consequences on the economy and welfare levels. By 2050, Italy will have lost a total of 4.5 million people. This is what the 57th CENSIS report shows. The demographic decline will result from a decrease of 9.1 million people under 65 at the same time as an increase of 4.6 million people over 65. Thirty-four point five percent of the population will be elderly and alone.

As we said, the government tried to give the impression of decency by proposing an aid plan for Africa for the future (while right now Africans are killed at sea and tortured on land), with the not-even-hidden ulterior motive of stopping migration from Africa to Europe through aid. The historian Andrea Graziosi writes, "Of course, Europe, and Italy have something to give Africa and it is right that they do so, in a relationship without a sense of superiority and echoes of past arrogance.[1] But in Africa today there is that kind of life and energy that was found in Italy and Western Europe at the time of the "economic miracle." (...) Now it is less us who help them grow, benefiting from it, but they who, by growing, can help us, gaining benefits from it, as we used to –do. (We could add that, not only is Africa the youngest continent on the planet, with an average age of 20 years, but it has 30% of the world's mineral resources and 60% of the planet's unused arable land). It is hard to accept it and realize that we need "an old age cane." This inability to accept reality is at the root of the "let's help them at home so they don't come here" rhetoric that has been reiterated with the Mattei Plan. This is wrong not only because it is completely unrealistic terms of basic facts but especially because, as things stand now, we are the ones in need the help from others."

NOTES

1 Graziosi A, *Così s'è ribaltato il rapporto con l'Africa: oggi siamo noi che abbiamo bisogno di lei*, Il Foglio, January 30, 2024.

FORUM

GENDER-BASED VIOLENCE IN FRAGILE COUNTRIES

This global phenomenon undermines the physical and mental health of those subjected to it wherever it occurs. In some low-resource countries, many in Africa, already afflicted by humanitarian emergencies and conflicts, gender-based violence takes on even more critical levels, aggravated by surrounding socio-cultural, behavioral, and environmental factors.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

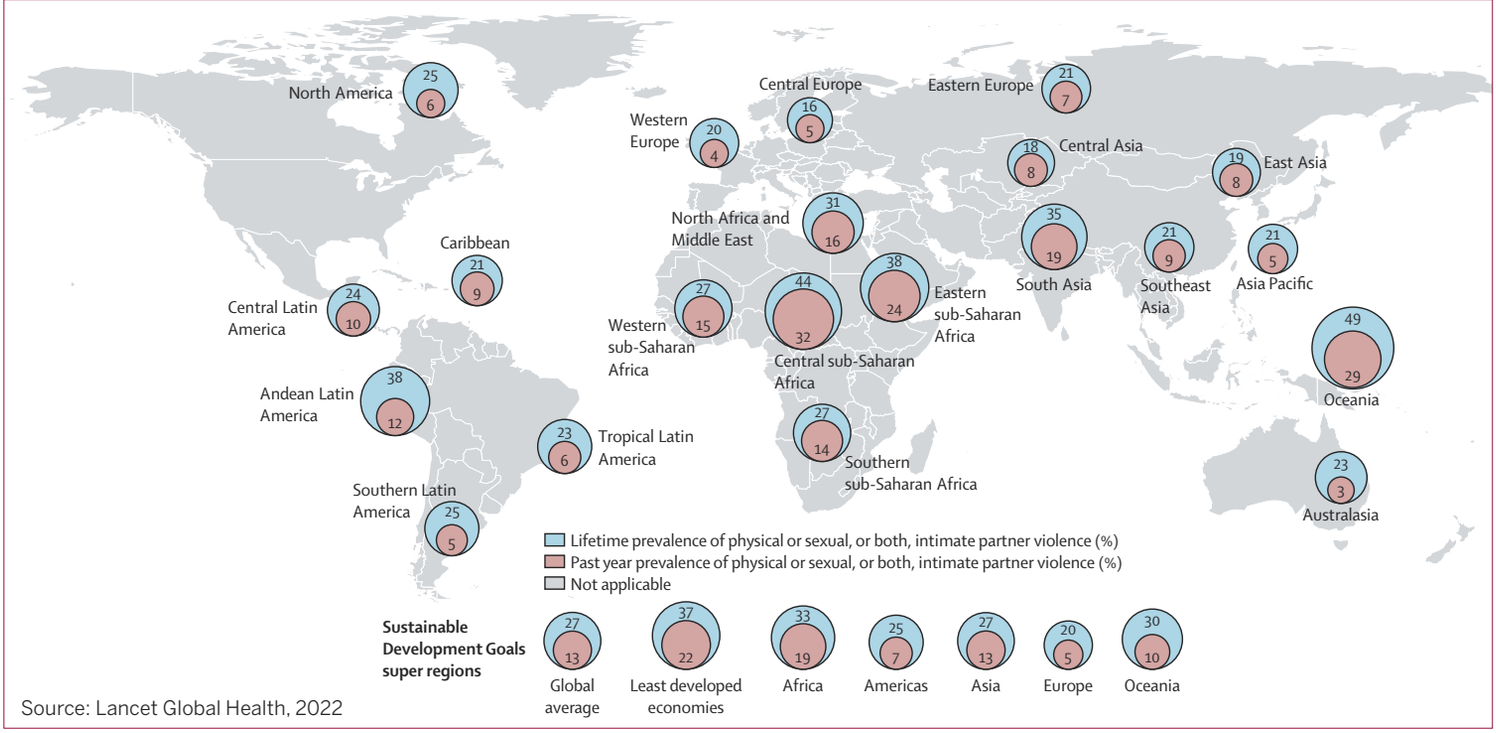
A GLOBAL CRISIS

Right now in history, talking about violence means talking about women and talking about complex conflicts and emergencies. Gender-based violence is a serious problem affecting the entire world. The focus on the issue is relatively new, and there is no universally recognized definition of the concept nor standardized tools and methods of data collection and analysis. The ways of GBV are still complex and inadequate. The most authoritative sources are the *WHO Global Database on Prevalence of Violence Against Women and Demographic and Health Surveys*. Intimate partner psychological violence is rarely measured. The effect of measuring women's empowerment has only been sporadically evaluated. As such, the numbers given here should be taken with appropriate caution.

GENDER-BASED VIOLENCE (GBV)

Gender-based violence is a human rights violation perpetrated by an aggressor against a person because of their gender or sex. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[1]
The most prevalent form of gender-based violence is committed by intimate partners (Intimate Partner Violence). Globally, it is estimated that, on average, 27% of women aged 15 to 49 have experienced violence by an intimate partner (IPV) or a non-partner during their lifetime and millions are those affected by other forms of gender-based violence, such as child, early, and forced

FIGURE 1 / MAP OF 2018 LIFETIME VERSUS PAST YEAR PREVALENCE OF PHYSICAL OR SEXUAL, OR BOTH, INTIMATE PARTNER VIOLENCE AMONG EVER-PARTNERED WOMEN AGED 15-49 YEARS BY GLOBAL BURDEN OF DISEASE REGION AND SUSTAINABLE DEVELOPMENT GOALS SUPER REGION



Source: Lancet Global Health, 2022

Marriage, sex trafficking, and harmful traditional practices. The highest prevalence of GBV globally is found in the regions of Africa and Oceania (**Figure 1**)[2].

EFFECTS

Intimate partner violence can have severe short- and long-term physical and mental health effects, including injury, depression, anxiety, unwanted pregnancies, abortions, sexually transmitted infections, and worse. GBV can affect social well-being, leading to loneliness, social withdrawal, and a sense of victimhood in the affected person. It can also lead to death. It is estimated that 38-50% of murders of women globally are committed by intimate partners.[3] Intimate partner violence also has significant social and economic costs for governments, communities, and individuals. For example, women in Tanzania who experience violence earn 29% less than those who do not experience any abuse; this increases to 43% for women subjected to more severe forms of violence[4].

GBV IN THE CONTEXT OF COMPLEX EMERGENCIES AND ARMED CONFLICTS

GBV is a complex, ubiquitous problem and it has significant differences based on the context. A recent survey published by the Lancet Global Health on GBV's national, regional, and global prevalence, involving 161 countries, identifies 28 countries with levels significantly above the global average. Many of these are low-income countries and are affected by complex humanitarian emergencies or armed conflict. Most of them are in Africa[5].
During complex emergencies and armed conflicts, GBV disproportionately affects women and especially girls, although men, boys, and lesbian, gay, bisexual, transgender and intersex people also experience various forms of violence[6]. In settings such as refugee camps, GBV may be perpetrated by family members (e.g. fathers, siblings, uncles) or by others in the wider community (e.g. teachers, community leaders, employers, strangers, or humanitarian workers). The places where violence is perpetrated are varied, including the home, school, work fields, water sources, the market, offices, and so on. Some studies have documented a frequency of GBV affecting up to three out of four women[7].
A particularly severe and horrific form is sexual and GBV violence (SGBV). With the increase in armed conflicts and wars, sexual violence perpetrated on a large scale as a "weapon of war and terrorism" is also growing[8]. In other words, during and after armed conflicts, women and girls are targeted for rape, intimidation, sexual and physical abuse, abduction and forms of sexual slavery, unwanted pregnancies, abortions, and/or murder by state or non-state armed groups.
The few independent studies that have been conducted in different countries reported a prevalence of sexual violence ranging from 2.6% in the current war crisis in Ukraine to 21.3% in South Sudan during the civil war between 2005 and 2011; to 9.7% in Tigray-Ethiopia in 2021. Significantly, between 80 and 90% of women who survived SGBV received no form of medical or psychological[9] assistance.
According to a recent report by the Secretary-General of the United Nations *"Sexual and Conflict-Related Sexual Violence"* for the year 2022, the countries where this violation of human rights is most widespread are the Central African Republic, South Sudan, Democratic Republic of Congo, Mozambique, Ethiopia, Libya, the countries of the Sahel and the Horn of Africa along with Ukraine, Afghanistan, Syria, Yemen, and Colombia[10]. Because of the particular heinousness of this crime, the United Nations has designated SGBV as a criminally prosecutable war crime in Article 8 of the Rome Statute of the International Criminal Court.

RISK FACTORS

The risk factors underlying GBV are multiple, concomitant, and mutually aggravating. A systematic review focused on countries with a high prevalence of GBV[11], identifies these risk factors as i) individual factors, including young age, illiteracy, and being unmarried; ii) societal factors such as poverty, unemployment, displacement, stress, and marital discord, residence in rural areas, absence of social support/protection, risky occupations, breakdowns of social norms on violence and patriarchal culture; iii) behavioral factors such as the use of alcohol and other substances and finally, iv) environmental factors such as complex emergencies, armed conflicts, and impunity. In addition, many of these factors were seen to increase after natural and health disasters such as the COVID-19 epidemic, suggesting that rates of violence increase in these contexts as well.
Knowledge of these factors and their combination are key to improving understanding of the prevalence, nature, and effects of GBV, as well as how it differs across age groups, countries, and regions. Many of these factors suggest that cultural characteristics underly GBV (e.g. the role of women in the family and society) are associated with structural inequalities such as girls' reduced access to education, health, and income. Interventions and prevention policies should develop out of awareness of these factors and their interaction in various situations.

THE MANAGEMENT OF GBV, POLICIES, AND PREVENTION PROGRAMS

In emergency and conflict contexts, essential interventions to be put in place to manage GBV cases are complex, and multisectoral, requiring diverse capacities[12] and a systematic approach[13]. These involve creating "safe" places for victims and providing

dedicated services such as health care, psychological, social, and economic support, protection and legal assistance, a referral system to emergency management centers, and coordination between all those involved[14]. The case of Cabo Delgado in Mozambique presented in this issue is an example of this type of intervention.

In terms of policies and programs to prevent GBV, the United Nations 2030 Agenda for Sustainable Development Goals (SDGs) includes Goal 5 on gender equality and women's empowerment. Target 5.2 aims to eliminate all forms of violence against women and girls in public and private contexts, including trafficking, sexual exploitation, and other types of violence.

This goal reflects the international community's commitment to addressing and eliminating gender-based violence as part of broader efforts to promote gender equality and women's empowerment.

Achieving this goal requires policies and actions at the national and global levels.

The framework to develop and implement national policies to prevent GBV is the WHO's RESPECT program, which proposes 7 evidence-based prevention strategies, which are: Relationship skills strengthened; Empowerment of women; Services ensured; Poverty reduced; Environments made safe; Child and adolescent abuse prevented; Transformed attitudes, beliefs, and norms[15]. At least 118 countries have established laws against intimate partner violence and even more countries have developed or updated national guidelines for health-sector responses to violence against women and girls based on WHO's suggested strategies[16].

Despite some improvements over the past two decades, the current situation of intimate partner violence remains troubling in low- and middle-income countries (LMICs). In some countries, there has even been a worsening of the prevalence of intimate partner violence[17]. Ultimately, the gap between policies and practices remains enormous and unacceptable. But the deeper challenge involves changing those cultural and behavioral traits, found in all societies that stand in the way of full respect for the dignity of women and their empowerment in the community.

These are reasons to continue working with determination on all fronts, especially in the field, addressing problems and adopting evaluation and research initiatives, lobbying, and advocacy, to keep the focus on the issue of violence against women, which challenges the conscience of us all, health professionals and the public at large.

NOTES

1 Resolution 48/104: Declaration on the Elimination of Violence against Women. Forty-eighth session of the General Assembly, 20 December 1993. New York (NY): United Nations; 1993.

2 Lynnmarie Sardinha, Mathieu Maheu-Giroux, Heidi Stöckl, Sarah Rachel Meyer, Claudia García-Moreno Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018 Lancet 2022; 399: 803–13.

3 Gender-related killings of women and girls (femicide/feminicide): Global estimates of female intimate partner/familyrelated homicides in 2022, UNODC. https://www.unwomen.org/en/digital-library/publications/2023/11/gender related-killings-of-women-and-girls-femicide-feminicide-global-estimates-2022.

4 Atalay R, Ayele G, Clarke S and Michael M (2022) The quarantine paradox: The economic cost of the increase in violence against women and girls in Sub-Saharan Africa. Front. Public Health 10:1029823.

5 Sardinha L, Maheu-Giroux M, Stöckl H, Rachel Meyer S, García-Moreno C, Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018 Lancet 2022; 399: 803–13.

6 Kiss, L., et al., Male and LGBT survivors of sexual violence in conflict situations: a realist review of health interventions in low-and middle-income countries. Conflict and health, 2020. 14(1): p. 1-26.

7 A Systematic Review of Prevalence Studies of Gender-Based Violence in Complex Emergencies, Lindsay Stark and Alastair AgerView all authors and affiliations Volume 12, Issue 3 https://doi.org/10.1177/1524838011404252.

8 Stark L, Wessells M. Sexual violence as a weapon of war. Jama. 2012;308(7):677–8. doi: 10.1001/jama.2012.9733.

9 Fisseha G, Gebrehiwot TG, Gebremichael MW, et al. War-related sexual and gender-based violence in Tigray, Northern Ethiopia: a community-based study. BMJ Glob Health 2023;8:e010270. doi:10.1136/bmjgh-2022-010270.

10 Conflict-related sexual violence - Report of the Secretary-General (S/2023/413) [EN/AR/RU/ZH].

11 Mannell J, Lowe H, Brown L, et al. Risk factors for violence against women in high-prevalence settings: a mixedmethods systematic review and meta-synthesis. BMJ Global Health 2022;7:e007704. doi:10.1136/bmjgh-2021-007704.

12 Inter-Agency Standing Committee (IASC), Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. 2015.

13 https://www.who.int/news/item/25-11-2021-gender-based-violence-is-a-public-health-issue-using-a-healthsystems-approach

14 IMC. IRC. UNFPA. UNICEF. UNHCR. USAID, Interagency Gender-Based Violence Case Management Guidelines. Providing care and case management services to Gender-Based Violence survivors in Humanitarian Settings. January 2017.

15 https://www.unwomen.org/en/digital-library/publications/2020/07/respect-women-implementation-package

16 Chandra-Mouli V, Ferguson BJ, Plesons M, et al. The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development. J Adolesc Health 2019; 65: S16–S40.

17 Ning Ma, Shaoru Chen et al Prevalence and changes of intimate partner violence against women aged 15 to 49 years in 53 low-income and middle income countries from 2000 to 2021: a secondary analysis of population-based surveys Lancet Glob Health 2023; 11: e1863–73.

FOGGIANO WORKERS' RIGHT TO HEALTH

Since 2015, Doctors with Africa CUAMM Bari in Puglia, with the support of the Region, has been providing health care services to migrants in the Foggiano region through a multidisciplinary camper clinic equipped for medical check-ups.

The health needs of migrants are those common to farm workers subject to demanding, strenuous work, and who live in informal settlements far from town centers without basic services such as running water, toilets, electricity, and heating.

CUAMM volunteers provide basic medical care in this setting and add mental health and psychological-social support services.

ARCHIVIO CUAMM

FORUM

THE ETHICS OF DISSENT

Thoughts on a tendency to a certain fanaticism of ideas – creeping but no less damaging – in some of our "Western world." This is an invitation, especially for doctors, to not lose sight of the moral necessity that people are always more important than absolute ideas and health is a right for everyone, without exception.

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

IF FANATICISM IS IN A SUIT AND TIE

A few thoughts on the fanaticism spreading today in Europe and the United States. This type of fanaticism is worrisome because it does not declare itself in loud, extreme, easy-to-condemn manifestations but in understated tones of supposed common sense and calls to universal values of peace and democracy. We could call it fanaticism in a suit and tie, which is to say that expressed by ruling classes that appeal to "values." These "values" are said to be Western values, European values, universal values, etc. What these values actually are is not so clear considering the wars in Iraq started by the U.S. and Britain, the South American dictatorships supported by the U.S. over the last 100 years, the European acquiescence to Israel's occupation of Palestine, the business that the EU and the U.S. do every day with dictatorships and rogue states. We struggle to see Western, European values actually embodied in ethically acceptable and defensible policies. These days, we see this suit-and-tie fanaticism applied on a regular basis to the conflict between the state of Israel and the denied state of Palestine.

IN THE ISRAEL-PALESTINE CONFLICT

Hamas fascists are now in the service of Iran's violent fascists. The Palestinian people need to free themselves from Hamas and rediscover the secular roots of their historic struggle against Israel's illegal occupation.
The support that Hamas gets is the result of years of weakening the fight to create a Palestinian state, due not only to the corruption of Fatah leaders but also to the self-serving support that Israel has given to Hamas with an anti-Palestinian purpose.
Netanyahu's fascists are at the service of a colonial, expansionist, and racist ideology that denies Palestinians the right to be free citizens, control their own lands, and be independent as a people/nation. It is urgent that the Jewish people in Israel and around the world finally accept criticism of the colonial policy of apartheid imposed on the Palestinians without silencing such criticism as "anti-Semitism."
Israel has the right to exist safely and in peace. Palestinians have the right to land and independence. Palestinian rights do not justify Islamic terrorism against innocent Israeli citizens.
The political, instrumental use of anti-Semitism to justify Israel's violence must cease. The carnage in Gaza is unacceptable under any international humanitarian law and is made even more inhumane by the continuous evocation of the Shoah by the government of Israel as if the genocide perpetrated by the Nazis constituted immunity and impunity for the governments of the state of Israel. The political and instrumental use of criticism of Zionism to justify Hamas' violence and legitimize any anti-Semitic inclinations.
May hatred of Israel not fuel new anti-Semitism. May revenge against Hamas not kill an entire people. May Israeli settlers cease violence against Palestinians in the West Bank illegally occupied by settlements that destroy the possibility of a legitimate Palestinian state. May those who really want peace not display the Israeli and Palestinian flags but support resuming the Oslo agreements.

FOR AN ETHICS OF DISSENT

Yet, those who make the arguments summed up in these few words would be condemned these days either as a monstrous anti-Semite or as a pro-Israel imperialist. Condemned by all sides. This is simply because those who make these arguments would not be fanatics but rather dissenters from the mainstreams on the right and the left. They would be criticized by the traditionally anti-Semitic right that displays Israeli flags as an anti-Palestinian statement and by the often anti-Semitic left that displays Palestinian flags as an anti-Israeli statement. Fanaticism dominates and few try to escape it.
Every doctor makes the commitment of the Hippocratic oath ("All houses which I enter, I will enter to benefit the sick..."). This means "all houses" without distinguishing between friends or enemies, between those who are like us and those who are different, between rich or poor. Who can say if when doctors make the oath, they understand that they are also adopting a moral guideline against that fanaticism that cuts with a sharp blade, separating "us" from "them," the good from the bad, never stopping to question and look at the man, woman, or child forced into the tragic role of the "other," the enemy.
We doctors ought to send the message to everyone that living beings are more important than big, absolute ideas. We ought to learn and teach how to be dissenters.

Dissenters from the Ethics, the Values, the Ideologies, and the Faiths. It is the capital letters that should make us suspicious. We need a dissenter's manual that reminds us that good is not being right in "everything" and that the "just battle" (and there are and have been just and sacrosanct battles) remains just only to the extent that it remains human.
Radical dissidence is calling us. There is no choice but that of truth and the doubts that come with it. We need an ethics of dissent.
We doctors have a lofty task: to remind everyone that before history there are the houses of everyone ("...all the houses I will enter, I will enter for the benefit of the sick...").
Because the justifications of history are often just tanks that crush all life they encounter.

GAZA: IF THIS IS NOT GENOCIDE...

The situation for civilians in Gaza is worsening by the day. The level of conflict with Israel is rising, and international institutions seem unable to act decisively to bring a resolution to the conflict.

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

Frantz Fanon (1925–1961) was a doctor, psychiatrist, and author of a seminal book on colonialism The Wretched of the Earth. His words about the relationship between colonizers and colonized people describe the relationship between Israelis and Palestinians exactly. "At times this Manicheism goes to its logical conclusion and dehumanizes the native, or to speak plainly, it turns him into an animal. In fact, the terms the settler uses when he mentions the native are zoological terms." This is exactly like what Yoav Gallant, Israeli Minister of Defense, said in the aftermath of October 7, "We are putting a complete siege on Gaza.

No electricity, no food, no water, no gas – it's all closed." He added, "We are fighting human animals and acting accordingly." These words spoken by a member of the Israeli government were part of what led the International Court of Justice to accept in part the demand for "urgent measures" made by South Africa, which accused the Israeli state of violating the Convention against Genocide in its war against Hamas. The judges in The Hague recognized that there is a case to be assessed – rejecting Israel's request for dismissal – and that the situation in Gaza requires rapid intervention to protect civilians. But they did not go so far as to impose an immediate ceasefire, which was South Africa's first demand.

Almost a month has passed since January 26, when the Hague Court decided not to close the case against Israel, whose government was asked to prevent genocidal acts and to take immediate measures to allow the provision of basic services and humanitarian assistance in the Gaza Strip. The January 26 sentence did not change the course of the war: the slaughter of civilians has continued along with attacks on the few still functioning health facilities. The people's living conditions have worsened dramatically due to the absolute lack of essential resources and malnutrition among children is increasingly widespread.
While I am writing these words, I read on the BBC "The World Food Programme has paused "life-saving" food deliveries to northern Gaza," leaving the 300,000 people left in the northern part of the Gaza Strip without food. What should we call this?

FORUM

OPERATIONAL RESEARCH TO BUILD HEALTH

How can research in the field be best integrated with health planning in developing countries? How can we bring the different actors in this area into dialogue? CUAMM talked about these questions with its international partners at an event on the occasion of CPHIA 2023, the International *Conference on Public Health in Africa*.

TEXT BY / FRANCESCA TOGNON AND JERRY ICHTO / DOCTORS WITH AFRICA CUAMM

A STRATEGIC RESOURCE

Last November 22, the meeting "Operational Research and Civil Society Contributions to Enhance Universal Health Coverage: The Experience of Doctors with Africa CUAMM" was held. The side event was planned by CUAMM as part of the official program of the African International Conference on Public Health – CPHIA 2023[1].
The event involved over 50 participants with different backgrounds – doctors, institutions, NGOs, stakeholders, and students. It alternated moments of in-depth study and active dialogue between participants to highlight the role of operational research from different perspectives.
This was an excellent opportunity to discuss a topic to which CUAMM is dedicated. CUAMM sees research as a strategic tool and planning to be essential to support actions on the ground, as proven by the over 240 publications in scientific journals that it has contributed to since 2013. This is also why we consider it key to give growing space to the voice of operational research in strategic decisions and building health policies that are truly effective, lasting, and fitting the specific qualities of the contexts for which they are intended.

SHORTCOMINGS AND CRITICAL ISSUES

However, we know that talking about operational research in low-resource countries is far from simple. There are many structural shortcomings to deal with and overcome by acting systematically with a medium-term perspective. As Giovanni Putoto, CUAMM's research and programming manager, noted, several critical issues become clearer in a general analysis: the need to involve local communities and stakeholders in operational research; the importance of making the transfer of knowledge between researchers and practitioners more effective; scant consideration for the experiences and needs of those working in the field in defining research priorities; lastly, the need to make the available health tools and data more usable and accessible. These are critical aspects that fit into already complex situations. They can suggest possible directions in which to act and the private and public players to be involved to work together in this process of change.

BEST PRACTICES FROM THE FIELD

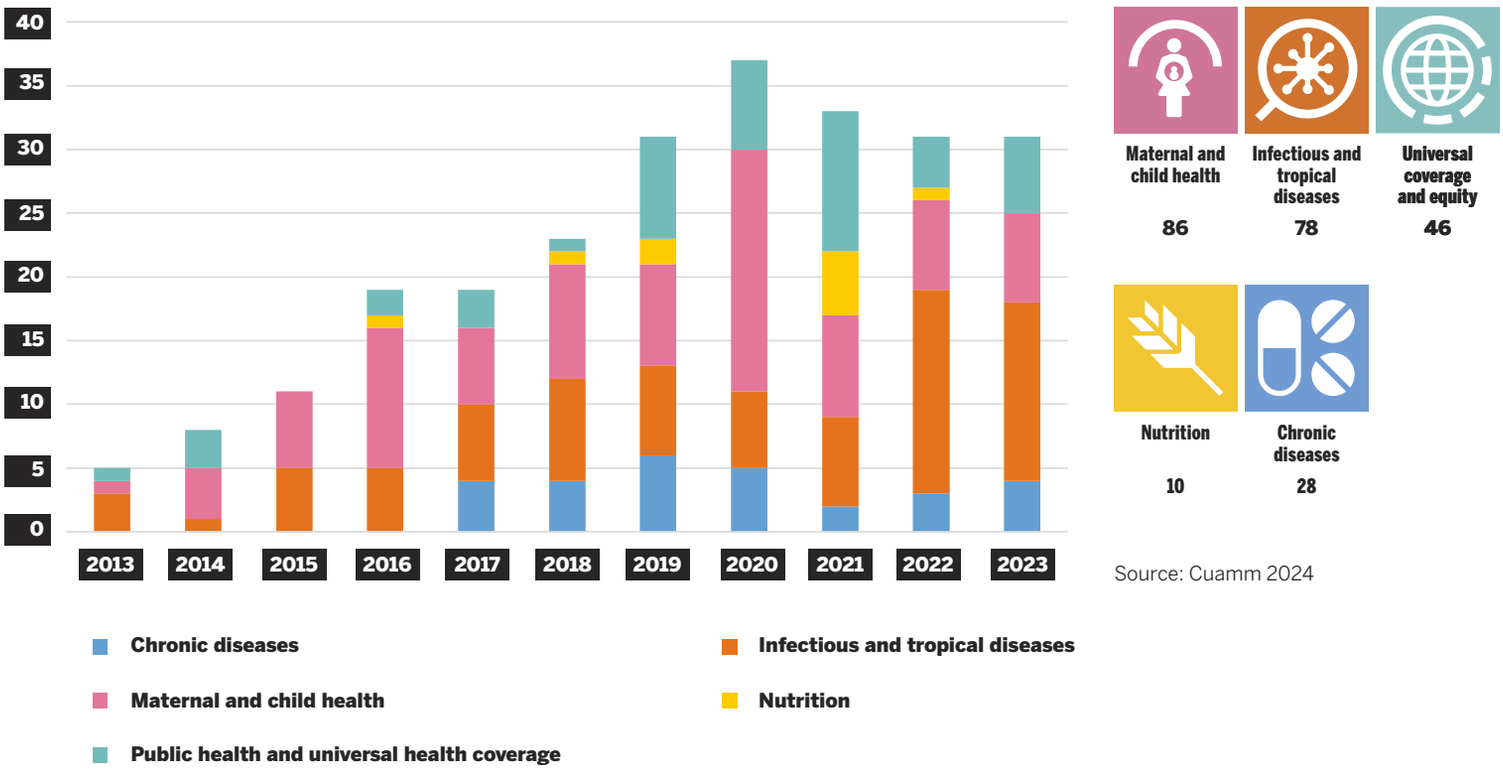
It is a long, complex path to contribute to operational research even more incisive and integrated, as described by the representatives of Makerere University in Uganda, UNICEF Mozambique, and CUAMM in a panel discussion on these topics. A first, agreed-upon answer emerged, highlighting the need for local communities, practitioners, and academics to dialogue to define lines of action. To these ends, it is key for the players involved in planning and implementing research to meet in technical working groups to share approaches and priorities. Only by strengthening such a network can operational research find its own space and contribute to developing systems and actions for the benefit of everyone's health.
Another significant aspect that came out during discussion is that non-governmental organizations can play a key role in operational research by providing evidence and bringing it to the attention of universities and Ministries to improve guidelines and policies. They may have platforms, contacts, and advocacy skills that put them in a good position to unite other stakeholders in the countries. For example, this already happens in Uganda where there are "technical boards" in which organizations contribute to developing national research agendas in the realms where the organization works.

NEW PERSPECTIVES AND TOPICS

The contributions shared by participants during the work groups of the side event were also of great interest. Starting from several critical points and three specific areas – infectious diseases, mother and child health, and chronic diseases – possible solutions and best practices were discussed to increase the impact of operational research in low-resource countries in sub-Saharan Africa.
Within the topic discussion, we tried to bring to light the possible research interest to further develop in different realms, and the modes and practical approaches to be adopted to make operational research increasingly effective in improving the health of the people. Among the research topics emerging most clearly were: gender-based violence (GBV) and mental illness and their

impact on the sphere of maternal and child health at all stages of pregnancy, childbirth, and postpartum; the need for a multidisciplinary approach in NCDs; the need to understand social-cultural determinants that guide behavior and its change.
We then discussed the need to involve community and field practitioners, i.e. health workers in primary care from the early stages of planning and the definition of research questions. Later on, these same figures should be made active players and spokespersons to spread the results at various levels (hospitals, districts, and ministries).
This is all to make operational research an even more incisive tool to facilitate dialogue between different stakeholders and contribute to true improvement in health services.

FIGURE / CUAMM OPERATIONAL RESEARCH 2013–2023 – TOPIC AREAS



Source: Cuamm 2024

NOTES

1 Conference on Public Health in Africa (CPHIA 2023) - https://cphia2023.com/

EXPERIENCES FROM THE FIELD

NCDs IN SUB-SAHARAN AFRICA

The spread of non-communicable diseases in sub-Saharan Africa has reached levels similar to those in higher-income countries. However, the amount of resources allocated to health in these two different worlds – the poor and rich – are still vastly unequal, which has major health, socio-economic, and political consequences.

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

NUMBERS BEHIND A WORLDWIDE PROBLEM

Noncommunicable diseases (NCDs) are the leading cause of death worldwide, killing 41 million people every year, accounting for 71% of all deaths globally. Among noncommunicable diseases, the top four killers, which together account for more than 80% of all premature deaths from noncommunicable diseases are cardiovascular diseases (17.9 million deaths annually), cancer (9.0 million), respiratory diseases (3.9 million), and diabetes (1.6 million). Every year, more than 15 million people between the ages of 30 and 69 die from non-communicable diseases; 85% of these "premature" deaths occur in low- and middle-income countries.

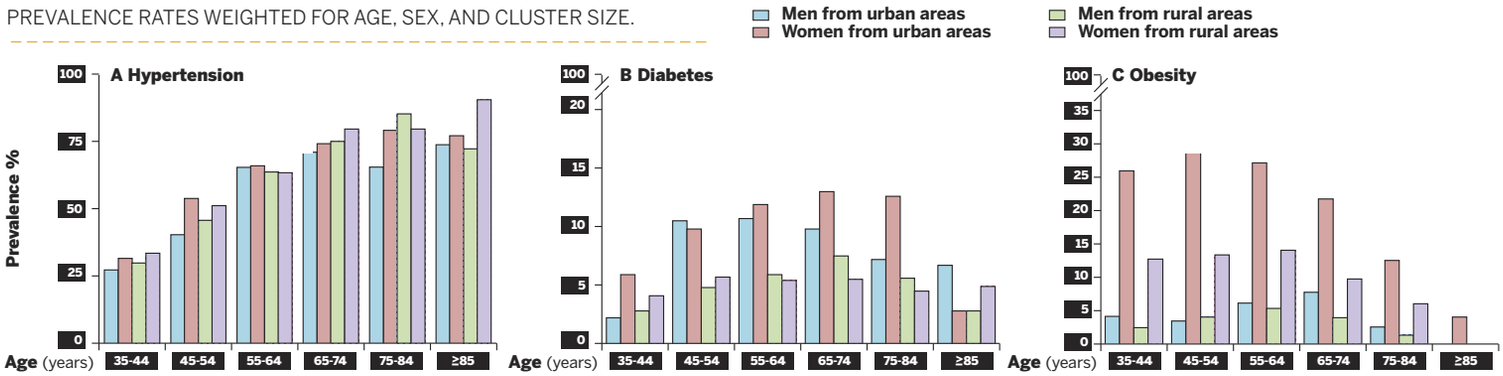
The past two decades have seen a surge in the burden of non-communicable diseases in sub-Saharan Africa, driven by a rising incidence of cardiovascular risk factors such as unhealthy diets, less physical activity, hypertension, obesity, diabetes, dyslipidemia, and air pollution. It is estimated that by 2030 in sub-Saharan Africa non-communicable diseases will surpass communicable diseases, maternal and neonatal diseases, and nutritional diseases, combined, as the leading cause of mortality.[1] The rise in non-communicable diseases in sub-Saharan Africa raises a multitude of issues, not only in terms of health but also in socio-economic and political terms. There is a general paucity of data, a lack of public information, under-consideration of the problem, and a resulting failed or delayed diagnosis of these pathological situations.

THE CASE OF THE GAMBIA

Nonetheless, studies are beginning to come out on a national scale, such as the one recently published in The Lancet on the prevalence of non-communicable diseases in the Gambia, in the adult population aged 35 years and over[2] (**Figure 1**). The prevalence of hypertension is 47% (49.3% women, 44.7% men), rising by 30% in the 35-45 age group with 75% in people aged 75 and over. The prevalence of diabetes is 6.3% (7.0 women, 5.6% men) which rises by 3.8% in the 35-45 age group to 9.1% in the 65-75 age group, and then drops. The prevalence of diabetes is greater in urban areas than in rural areas. The higher prevalence of hypertension and diabetes in women is affected by the higher rates of obesity in women (20.2%) than in men (3.9%).

While we see that the levels of the spread of non-communicable diseases in sub-Saharan Africa have quickly become similar to those in higher-income countries, the amount of resources allocated to health in the two different worlds – the poor and the rich – continues to be vastly unequal: on average $ 37 per capita per year in the poor world and $ 5,251 per capita per year in the rich world (World Bank data for 2014).

FIGURA 1 / PREVALENCE OF OBESITY, HYPERTENSION, AND DIABETES BY AGE GROUP AMONG ADULTS AGED 35 YEARS OR OLDER IN THE GAMBIA. PREVALENCE RATES WEIGHTED FOR AGE, SEX, AND CLUSTER SIZE.



NOTES

1 Bigna JJ, Noubiap JJ, *The rising burden of non-communicable diseases in sub-Saharan Africa*, www.thelancet.com/lancetgh Vol 7 October 2019.

2 Jobe M. et Al, *Prevalence of hypertension, diabetes, obesity, multimorbidity, and related risk factors among adult Gambians: a cross-sectional nationwide study*, Lancet Glob Health 2024;12:and55–65.

EXPERIENCES FROM THE FIELD

A STUDY FOR EDEMA ULTRASOUND IN SIERRA LEONE

Sierra Leone has one of the highest maternal mortality rates in the world, mainly due to pregnancy-related complications. CUAMM has been working in the country for years, supporting mothers and children in the field and through operational research projects, such as the TiPER study on eclampsia patients and the early diagnosis of pulmonary edema.

TEXT BY / SERENA CRISCI / CATHOLIC UNIVERSITY OF THE SACRED HEART, ROME; SIMONE DI FILIPPO / UNIVERSITY OF INSUBRIA; MICHELE ORSI /POLICLINICO OF MILAN; LUIGI PISANI / MAHIDOL OXFORD TROPICAL RESEARCH UNIT, BANGKOK

MATERNAL MORTALITY IN SIERRA LEONE

Sierra Leone has one of the highest maternal mortality rates in the world, with 1,120 deaths per 100,000 live births. This tragic record is mainly due to pregnancy-related complications, aggravated by the delay in recognizing the warning signs during pregnancy, difficulty in reaching health facilities on time, and the lack of adequate care. This underscores the importance of a timely diagnosis to ensure positive outcomes for both mother and child. Since 2016, Doctors with Africa CUAMM has been working with the district health authorities at the Princess Christian Maternity Hospital (PCMH), a tertiary hospital for referring obstetric-gynecological cases.

Hypertensive disorders in pregnancy are the second leading cause of maternal mortality after obstetric bleeding. Preeclampsia can occur after the twentieth week of gestation, coming with systemic manifestations, such as proteinuria or signs of organ damage. Eclampsia is the final manifestation of the spectrum of hypertensive disorders in pregnancy, defined as the onset of new seizures or coma in a preeclampsia patient in the absence of other causal factors.

RESEARCH GAP AND THE TIPER STUDY

The literature leaves unclear how frequent and severe the concomitant pulmonary involvement is and whether it really impacts the prognostic picture in obstetric patients in severe conditions suffering from preeclampsia or eclampsia. There is also limited evidence regarding the etiology and evolution of pulmonary edema[1]. The TiPER study, an acronym for SeveriTy of Pulmonary Edema and Timing of Resolution in patients with severe pre-eclampsia and eclampsia, stemmed from the understanding that an accurate assessment of patients with pulmonary involvement combined with a pulmonary ultrasound could lead to early diagnosis of pulmonary edema. Point-of-care ultrasound, performed with low-cost, portable devices, is a diagnostic technique with some "frugal technology" features. The study was conceived and implemented by Junior Project Officers (JPO) as part of a dissertation project in Anesthesia and Resuscitation at the Catholic University of the Sacred Heart and the University of Insubria. It is focused on patients with severe preeclampsia or eclampsia and is a follow-up to a previous ultrasound study in the same setting[2].

The study involves performing a 12-field lung ultrasound at two separate points, one before and one after childbirth – within 72 hours. The primary objective is to record the incidence and severity of pulmonary edema. Its strengths are being a prospective and longitudinal study, with the use of a low-cost diagnostic method as well as standardized operating procedures. The inclusion of clinical parameters will also be for the cross-checking of ultrasound data with the real clinical impact due to observed pulmonary alterations.

PRELIMINARY RESULTS AND PERSPECTIVES

After enrolling 83 patients, 30 of them (36.6%) were compatible with the ultrasound diagnosis of pulmonary edema. However, the severity of this edema, which was estimated with the lung ultrasound score, was mild, and most patients with an ultrasound of interstitial involvement did not present with respiratory distress. No patients presented with areas of consolidation or pleural effusions.

The enrollment deadline is April 2024. In limited-resource contexts, these data will facilitate the early interception of pre-eclampsia and eclampsia patients with severe pulmonary involvement, impacting early therapeutic choices such as early onset of diuretics or dialysis, transition to non-invasive or invasive ventilation, and admission to intensive care – with the aim of reducing adverse outcomes.

NOTE

1 Dennis AT, Solnordal CB. *Acute pulmonary oedema in pregnant women. Anaesthesia*. 2012 Jun;67(6):646-59.

2 Pisani L, De Nicolo A, Schiavone M, Adeniji AO et al. *Lung Ultrasound for Detection of Pulmonary Complications in Critically Ill Obstetric Patients in a Resource-Limited Setting. Am J Trop Med Hyg*. 2020 Dec 14;104(2):478-486

EXPERIENCES FROM THE FIELD

GENDER-BASED VIOLENCE; TRAGEDY AND CHALLENGES TO FACE

The WHO defines health as a state of complete physical, mental, and social well-being. Gender-based violence deeply damages all of these aspects. Gender-based violence is a widespread phenomenon whose levels are still dire, especially in low-resource countries where they often intertwine with conflicts and social situations that aggravate its severity and spread.

TEXT BY / MICHELE ORSI / DOCTORS WITH AFRICA CUAMM; LAILA GIORGIA MICCI / FONDAZIONE IRCCS CA' GRANDA OSPEDALE MAGGIORE POLICLINICO, MILAN; EDGARDO SOMIGLIANA / DOCTORS WITH AFRICA CUAMM; GIUSSY BARBARA / FONDAZIONE IRCCS CA' GRANDA OSPEDALE MAGGIORE POLICLINICO, MILAN

SNAPSHOT OF A CRISIS

Gender-based violence is a widespread phenomenon across the world, stopping at no demographic or social barriers.
Sexual violence in particular is one of the worst atrocities that humans perpetuate on each other. Gang rape is always part of genocides and a frequent part of armed conflict, used as a full-fledged weapon of war.
Until more recent times, the omnipresence of rape in human history was tied to the invisibility of victims before the law. Suffice to remember that marital rape was not a crime in any country until the 1970s. In the last 50 years, the situation has much improved in the Western world. Cases of sexual violence have declined by more than 80% and the rate of femicide has reached minimal levels. In Italy, the rate of femicide was cut by half again in the last 20 years and is now around 0.3 per 100,000 women per year, among the lowest in the world. The major media attention that femicides elicit in Italy today, despite this improvement, speaks to the profound change in society's sensitivity to this form of violence.

CRITICAL SITUATION IN RESOURCE-LIMITED COUNTRIES

Unfortunately, the situation is much worse in areas with limited resources and even worse in areas where there are conflicts. According to WHO estimates, the prevalence of women who have been victims of violence in the last 12 months and over their lifespans is 22%, and 37%, respectively (WHO, 2018); Pregnancy is not a time safe from sexual violence, particularly in very young women. A recent review reported that in the Sub-Saharan area, there was an incidence of sexual violence among pregnant adolescents between 8% and 43% (Adjimi Nyemgah et al., 2024). Violence in limited-resource countries also has certain features that have disappeared or are very rare in the Western world, such as selective infanticide of female infants, genital mutilation, forced marriages, trafficking of girls into prostitution and sexual slavery, honor killings, corporal punishment of disobedient wives, and mass rape during war or genocide. War situations further exacerbate this largely silent tragedy. The accounts of women raped in the ongoing conflicts in Europe and the Middle East are widespread right now. Sexual violence, mutilation, videos of rapes sent with the victims' cell phones to relatives and friends, and guns fired at intimate parts. Some figuratively speak of mass "femicide."
The Red Line Initiative has recently been launched, a campaign to recognize rape during wartime as a crime against humanity, a crime that cannot be overlooked once the war is over, for which there must be a legal prosecution and recognition of the victims (Mukwege and Conry 2023). A systematic analysis is needed of the evidence of war rapes, collecting testimonies, semen samples on the body of the victims, and asking for the autopsy of those who have died, when there is often a rush to identify them and then bury or cremate the body (*Physician for Human Rights*, 2023).

THE CHALLENGE OF MULTIDISCIPLINARY CARE

Care clinical management of cases of gender-based violence is complex. This multidisciplinary assistance involves psychologists, gynecologists, social workers, and lawyers. This model is followed by all Western anti-violence centers (Barbara et al., 2019) and is also supported in countries with limited resources. Denis Mukwege, a gynecologist from the Democratic Republic of Congo and 2018 Nobel Peace Prize laureate, played a key role in spreading this integrated model of care. He first implemented it in Banzi where he originally worked, but then spread it to many other areas of Sub-Saharan Africa. Violence against women is a complex problem that needs a many-faceted response; there are no shortcuts. The WHO defines health as a state of complete physical, mental, and social well-being. Gender-based violence deeply damages all three of these aspects of health. We cannot talk about reproductive health today without addressing the problem of gender-based violence. It is an enormous challenge, but one we must face without looking away.

BIBLIOGRAPHY

1 Adjimi Nyemgah C. et al. *Intimate partner violence during pregnancy against adolescents in sub-Saharan Africa: a systematic review*. Inj Prev. 2024.
2 Barbara G. et a. *Sexual violence against women: a multidisciplinary integrated care model*. BMJ. 2019.
3 Mukwege D. et al. *A call to action: Drawing a red line to end conflict-related sexual violence*. Int J Gynaecol Obstet. 2023.
4 *Physician for Human Rights. Position Paper: Sexual & Gender based violence as a weapon of war. During the October 7, 2023. Hamas attacks.* https://www.phr.org.il. November 2023.
5 Pinker S. *Il declino della Violenza*. Mondadori, 2017.
6 WHO, VAW-IAWGED. Violence Against Women Prevalence Estimates, 2018.

EXPERIENCES FROM THE FIELD

MANAGEMENT AND TREATMENT OF NCDs: TANZANIA

The rise of NCDs (Non-Communicable Diseases) is a new phenomenon with a growing impact in Africa, as well as the number of patients and premature deaths. In Tanzania, CUAMM manages health centers that treat patients with chronic diseases, acting both on clinical and structural aspects and improving the population's awareness of NCDs.

TEXT BY / NOEMI BAZZANINI / DOCTORS WITH AFRICA CUAMM

NCDS IN AFRICA

It is now well known that chronic non-communicable diseases (NCDs) are an urgent global health issue. What may be less known is the role that NCDs have as causes of illness and death in African countries. In 2000 in Africa, people mainly contracted and died of infectious diseases, but in 2023 they get sick and die less often of infectious diseases get more often sick with NCDs, and die prematurely from them. The data show that three-quarters of global deaths from NCDs are in Low-and Low-Middle Income Countries (L-LMICs) and, more importantly, 86% of premature deaths from NCDs are in L-LMICs[1].

THE CASE OF TANZANIA

CUAMM began working with NCDs in Tanzania in 2016 and opened a dedicated clinic in the Outpatients Department of Tosamaganga Hospital. Since 2019 the project has extended to the network of health centers in the district. In the clinic and the nine health centers, patients are treated for hypertension and diabetes, two extremely common diseases in Tanzania. Thirty-three point two percent of the adult population is hypertensive (WHO)[2], while the prevalence of diabetes has increased from 2.8% in 2011 to 12.3% in 2021, the highest in Africa (International Diabetes Federation, 2021).

In most cases, however, there is a lack of awareness and knowledge of the diseases; and there is a lack of services and economic and access barriers that make it more difficult to manage the diseases. According to the data (The Tanzania NCDI Poverty Commission, 2020), 3% of hypertensive people realize they are hypertensive and are undergoing treatment and effectively managing it; for diabetes, the figure is 6%. The majority of the population does not know that they are sick, or if they do know it, are not undergoing treatment or, if they are being treated, it is not effective.

Since 2019, more than 2000 patients have been registered at the Tosamaganga Hospital clinic: about 60% of them are in treatment for six months. From the data, it emerged that the main barrier that prevents patients from continuing to follow up on their care is the distance between their home and the hospital, due to the unsustainable cost of travel. This is why, starting June 2023, CUAMM doctors involved in the project travel to each of the health centers once a month to reach patients and not interrupt their treatment.

At the same time, a network of peer supporters was created to address the issue of low awareness of these problems in the community. These are patients who help their peers and bolster awareness and understanding of the issue.

A NEW PROBLEM

The NCDs issue is still new in Africa. There are many aspects on which work is needed, including increasing awareness in the community and better access to medicines, ensuring their supply, and lowering economic barriers.

In terms of awareness, prevention, and management of NCDs, there is a noteworthy new aspect related to changes in lifestyles. Specifically, 29% of patients treated in CUAMM health centers are overweight and 26% are obese. This is related to the excessive consumption of sugary drinks sold at lower prices than water in every remote village in Tanzania, without any limitation by the government.

This is another factor to be considered in managing NCDs and requires an integrated approach to build a suitable treatment scenario for these “new” diseases.

NOTES

1 https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

2 https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-hypertension-among-adults-aged-30-79-years

EXPERIENCES FROM THE FIELD

GBV AND MHPSS RESPONSE IN CABO DELGADO

In the province of Cabo Delgado in Mozambique, which is beset by conflict and persistent humanitarian and structural crises, a CUAMM experience combines operational research and field actions to provide psychological support (MHPSS) and integrated clinical and legal assistance to victims of gender-based violence (GBV).

TEXT BY / VITTORIA TANI / DOCTORS WITH AFRICA CUAMM

AMIDST CONFLICTS AND EMERGENCIES

For 7 years, the province of Cabo Delgado has been a conflict zone, with about 834,304 internally displaced people[1], widespread insecurity, economic crisis, and serious human rights violations. In this context of displacement and conflict, gender-based violence is among the major safety problems. This is why UNHCR and CUAMM joined other local partners to conduct a series of assessments to better understand the different forms of gender-based violence – physical, psychological, sexual, and economic – and identify the most vulnerable groups, risk factors, and response capacities according to global standards.

RISK FACTORS AND VULNERABLE GROUPS

The assessments made were based on the methodology described in "A Rapid Assessment of the Gender-based Violence: *Situation and Response in Cabo Delgado, Mozambique*"[2] and developed by the London School of Hygiene and Tropical Medicine with UNHCR. It used a qualitative analysis method based on collecting data and information obtained through interviews and focus group discussions (FGDs). The GBV safety audits confirmed alarming levels of risk, particularly among displaced women and girls, who are the most vulnerable groups. Adolescent girls, families with single women, sex workers, and women and girls with disabilities were identified as most at-risk. Gender discrimination, cultural customs and practices, and the increased socio-economic vulnerability of women and girls during displacement exacerbate the danger. This is a complex situation worsened by the unsafe conditions of shelters, the limited participation of women in community decision-making, and the presence of armed people.

INTERVENTIONS IN THE FIELD

Based on the results obtained from assessments, CUAMM designed several interventions, from 2021 to the *present, to mitigate GBV risks and improve responses for survivors, actively involving communities, raising public awareness, and addressing the urgent need to provide integrated services.* This aims to ensure safe and inclusive access and psychosocial support for survivors and people at risk of GBV and SEA (*Sexual Exploitation and Abuse*).
Today there are 12 supported safe spaces in Cabo Delgado that offer care, psychosocial support, and information for other services related to safety and health needs. There were 900 people supported in 2023 for GBV or MHPSS (Mental Health and Psychosocial Support). The program includes legal assistance for survivors, in coordination with government legal services, implemented through a partnership with the Mozambican Muleide Association, which is committed to promoting gender equality and women's rights and providing them with legal assistance. Over 60 women have been supported and legally assisted to date.
Since the beginning of 2023, more than 60,000 people have been involved in awareness-raising interventions on prevention and risk mitigation, because community stigma and discrimination are major deterrents for women in seeking support.

CRITICAL ISSUES AND FUTURE ACTIONS

There is still much to be done to ensure a comprehensive response to internally displaced peoples and host communities. Some of the priorities identified are working on MHPSS, considering that among the greatest difficulties are scarce psychological and social support services and inadequate follow-up of reported cases; legal support for survivors; enhancing the capacities and skills of government and community players to promote gender equality and prevent, mitigate, and respond to this problem.

NOTES

1 https://reliefweb.int/attachments/0fac553a-f76a-4aac-847b-f8aaa551a243/UNHCR%20Mozambique%20%E2%80%93%20Cabo%20Delgado%20ID%20P%20Response%20July%202023%20%28English%29.pdf
2 https://www.lshtm.ac.uk/media/56321

REVIEW

TACKLING NCDs AMONG UKRAINIAN REFUGEES IN MOLDOVA

Between June and December 2022, CUAMM assisted Ukrainian refugees in Moldova, working in two refugee centers in the city of Chișinău. It helped over 1,000 patients in this period, most of whom came with health needs due to chronic non-communicable diseases, such as cardiovascular and neoplastic diseases.

TEXT BY / EMANUELA PAROTTO / MD, MSC HOSPITAL - UNIVERSITY OF PADUA

A MISSION TO ASSIST REFUGEES

The escalation of the armed conflict in Ukraine began by Russia's military invasion in February 2022 has forced millions of refugees to cross the borders to neighboring countries such as Poland, the Czech Republic, Romania, and Moldova. These countries' fragile health infrastructure, the absence of dedicated medical staff, and the shortage of adequate medical supplies have not only made it difficult for the population to access essential health services but have also led to the interruption of prevention, diagnosis, and services for the treatment of non-communicable diseases (NCDs) such as cardiovascular diseases, chronic respiratory diseases, diabetes, and cancer.

In May 2022, the Ministry of Health of Moldova, in agreement with the World Health Organization (WHO), requested the intervention of Doctors with Africa CUAMM to support the country's health and assist the population of Ukrainian refugees temporarily settled in Moldova. CUAMM accepted the request, managing a daytime outpatient activity as an Emergency Medical Team (EMT) type 1 (**Table 1**) in the two refugee centers "Moldexpo" and "Testemitanu" in the capital city, Chișinău.

The health services were provided by a team of a CUAMM volunteer doctor and two local nurses, who were essential, both for covering shifts to support the doctor in the clinic and as full-fledged mediators in the doctor-patient relationship. The CUAMM volunteer doctor was asked to stay for a minimum of about 2 weeks to ensure continuity in patient visits and a smooth handover to the next doctor.

NCD MANAGEMENT IN EMERGENCY CONTEXTS

In the period between June and December 2022, the CUAMM Emergency Medical Team treated a total of 1,173 patients, the majority of whom were adults (70.8%) with an average age of 51.9 years. Of these, 569 (68.5%) were female and 258 (31%) were male.

Most of the people assisted (88.7%, n=1040) had health problems not directly related to the conflict: the most frequent diag-

TABLE 1 / CLASSIFICATION OF EMERGENCY MEDICAL TEAMS ACCORDING TO THE WORLD HEALTH ORGANIZATION.

EMERGENCY MEDICAL TEAMS (EMTs)	
Definition	**Groups of health professionals, including doctors, nurses, paramedics, support workers, logisticians, who treat patients affected by an emergency or disaster**
Type 1 mobile	Outpatient initial care and referral for further investigation using mobile medical teams in multiple locations and serve hard to reach populations according to the context of the emergency
Type 1 fixed	Outpatient initial care of injuries and other health-care needs and referrals for ongoing investigation or care and community based primary care from a fixed location
Type 2	Inpatient acute care for medical conditions (communicable and noncommunicable diseases), general and obstetric surgery for trauma and other major conditions and can receive, screen and triage new and referred patients in an outpatient and emergency department type setting
Type 3	Complex referral-level inpatient care for medical and surgical conditions and intensive care capacity in a temporary facility of tents, prefabricated buildings or vehicles

noses are attributable to cardiovascular (23.4%, n=177), gastrointestinal (7.4%, n=56), musculoskeletal (6.1%, n=46) and neoplastic diseases (4.7%, n=36).
The data collected during the outpatient treatments offer significant points of consideration. Firstly, non-communicable diseases were a major health problem for the assisted population, confirming that these conditions are also a significant problem in humanitarian emergency contexts. Yet, on the patient evaluation sheets that the WHO made available for type 1 TMS, non-communicable diseases are still classified indistinctly under code 29 - "other diseases, not specified above," a generalized category that does not allow a precise classification of the diseases, to the detriment of the timely treatment of the patient and a complete understanding of the health needs of the affected population.
Secondly, the choice to support CUAMM doctors with the experience of local nurses made it possible to provide effective health care for Ukrainian refugees, overcoming language barriers as well as promoting hygienic-sanitary measures in the population and planning management strategies to ensure the follow-up of chronic patients.

EMERGENCY-URGENCY VS CONTINUITY

When health resources are strictly limited, priority is given to urgent and emergency diseases, to the detriment of evaluating and treating non-communicable diseases that require continuity of care and constant monitoring over time. Handling NCDs during humanitarian crises is a growing global challenge, which requires a multidisciplinary health approach integrated with local health systems to implement diagnosis, treatment, and follow-up for patients who are victims of humanitarian disasters.

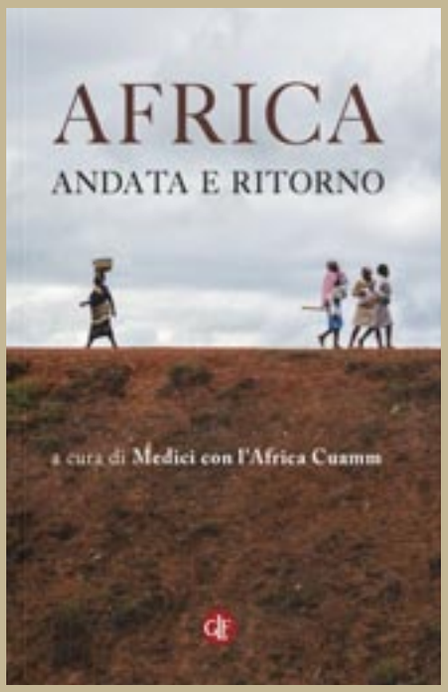
REVIEW

"AFRICA, ANDATA E RITORNO": A MANY-VOICED STORY

Thirty CUAMM volunteers – from diverse backgrounds with diverse aspirations – tell us about their experiences in Africa in the form of letters. "Africa andata e ritorno"is a book that shines a light on many facets of Africa through genuine, vivid stories of volunteers who worked and lived in Africa to improve health.

TEXT BY / FRANCESCO VLADIMIRO SEGALA / UNIVERSITY OF BARI

The local scents. First, there is the scent of the earth, the red earth that comes in the windows and gets in your eyes and sticks to your skin, yours, and that of your patients. The earth you breathe in when you go jogging and that runs down the shower drain at night. Then there is the scent of grass, which is different from our grass, and the sweet scent of burnt brushwood, the small fires lit every day out of boredom and to prepare the fields for rain. There are few flowers, and they are red, like the sky and the earth, every now and then they blossom on dry branches like wounds, and they are beautiful. There is the scent of cattle and manure. At home, there is the smell of insecticide, cleanser, and the things that Polly cooks: beans, rice, black tea, coffee, mango, avocado, river fish, and stew. Then there's the hospital, with its smell of dirt, urine, feces, and sweat. Sweat smells like open air and something like dirty leather and hay, or it smells like mud and standing water, and that is the scent of malaria. The scent is not strong because the windows are always open, patients are washed daily by family members (who are always by their side), and because in the hospital, too, the earth dominates, taking up the two lower swaths of air and coloring the sun red every morning. Since I arrived, it has rarely rained, and when it has there were different scents. In the evening there was the scent of grass. This is the scent I smell as I'm writing you now.
(from *Africa andata e ritorno*, Editori Laterza - Laterza Publishers, 2023)



THE ORIGIN OF A PROJECT

Tell about my experience as a doctor in Uganda and do so in the form of a letter. When CUAMM asked me to do this, my first reaction was gratitude. The invitation was a chance to write about my work in Aber, which I had long wanted to do. But soon after, the doubts came: should I talk about the hospital, the operational research, the places, or my experience? And what tone should I use? Africa – especially when it comes to health – is a place of life and joy but also one of suffering and injustice.
My letter was one of the 30 letters written by 30 doctors, volunteers, and aid workers who have come to Africa with CUAMM over the years, gathered in the book *Africa andata e ritorno* published in 2023. This collective portrait alternates multifaceted, diverse points of view: some wrote of illness, others of family, travel, fragility, and culture. This let me choose to talk about just one aspect of my experience, and the others would do likewise. One episode, one idea, or one feeling that could convey to the readers, even those not already involved in CUAMM, what it had been like for me to live and be a doctor in Aber.

DIFFERENT VOICES TO TELL ABOUT AFRICA

The theme of my letter ended up emerging on its own: I would write about malaria. In Uganda, this disease is everything, part of the ecosystem itself, filling the pediatric and medical wards in the rainy months. It is a disease that one in three pregnant women contracts. During my time in Uganda, this was my subject of study and research in the field. My letter talks about this, in the form of the pain of a hospitalized child, a study, and a run at the end of the day.
Africa andata e ritorno is a mosaic of experiences like mine. In all of them, there is an aid worker, a volunteer, or a doctor who immerses themselves in Africa with their eyes, their heart, and their doubts and recreates it for us with sincere words. This book succeeds in a mission that is anything but easy, conveying one the most complicated and beautiful things about Africa: that it is not one, but many Africas.

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 **73** years of existence
- more than **200** programs have been carried out;
- **2,200** individuals have worked on our projects;
- **43** countries have partnered with our organization;
- **239** hospitals have been assisted;
- **1,200** 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
- **Online** www.mediciconlafrica.org

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

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

WHAT AFRICA 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)

MEDICI CON L'AFRICA
CUAMM
Doctors with Africa

Magazine on
International Development
and Health Policy
February 2024 — No. **88**
www.doctorswithafrica.org

"As health professionals, we keep on fighting for health to be a right for everyone, including in these turbulent times."