



HEALTH AND DEVELOPMENT

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Fleeing towards inequality





NEWS

Italian Healthcare: The Burden of Inequality

According to the Organisation for Economic Co-operation and Development (OECD), Italy is one of the countries whose citizens face the most difficulties in accessing health care services, due to excessive cost or traveling distance and long waiting times. As could be expected, the hardest hit are people in low-income groups. In 2013, Italy ranked alongside Greece in terms of unmet care needs for medical examination, by income level.

FIGURE / UNMET CARE NEEDS FOR MEDICAL EXAMINATION, BY INCOME LEVEL, 2013



Source: EU-SILC 2013
EU Statistics on Income
and Living Conditions 2013

Note: Unmet care needs for the following reasons: too expensive, too far to travel or long waiting times

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TRANSLATION

Sara Copeland Benjamin

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Massive migration flows as the result of people fleeing their homes to
escape famine, conflict, natural disasters and the devastating
consequences of climate change. Every day thousands of human beings
move from one region or country to another, many undertaking extremely
dangerous sea crossings. We would like to dedicate this edition of our
magazine to these individuals, to all those who are forced to migrate in
search of lives of health, dignity, and economic and social opportunity.



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Text by / Sandro Spinsanti



DIALOGUE

LIFE ON THE EDGE

Drought, food insecurity, war, climate change, migration – the factors determining the stability and health of a country and its people are multiple, and often push communities already living on the edge into a spiral of ever greater hardship and insecurity. Convinced that there can be no development without good health, we're resolved to keep working to ensure that everybody can access essential health services.

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

You never get completely used to working in the most isolated parts of the world. You learn to put yourself at the service of those in need and to hone your working methods and tools to make them as effective and sustainable as possible, yet you are always acutely aware of the fragility of the system you're working in. In this edition of *Health and Development* we will talk about the repercussions of such fragility – the impact it has both on the communities we serve and on our own everyday work. The environment and the climate, forced migration, conflicts, war and food insecurity are in fact straining the region south of the Sahara to the limit, accelerating a downward spiral into instability and poverty, with dire consequences for human health. Since 2015, many of the countries in this region have been affected by a prolonged drought that has severely impacted crop production and put great swathes of the population at risk of food insecurity, with consequent rising levels of malnutrition. Forty-eight percent of the South Sudanese population was estimated to be at risk of hunger last year, with the figure rising to 78% in some areas of the country. The situation is alarming in Angola and Ethiopia as well: in the former, some 38% of children are malnourished, while in the latter the figure is almost 50%, with nearly 10% of children affected by severe acute malnutrition. Despite the progress seen there in recent years, Tanzania, too, is one of the ten worst affected countries in the world in terms of malnutrition. Civil wars also weaken the social fabric of countries, as can be seen, for example, in South Sudan: warring factions there finally signed a peace agreement last August, yet the country remains in a state of emergency. Such conflicts leave people in dire circumstances, their social and work networks as well as the foreign aid disbursements they depend on severely disrupted. Similar dynamics are seen in the aftermath of epidemics. We've talked about the Ebola outbreak in Sierra Leone in recent editions of this magazine. With the crisis now over, we are doing our part to help local communities, who are working in turn alongside local institutions in an effort to rebuild the country. But it is not easy, especially for those who have lost everything, including their families. It's no coincidence that post-Ebola, teenage pregnancies are very much on the rise – a phenomenon linked to instability both at the household level and in the wider society.

People's response to this multitude of problems – war, drought, environmental disasters, famine and more – is often to flee, abandoning their homes, regions and sometimes even countries of origin in search of security and a life of dignity. Global migration is a complex phenomenon, and precise figures are impossible to come by. The International Organization for Migration (IOM) recently reported that in the first five months of 2016, some 204,311 migrants and refugees entered Europe via the Mediterranean sea alone, while even greater numbers of people migrate by land, both within countries and from one country to another. The top three nationalities of Mediterranean sea arrivals are Syrians, Afghanis and Iraqis, but many thousands of people from Sub-Saharan African countries continue to flee as well; indeed, in 2015 more than 600,000 of South Sudan's citizens left their homeland – five percent of the total population. The routes taken by such individuals are both uncertain and dangerous. Many seek temporary refuge in bordering countries including Ethiopia, which has had to absorb over one million displaced people in transit from Somalia, South Sudan and Eritrea over the last twelve months. Thus this country now has to cope not only with its own vulnerabilities, but also with the complexities of being a refugee-hosting country.

We at Doctors with Africa CUAMM continue to respond to this complex scenario the best way we know how: by working tirelessly alongside local authorities and in synergy with international institutions, taking a bottom-up approach to bring care to local populations. We tailor and implement services to meet the precise needs of communities facing growing food insecurity. In Ethiopia, we help treat some 3,000 children every year in the Wolisso Hospital's nutritional therapy unit. In South Sudan, we help carry out nutrition screening for children and activities to teach families about good nutrition. In Angola, too, we are helping set up nutritional therapy units in the hospitals with which we partner in Chiulo, Xangongo and Cahama.

We don't have the power to prevent wars and environmental and climate-related disasters, but we can forge ahead with the work we've always done to expand access to essential health services for all, especially the poorest. We can continue to improve the lives of the children, mothers and families we encounter day in and day out. And we can alleviate the worst cases of hardship, cutting down on the number of people who believe that in order to find lives of dignity, they have no choice but to run away. Indeed, for more than 65 years we have stood firm in our conviction that without good health, there can be no development or human dignity.



DIALOGUE

POPE FRANCIS'S VISION OF HEALTH

On 7 May 2016 Doctors with Africa CUAMM met with Pope Francis in a special audience. The Pope's address focused on the right to health – one that is denied to people in many parts of the world, particularly in the African region. Applauding CUAMM for its long-term approach, the Pope urged the NGO to continue using its know-how and perseverance to help local communities develop in a sustainable way.

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

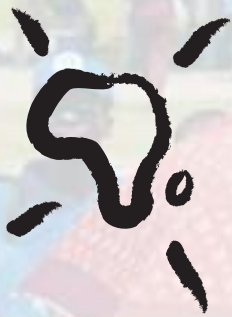
It was the daily newspaper of Vatican City State, *L'Osservatore Romano*, that chose the most effective headline to report on the address that Pope Francis gave to the more than eight thousand people who had gathered in the Vatican's Paul VI audience hall to hear him: *"Health denied: access to medical care and drugs as a right, not a privilege"*. This was, in fact, the central focus of the Pope's talk: «Healthcare, especially at the most basic level, is indeed denied – denied! – in many parts of the world and many regions of Africa. It is not a right for all, but instead remains a privilege reserved for the few, those who can afford it. Access to healthcare services, treatment and medicines remains a mirage. Unable to pay for them, the poorest are excluded from hospital services, even the most essential primary care.»

The Pope's brief address revolved around three main ideas:

- To begin with, health is a universal right, and as such it must be safeguarded by national and supranational institutions; charity and compassion are not enough.
- Francis then underscored the notion of basic healthcare, in an obvious reference to the principles of the 1978 Alma-Ata Declaration. That document famously called attention to the fundamental importance of primary health care, highlighting the need for governments to develop health systems providing essential services to all of their citizens, as well as to address the social determinants of health such as access to water. The Pope had focused attention on this last issue in his May 2015 encyclical *Laudato si'*, where he wrote: «The scarcity of public water affects Africa in particular, with much of the population lacking access to safe drinking water. The poor quality of the water available to the poor is a particularly serious problem; every day, unsafe water results in numerous deaths.» The natural environment, like health, must be a common good.
- The third key topic dealt with the issue of out-of-pocket medical care. Throughout Africa, people are obliged to pay for services in both private and public health care facilities, even non-profit ones managed by the Catholic Church. Thus «access to healthcare services, treatment and medicines remains a mirage» from which «the poor are excluded». This was a clear rebuke to international institutions which have championed the notion of health as a business for decades; to African nations, which have, generally speaking, focused little attention on the issue of public health and the problem of access to healthcare services; and indeed to African bishops, many of whom consider hospitals as a source of revenue for the diocese. Francis's words were truly caustic with regard to this last matter: the Church, he said, is not a "super-clinic for VIPs", but a "field hospital".

Another key theme in the Pope's address was the need for patience, that is, the wisdom of maintaining a long-term outlook and approach as well as providing aid in times of emergency. «To foster authentic, long-lasting development» – Francis told his audience – «one must work on a long-term basis, sowing seeds in a spirit of trust and waiting patiently to reap the fruits of that labor. This is borne out by the work that your own organization has done for more than sixty-five years now, in its ongoing commitment to the poorest in Uganda, Tanzania, Mozambique, Ethiopia, Angola, South Sudan and Sierra Leone. Africa needs to be accompanied over the long term, with patience, continuity, tenacity and competence. Development activities must be based on careful planning and research, and involve innovation as well as transparency towards donors and the general public. (...) I urge you to continue to take your special approach to local communities, helping them grow and leaving them on their own once they are able to go forward by themselves, based on a vision of sustainable development. This is the notion of sowing seeds, which vanish and cease to exist to bring forth lasting fruit».

Pope Francis closed with a warm reminiscence of Don Luigi Mazzucato: «After serving as Doctors with Africa CUAMM's director for 53 years, Don Mazzucato passed away last year on 26 November at the age of 88. It was he who inspired the fundamental choices made by the organization, first and foremost the decision to meet poverty head-on. This is what he wrote in his spiritual will: 'I was born poor and have always tried to live with the bare essentials. I own nothing and have nothing to leave to anyone; please donate the little clothing I have to the poor'. Following such exemplars of an evangelically rich, close-to-the-people missionary approach, carry on with your courageous work, expressing the big-heartedness of our church, a church that is close to all those who have been hurt and humiliated that over time and that is here to serve the world's poorest».



HELPING ADOLESCENTS AVOID HIV INFECTION

Population growth in Sub-Saharan Africa is leading to higher HIV prevalence rates among young people in the region. In order to tackle this new emergency in Mozambique, Doctors with Africa CUAMM is working in partnership with *Serviços Amigos do Adolescente e Jovem* (SAAJ), local clinics that provide services and information about contraception and HIV treatment to teenagers and other community members. Use of the services is on the rise: **some 6,000 consultations were provided in 2013, while the number climbed to 102,533 in 2014** and has continued to rise ever since – impressive figures which we presented this June at the Italian Conference on AIDS and Antiviral Research (ICAR) in Milan to underscore the importance of carrying out HIV awareness and prevention campaigns.







UNCERTAIN ROUTES AND DENIED HUMAN RIGHTS

Most of those who leave their homelands have fled from them in an attempt to escape from war, poverty or the effects of climate change. But such individuals take different routes, meeting different fates and seeing their human rights affected in different ways. With migrant flows at an all-time high (from January to June 2016, 204,311 people reached Europe via the Mediterranean), the issue of denied human rights ought to concern us all.

TEXT BY / ANDREA BERTI AND SIMONE AGOSTINI / ITALIAN MEDICAL STUDENTS' ASSOCIATION (SISM)

CROSSINGS

Fleeing war. **Hanaa** wakes up late, when the sun is already high in the sky; she's in a refugee camp on the border between Syria and Lebanon. The eleven-year-old girl arrived at the camp only recently and still has to get used to the way things work around here, a place where "might makes right". Hanaa and her sister ran away from their home about a month ago after two men, probably supporters of the regime, broke into their home in the dark of the night and killed their father and brother, who had joined a rebel group at the start of Syria's civil war.

Fleeing one's homeland to avoid famine and/or devastating climatic conditions: **Choul** is wading through a marsh, hidden by reeds, when he hears shots in the distance. If he were alone he would speed up, but he can't; his grandmother is trailing behind him. The two of them are the only members of their family who have survived the devastating drought that recently struck their village in eastern Ethiopia. The country is suffering from what is probably its worst drought-induced famine since 1984. Choul does not believe he is going to survive for long, but he has to try; before his father died, he promised him he would.

Fleeing poverty: **Kneer** studies at the Polytechnic Institute for Engineering, Commerce and Administration in N'djamena. He's 25 years old and feels he's doing the right thing; he's just told his mother that they will probably never see each other again. After receiving his father's blessing, Kneer says goodbye to his sister and leaves. He is one of the many bright young Chadians who decide to leave their country of birth because of the lack of social progress there, the result of a combination of exponential population growth and economic crisis. Chad, in Sub-Saharan Africa, is one of the world's least developed nations, characterized by political turmoil and a chronic lack of qualified human resources.

ON THE ROAD TO NOWHERE

There will be no peace for people like Hanaa, Kneer and Choul – none in the places from which they have fled, nor those they must now cross through, nor those they hope to finally reach. They are on their own, abandoned by the rest of the world. Encircled by walls made of human bones, Europe awaits them. The International Organization for Migration estimates that in the first five months of 2016 more than 204,311 people reached Europe¹, most via the so-called Eastern Mediterranean route that connects Turkey and bordering countries with Greece's islands and from there, with its mainland. Since the middle of 2015, a massive flow of migrants, most of them from Syria, Afghanistan and Iraq, have used this route to get to Europe; estimates put the number at over a million, 850,000 of whom have reached and transited through Greece. Tragically, in the first few months of 2016 more than 2,400 of these migrants drowned before getting the chance even to see Europe's coasts². But this figure is only partial; it doesn't include the countless deaths and acts of brutality that have taken place as migrants attempted to cross the Sahara Desert, nor the many other deaths that we will never even know about.

ONE NAME, BUT DIFFERENT FATES

Although these individuals are all labeled with a single word – "migrant" – international conventions mean that they will meet very different fates. **Table 1** shows what awaits Hanaa, Choul and Kneer. Current law – specifically, the 1951 Refugee Convention, whose underlying principles were aligned with those of European Union state-members through the Council Directive 2004/83/EC of April 29, 2004 – means that only Hanaa has the right to apply for political asylum or subsidiary protection. This is because she is the only one whose life is seen as being threatened by indiscriminate violence in a situation of armed civil conflict, a requisite for obtaining international protection. Currently, there are no legal means with which to protect people who have fled their homelands for other reasons, such as Choul and Kneer.

HERE WE FINALLY ARE. AND NOW WHAT?

At the moment Europe's response to the situation is truly schizophrenic. Take, for example, the deal agreed to by the European

TABLE 1 / INEQUALITY AMONG MIGRANTS

HANAA	CHOUL	KNEER
REQUEST FOR POLITICAL ASYLUM		
LEGAL ASSISTANCE		
RIGHT TO NON-REFOULEMENT *		
FREEDOM OF MOVEMENT WITHIN THE EUROPEAN UNION**		
RIGHT TO WORK		
MEDICAL ASSISTANCE	MEDICAL ASSISTANCE	MEDICAL ASSISTANCE
FAMILY REUNIFICATION		

* This right makes it illegal to forcibly return individuals to the country from which they have fled, and where they are liable to be subjected to persecution, if they have international protection or have applied for it.

** This right is now heavily restricted due to recent policies to temporarily suspend the Schengen Area.

Union and Turkey on 17 March 2016. This agreement not only blatantly disregards rights sanctioned by prior international proclamations and conventions; it also puts on the table sensitive political matters such as the negotiations regarding Turkey's much-debated possible accession to the EU. Hence there is a risk not only of violating international treaties by allowing collective expulsions that lack any legal basis, but also of funding and aiding those who are doing this, and who will continue to do so with impunity. At the same time, it is the EU member-states whose economies are expected to grow the least over the next few years that, amid a myriad of other problems, are taking in the migrants knocking on Europe's doors.

The situation is extremely difficult in mainland Greece as well. In general, migrants coming from the country's islands, once they have landed at Athens' Port of Piraeus, end up on what in recent years has become known as the "Balkan route" to Europe, one involving countries that are patently unwilling to tolerate masses of refugees. For months, thousands of such individuals were held at the makeshift refugee camp in Idomeni, on the Greek-Macedonian border; by March 2016, there were some 11,200 people there, nearly a third of whom children, waiting for the border to be opened so they could make their way to continental Europe. The dangers of being trapped in such places against one's will – not only in terms of physical, but also social and psychological health – quickly became evident. The precarious nature of essential services leads to the perfect conditions for the spread of infectious diseases, and respiratory illnesses including pneumonia, sepsis and other infections (including hepatitis A and scabies) were seen in the camp. The horrific conditions in which people were forced to live also led to some becoming hysterical or having psychotic attacks.

At the end of May Greek police cleared the Idomeni camp, with the thousands of people being held there, including many families and children, moved elsewhere without any certainty whatsoever about where they were being taken, let alone what their final destination and future might end up being; most likely, new refugee camps featuring the same appalling conditions and existential limbo.

FUTURE PROSPECTS

Hanaa wakes up late, with the sun already high in the sky; she's in a refugee camp on the border between Greece and Macedonia. What fate awaits her now? There is no road ahead for Hanaa. Perhaps she could join the crowds protesting against the inhumanity of a Europe that has manifestly lost sight of its very identity, or wait and hope, like so many others, that the route will be opened, or that she will be given a safe-conduct. Or perhaps she could entrust her life to the smugglers who have promised to get her to European shores for the sum of around 1,500 Euros.

Perhaps Idomeni's train tracks are bringing us to the final stop. As we accompany her across the camp, Hanaa turns to us, and with a downcast expression on her face, asks: "What will become of Choul and Kneer?"

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CLIMATE JUSTICE: A SHARED RESPONSIBILITY

The concept of “climate justice” – a term denoting concrete, indispensable actions to address the causes of climate change and ensure that people worldwide are given equal opportunities and treatment to face its challenges – made a brief appearance in the Paris Agreement negotiated at the 2015 United Nations Climate Change Conference (COP 21).

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COP 21: THE CONSEQUENCES OF CLIMATE CHANGE

“(...) being guided by (...) the principle of equity and common but differentiated responsibilities and respective capabilities, in the light of different national circumstances; Recognizing the need for an effective and progressive response to the urgent threat of climate change on the basis of the best available scientific knowledge; Also recognizing the specific needs and special circumstances of developing country Parties, especially those that are particularly vulnerable to the adverse effects of climate change (...); Emphasizing the intrinsic relationship that climate change actions, responses and impacts have with equitable access to sustainable development and eradication of poverty.”

This is an excerpt from the Preamble to the Paris Agreement, the global climate deal adopted by nearly 200 countries in December 2015, at the end of the twenty-first session of the Conference of the Parties (COP 21) in Paris. The document puts forth a global view of

the environment where the climate and the well-being of the world's communities and individuals are seen as closely intertwined. Importantly, the concept of “climate justice” made an unprecedented appearance in the Agreement. For its advocates, the term denotes indispensable actions to address the causes of climate change and to ensure that people worldwide are given equal opportunities to face its challenges. It is clear, in fact, that it is the world's poorest countries that are forced to bear the brunt of climate change. And it is equally clear that these decisions have consequences not just for the environment, but also for the health of individuals and communities. At COP 21, a consensus was reached by all of the international representatives present for the first time ever that human activities – industrial processes, over-building and urbanization – are driving the global environmental crisis.

ENVIRONMENTAL DETERMINANTS

Relationships between the environment and human beings vary greatly, and depend on a myriad of factors including the climate zone, history and economy and whether the country is at peace or at war either internally or externally. The specific setting (**Figure 1**) spotlights the fundamental elements at play in generating inequalities not only between individuals and countries, but also between regions and different social strata within countries.

The world's wealthiest nations and others that have recently begun to see strong economic growth are pillaging and polluting the environment at a far greater rate than other countries. In 2013 over 9 million tons of CO₂ were produced globally; twenty countries were responsible for 81.42% of these emissions, with China (over 37%) and the United States (17%) at the top of the list.¹ (**Figure 2**)

Low-income countries are much more vulnerable than wealthy ones to the impacts of environmental pollution; their economies are based mainly on agricultural production, stock breeding and natural resource extraction, all of which are adversely affected by climate change.²

ENVIRONMENTAL INEQUALITIES ARE HEALTH INEQUALITIES

Everywhere, it is the poorest and most vulnerable who are the hardest-hit by environmental risks. Families of workers and their de-

FIGURE 1 / ENVIRONMENTAL DETERMINANTS

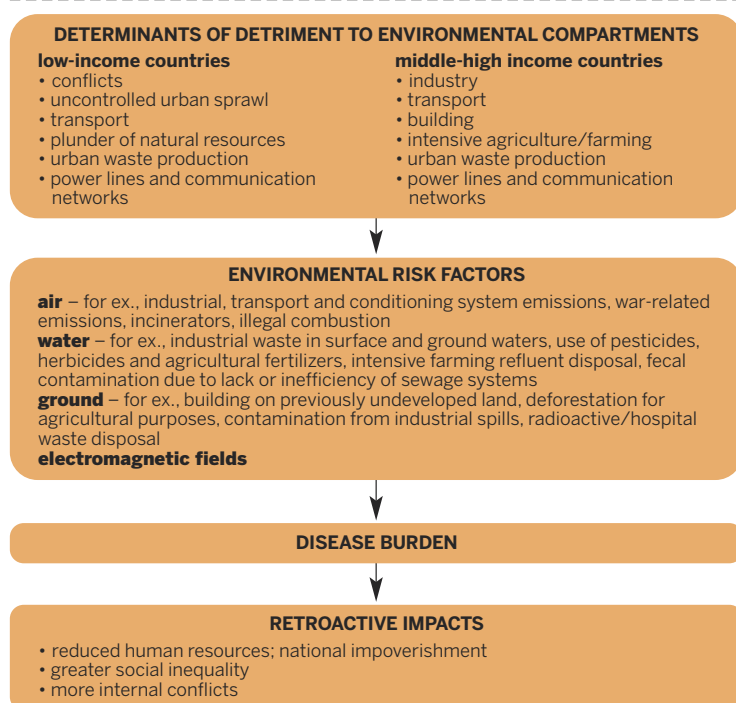
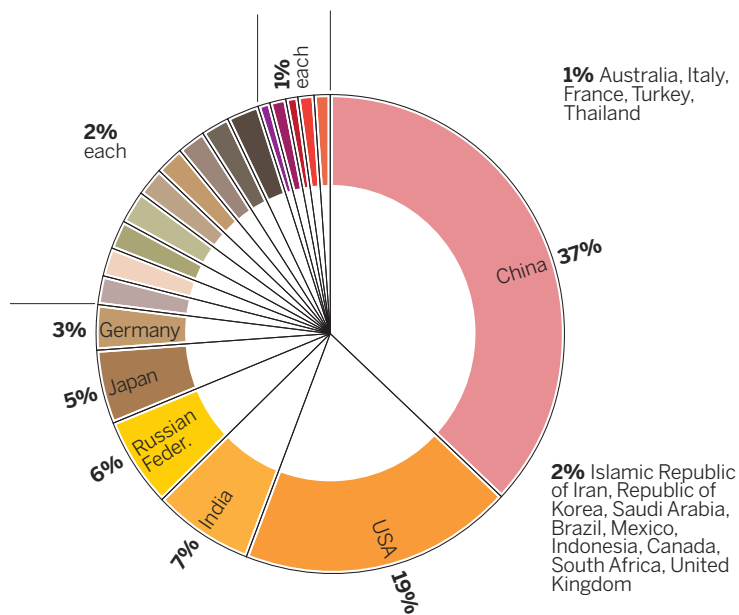


FIGURE 2 / THE TOP TWENTY LARGEST CO₂ PRODUCERS (81.42% OF GLOBAL EMISSIONS)



scendants often inhabit former and still-active industrial areas³, and urban slums or Roma encampments frequently spring up in areas at high hydrogeological risk.

As is well known, the greenhouse effect is a major driver of the climate change that is currently underway; and the latter itself has a direct impact on human health (**Figure 1**). The determinants of health are now the focal point of public policies and economic interests, spheres in which both governments and economic lobbies play critical roles.

One good example is the way urban sprawl tends to expand. The weaker a nation's juridical power is, the more unchecked such development is: cities consume undeveloped land in poor and rich countries alike, generating severe traffic congestion and huge amounts of waste that these "urban organisms" lack the capacity to process. Masses of impoverished people live tightly crammed together in vast, underdeveloped megalopoli, contaminating the soil and groundwater, while in wealthier parts of the world unhindered construction continues to invade previously undeveloped areas like the metastasis of cancer cells.⁴

Meanwhile, internal and international conflicts not only kill people, but are also an environmental determinant: they often involve the toxic use of exfoliants and herbicides, the burning and spilling of oil at sea, deforestation and ground and water contamination in refugee camps, and the lacing of arable land with mines that makes it impossible to farm and fouls groundwaters when the mines explode. The environmental hazards of nuclear tests speak for themselves.⁵

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THE IMPACT OF ENVIRONMENTAL FACTORS ON HUMAN HEALTH

Determinants impact environmental matrices, and a change in a single determinant can wreak damage on several different matrices. This damage produces toxic elements that are "absorbed" by human beings, at times accumulating in their bodies for lengthy periods (**Figure 1**).

Thus the risk factors translate into a health burden for human beings everywhere. A recent report by the World Health Organization⁶ estimated that in 2012, 23% of global deaths and 22% of the disease burden in disability-adjusted life years (DALYs) – a combined measure of years of life lost due to mortality and years of life lost due to disability) were attributable to environmental factors. The disease burden attributable to preventable environmental risks in DALYs is as follows: non-cancerous respiratory diseases 93 million, cardiovascular diseases 119 million, gastrointestinal infections from polluted water and malaria, whose spread is facilitated by climate change, another 80 million, and cancer 49 million.

If we compare how environmental factors influence health in better-off countries versus lower-income ones, we find an inversely proportional relation in terms of the polluting actions of the single countries. Sub-Saharan Africa bears 24% of the disease burden and 23% of deaths attributable to environmental pollution, while the figures in Southeast Asia are 24% and 28%, respectively. In contrast, Europe – meaning OECD member countries – limits the damage of pollution to the health of its citizens, with 13% of the disease burden and 12% of deaths attributable to environmental factors, while the figures in the wealthiest countries in the Americas (i.e., those that are OECD members) are 12% and 11%, respectively.

Thus it is not only individuals who pay a heavy price for environmental pollution; it also takes a heavy toll on the growth of countries by restricting the development of their economies and productive capacities⁷. Furthermore studies show that climate change seems to stimulate human conflict⁸, setting in motion lethal vicious circles. For all these reasons, it is not enough for those working to improve health in low-income countries to "simply" provide healthcare services; it would be a good idea to also attempt to keep a check on pollution, educating young people about the importance of safeguarding the natural environment and advocating to those who hold political and administrative power for legislation to protect it. Finally – as the Paris Agreement stated – «acknowledging that climate change is a common concern of humankind, [the] Parties [to the Agreement] should, when taking action to address climate change, respect, promote and consider their respective obligations on human rights, the right to health, the rights of indigenous peoples, local communities, migrants, children, persons with disabilities and people in vulnerable situations and the right to development, as well as gender equality, empowerment of women and intergenerational equity».

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DEBATE ON THE MIGRATION CRISIS AMONG THE WORLD'S LEADERS

Every day, thousands of people put their lives at risk in an attempt to find protection outside the borders of their own countries. But those who actually succeed in reaching a reception facility or temporary shelter often find only substandard health and living conditions and increasingly uncertain futures. The massive scale of the current migration crisis and the needs of today's refugees were among the main topics on the agenda of the G7 summit held this May in Japan. Calling it "a global challenge which requires a global response", the leaders of the world's most developed countries committed to increasing aid contributions to the countries most directly affected by the refugee crisis.







EXPERIENCES FROM THE FIELD

PREVENTING CERVICAL CANCER IN ETHIOPIA

A study surveys knowledge, attitudes and practices relating to cervical cancer among women in Ethiopia's South West Shoa Zone, examining barriers to screening and prevention and underscoring the decisive role of education in this regard. Indeed, the study shows that women who have had the opportunity to study are ten times more likely to go for screening than those who have not.

TEXT BY / DONATA DALLA RIVA AND FABIO MANENTI / DOCTORS WITH AFRICA CUAMM

PREVENTION AND SCREENING IN LOW-RESOURCE SETTINGS

"Ensuring healthy lives and promoting well-being for all at all ages": this is the third of the seventeen new Sustainable Development Goals (SDGs)¹. Doctors with Africa CUAMM plans to work towards achieving them both by providing medical support at the community and hospital levels and by conducting scientific analyses and operational research². We will focus in particular on reaching the seventh target for SDG3 (SDG3.7), helping to achieve universal access to sexual and reproductive health care services by 2030.

Cervical cancer is one of the most common cancers affecting women; every year approximately 530,000 women are diagnosed with the disease worldwide, and 265,000 women die from it. Eighty-six percent of all new cases occur in low- and middle-income countries. In Ethiopia approximately 7,095 new cases of cervical cancer are diagnosed annually³; indeed, data collected from 1996 to 2008 in the country's largest referral hospital, Tikur Anbessa, show that 30.3% of the malignant tumors diagnosed in the facility were cancers of the cervix⁴.

Unlike other female reproductive system cancers, cervical cancer is highly preventable: screening programs for precancerous lesions can significantly reduce the morbidity and mortality rates associated with it. However, most women in lower-income countries do not have access to Pap test screening since it is generally available only in private hospitals or large referral ones located in urban areas, with long response times that make it unsure whether confirmed cases will be treated or not⁵.

This is why the screening method recommended for use in lower-income countries such as Ethiopia is Visual Inspection with Acetic Acid (VIA). The method has high sensitivity (i.e., it is good at identifying true positive results, thus identifies few false-negative results), but limited specificity (i.e., it is good at identifying only true positive results, thus identifies few false-positive results), requires little technology and provides results in a matter of minutes. Although the method does not guarantee 100% certainty in the detection of cancerous lesions, it does make it possible to immediately treat suspected cases with cryotherapy, eliminating the risk that the patient will fail to return as she awaits her diagnosis (as occurs, for example, with the Pap test).

A STUDY TO HELP UNDERSTAND ETHIOPIAN WOMEN'S KNOWLEDGE OF AND ATTITUDES ABOUT CERVICAL CANCER

Earlier studies have shown that in order for women to actually use screening services, they must be aware of the existence of cervical cancer as well as of the availability of screening methods and early treatment⁶. At present very few health care facilities offer screening services in Ethiopia, so access to them is very limited. Last year, in partnership with the Ethiopian government, the Bristol Myers Squibb Foundation and Pink Ribbon Red Ribbon, Doctors with Africa CUAMM launched a program for the screening and treatment of precancerous cervical lesions in three districts near the urban area of Wolisso, in South West Shoa Zone, Oromia Region.

In August 2015 we conducted a study to survey knowledge, attitudes and practices related to cervical cancer among the local female population. The study had two main objectives:

- to investigate the degree of knowledge about, and attitudes towards, cervical cancer among the women in our target population aged 30 to 49;
- to identify the main barriers (cultural, economic and educational) impeding these women's use of the prevention and treatment services available.

Our findings helped us to develop better-tailored initiatives for educating, informing and raising awareness about the disease in the women, their communities and local health care workers. They also made it possible to define a baseline against which to assess the effectiveness of the project once it came to a close.

We used multistage cluster sampling methods to carry out a cross-sectional study: 772 women aged between 30 and 49 were randomly selected in three rural districts and one urban district, in numbers proportional to the population size of each area.

We also defined the respondents' profiles (age, marital status, socioeconomic level, educational level and religious background) through direct observation and interviews.

The analysis enabled us to determine both the degree of awareness, attitudes and practices relating to cervical cancer among the women living in the four districts and the main barriers impeding their use of screening services. It also allowed us to pinpoint possible influencing factors (determinants) among them, by matching findings with the respondents' personal profiles and area of residence (rural or urban).

EDUCATION IS CRITICAL

Only 26.2% of the women surveyed reported having heard of cervical cancer. Of these, only 9.5% had a good (1.6%) or sufficient (7.9%) degree of knowledge. Most of the women lived in urban areas, and the most frequently mentioned sources of information were television (30.7%), radio (26.5%) and health care providers (16.4%).

The only determinant that was significantly associated ($p < 0.05$) with the degree of knowledge about cervical cancer was the educational level attained: women who had completed secondary and higher education were 37 times more likely to have good knowledge of the disease than their uneducated counterparts. Fifty percent of the respondents knew nothing about the symptoms of cervical cancer, while 59.3% were unable to mention a single risk factor. Only 39.2% of the women who stated that they knew something about the disease were able to describe one of its symptoms (for example, vaginal bleeding or discharge), and only 32.8% were able to describe at least one risk factor (for example, having multiple sexual partners).

Most of the women (67.2%) felt positive about screening and treatment; however, only 2.2% of the respondents reported having undergone at least one such test. The main reasons for not having done so included a lack of information (57.6%) and the respondents' belief that screening was unnecessary because they "felt" healthy (51%).

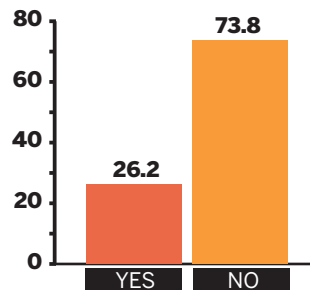
In terms of practices – i.e., having gone for a screening – there was also only one significant determinant: higher education. Indeed, educated respondents were ten times more likely to have had one than non-educated ones, while women from rural areas were 0.11 times less likely than urban women to have had one⁶. There were no significant determinants associated with positive attitudes towards cervical cancer screening services.

RAISING AWARENESS IN THE MOST ISOLATED PLACES: MASS MEDIA AND RURAL AREAS

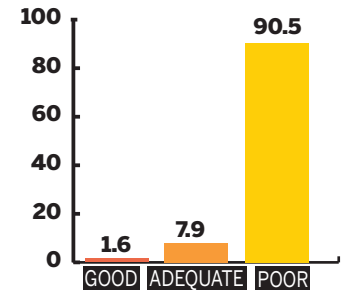
Our findings are similar to those found in other such studies conducted in Sub-Saharan Africa⁷⁻⁸⁻⁹⁻¹⁰: a low degree of awareness of the problem of cancer, the availability of screening and prevention services, and especially the appropriate use of the latter. As

FIGURES /

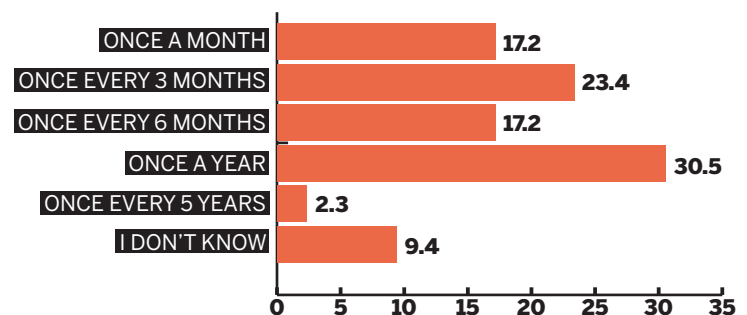
Have you ever heard of cervical cancer?



Knowledge about the issue



Frequency of screening for precancerous lesions of the cervix



a result, many patients present at hospitals when their cancers are already at an advanced stage. Indeed, 80% of cancers in Sub-Saharan African countries are diagnosed at an advanced stage, and are therefore associated with low survival rates even when treated surgically and/or with radiotherapy.

Our study underscores the need to increase education efforts on the symptoms and risk factors for the disease as well as on the prevention and treatment services available to the local population. To this end, greater use should be made of radio and television, and more training should be provided to health care workers. More attention should also be addressed to rural communities and to the most economically disadvantaged and least educated segments of society. Finally, screening and treatment services should be made available in all health care centers, so that increasing numbers of women will make use of them.

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EXPERIENCES FROM THE FIELD

FROM ZERO EBOLA TO ZERO MATERNAL MORTALITY IN SIERRA LEONE

Sierra Leone is facing a new challenge in the wake of the Ebola crisis: the urgent need to reduce maternal mortality, which remains far higher than the global or even regional average. To manage obstetric emergencies in the most effective way possible, Doctors with Africa CUAMM is carrying out a three-tiered project that works at the community, primary care and hospital levels and brings into play an efficient transport system.

TEXT BY / GIULIA SEGAFREDO AND ENZO PISANI / DOCTORS WITH AFRICA CUAMM

REDUCING MATERNAL MORTALITY IN THE AFTERMATH OF THE EBOLA OUTBREAK

In March 2016, Doctors with Africa CUAMM held a workshop in Freetown, Sierra Leone, entitled “From Zero Ebola to Zero Maternal Mortality: Can Investing in the Referral System Make A Difference?”. Its purpose was to bring together institutional and financial stakeholders for a presentation of CUAMM’s activities; however, it also gave us the opportunity to review and analyze the work we are doing in Sierra Leone, particularly in Pujehun District, against the backdrop of the recent Ebola outbreak. Indeed, maternal mortality remains one of the true emergencies in this country, and consequently one of CUAMM’s top priorities.

Global statistics from the World Health Organization (WHO) show that between 1990 and 2015 the global maternal mortality ratio (MMR) fell by about 44%, dropping from 385 to 216 maternal deaths per 100,000 live births – a 2.3% annual rate of reduction. However, in Sub-Saharan Africa levels remain unacceptably high, with a regional MMR in 2015 of 495 maternal deaths per 100,000 live births. And in Sierra Leone, where infant and maternal mortality rates were already among the highest in the world prior to the most recent Ebola outbreak (in 2014, the former was 182 deaths per 1,000 live births and the latter 1,360 deaths per 100,000 live births – WHO data, 2015)¹, the direct and indirect consequences of the epidemic have exacerbated the situation, leading to a 19% increase in the MMR.

There is a general consensus regarding the priority interventions that are needed to reduce maternal deaths and improve reproductive health generally. These include the provision of universally available and accessible emergency obstetric care (EmOC) of good quality, the presence of a professional skilled birth attendant at all births, and the integration of these key services into health systems².

INTEGRATING THE HEALTHCARE SYSTEM TO ENSURE THE QUALITY OF SERVICES

Doctors with Africa CUAMM has been active in Sierra Leone since 2012, in Pujehun District, located in the country’s southernmost

province. With a population of about 375,000, this district has one of the lowest population densities in Sierra Leone: most of its inhabitants live in villages with fewer than 2,000 people. There is only one district hospital in the entire district, which includes a main hospital and a maternity complex; there are also 77 peripheral health units (PHUs), five of which provide basic emergency obstetrics care (BEmOC).

The high number of facilities would seem to point to high health system coverage. However, if a substantial reduction in the MMR is to be achieved, universal coverage of life-saving interventions needs to be matched with comprehensive emergency care and overall improvements in the quality of maternal health care. For this reason, Doctors with Africa CUAMM has been working both on improving primary health care (through the peripheral health centers in the area of Pujehun) and working with the hospital to enable it to meet the demand for higher quality care and respond to the obstetric emergencies that are referred to it by the peripheral centers.

The challenge CUAMM faced upon arriving in Pujehun was that of building an effective health care system providing access to quality care. This necessitated community awareness, transport, skilled human resources, an effective supply chain, safe blood transfusion and around-the-clock emergency care. In fact, in order to overcome the delays generated when patients seek out treatment, thereby reducing maternal and child illness and mortality, a comprehensive, integrated healthcare system that takes into account the relationship between central hospitals and peripheral communities has been strongly recommended³⁻⁴⁻⁵⁻⁶⁻⁷⁻⁸⁻⁹.

AMBULANCE SERVICES: INTEGRAL TO SUCCESSFUL OBSTETRIC EMERGENCY MANAGEMENT

Fifteen thousand deliveries were expected to take place in Pujehun District in 2015, 12,000 (80%) of which in healthcare facilities. Thirty percent of expected obstetric complications were managed in health care facilities; one third of the cases of obstetric emergency, most of which were due to prolonged or obstructed labor, concerned teenage girls.

One of the main obstacles to achieving our objective of reducing maternal mortality was the issue of patient transport to health

TABLE 1 / INDICATORS FOR MONITORING THE MANAGEMENT OF OBSTETRIC COMPLICATIONS

INDICATORS	RESULTS	NOTES	CONCLUSION
1. N.A.*			
2. GEOGRAPHICAL DISTRIBUTION OF EMOC FACILITIES		The recommended number of basic EmOC facilities per every 500,000 inhabitants is 5, plus 1 comprehensive EmOC facility. This target has been reached and surpassed in Pujehun.	Indicator met
a. No. of EmOC facilities for every 500,000 inhabitants	8.0		
b. No. of comprehensive EmOC facilities for every 500,000 inhabitants	1.3		
3. PROPORTION OF ALL BIRTHS IN EMOC FACILITIES		Indicator 3.a considers all the deliveries that took place in Pujehun Hospital and in the 5 BemOCs. Indicator 3.b considers all institutional deliveries.	No target reference available
a. % of births in EmOC facilities	16.2%		
b. % of births in all surveyed facilities	81.3%		
4. MET NEED FOR EMOC		Since the goal is for all women who have obstetric complications to receive EmOC, WHO recommends that the minimum acceptable level should be 100%. Although our results fell below this value, they were still much improved compared to the 2014 figure (29.3% vs. 12%, respectively).	Unmet indicator
a. % of women estimated to have major direct obstetric complications who are treated in a health facility providing EmOC	29.3%		
5. CAESAREAN SECTIONS AS A PROPORTION OF ALL BIRTHS		Although the proportion of Caesarean sections provided fell below the expected percentage (5% to 15%), it was still much improved compared to the 2014 figure (2.3% vs. 0.9 %, respectively).	Unmet indicator
a. Caesarean sections in EmOC as a proportion of all births	2.3%		
6. DIRECT OBSTETRIC CASE FATALITY RATE		WHO states that the maximum acceptable value is <1%. The indicator is therefore in line with the expected value.	Indicator met
a. Direct obstetric case fatality rate in EmOC facilities	0.8%		
7. INTRAPARTUM AND VERY EARLY NEONATAL DEATH RATE		This indicator was calculated twice: first for all children and subsequently for children weighing >2.5Kg at birth. The objective of this indicator is to measure the quality of intrapartum and newborn care. It is recommended that newborns weighing less than 2.5 kg be excluded from the numerator and the denominator whenever the data permit, since low birth weight infants have a high fatality rate in most circumstances.	No target reference available
a.1 Intrapartum and very early neonatal death rate in EmOC facilities	3.0%		
a.2 Intrapartum and very early neonatal death rate in EmOC facilities; only children weighing > 2.5kg at birth	1.0%		
8. PROPORTION OF DEATHS DUE TO INDIRECT CAUSES IN EMOC FACILITIES		This data represents the CemOC indirect mortality rate. This indicator does not lend itself easily to a recommended or ideal level. Instead, it highlights the larger social and medical context of a country or region and has implications for intervention strategies, especially in addition to EmOC, where indirect causes kill many women of reproductive age. In 2015 3 out of 9 deaths in EmOC facilities in the Pujehun District were due to indirect causes.	No target reference available
a. Proportion of deaths due to indirect causes in EmOC facilities	33.33%		

* Indicator 1 was not included because it deals with the national context.

Source: *Trends in Maternal Mortality: 1990 to 2015 estimates by WHO, UNICEF, UNFPA, the World Bank Group and the United Nations Population Division.*

care facilities. To tackle the problem of lack of access to emergency obstetric services, Doctors with Africa CUAMM set up a central emergency obstetric and neonatal care (EmOC) facility at Pujehun Hospital coupled with a 24-hour communication network to facilitate ambulance referrals for the transfer of women with obstetric complications from peripheral maternity units to the facility. The ambulance service is one of the most important factors in achieving the goal of improving access to and the quality of reproductive health, especially in remote settings such as Pujehun **4-5-6-7-10**.

Between 2011 and 2015 the referral of obstetric complications from PHUs to the Pujehun maternity ward rose sharply, with 63 such cases in 2011, 181 in 2013 and 720 in 2015. This was a consequence of the availability of transportation and the activities that were carried out to make the population aware of the service.

In January 2015 Doctors with Africa CUAMM further improved the referral system in Pujehun District by providing two more ambulances (for a total of three) for free transportation from primary

health care units to the second level of care. That year obstetric referrals rose +251% compared to 2014, and 464 of the 679 MDOCs managed at Pujehun Hospital (63%) were referred by ambulance.

INDICATORS FOR MONITORING EMERGENCY OBSTETRIC CARE

At this point the question arose as to whether it would be possible to use a standardized approach to monitor the management of obstetric complications. In 1991, UNICEF asked a team from Columbia University to design a new set of EmOC indicators to make it possible to monitor the availability, accessibility, quality and use of services for the treatment of complications that can arise during pregnancy and childbirth. In 2009, these indicators were reviewed and, despite being heavily criticized, continue to be used to monitor and measure the implementation and

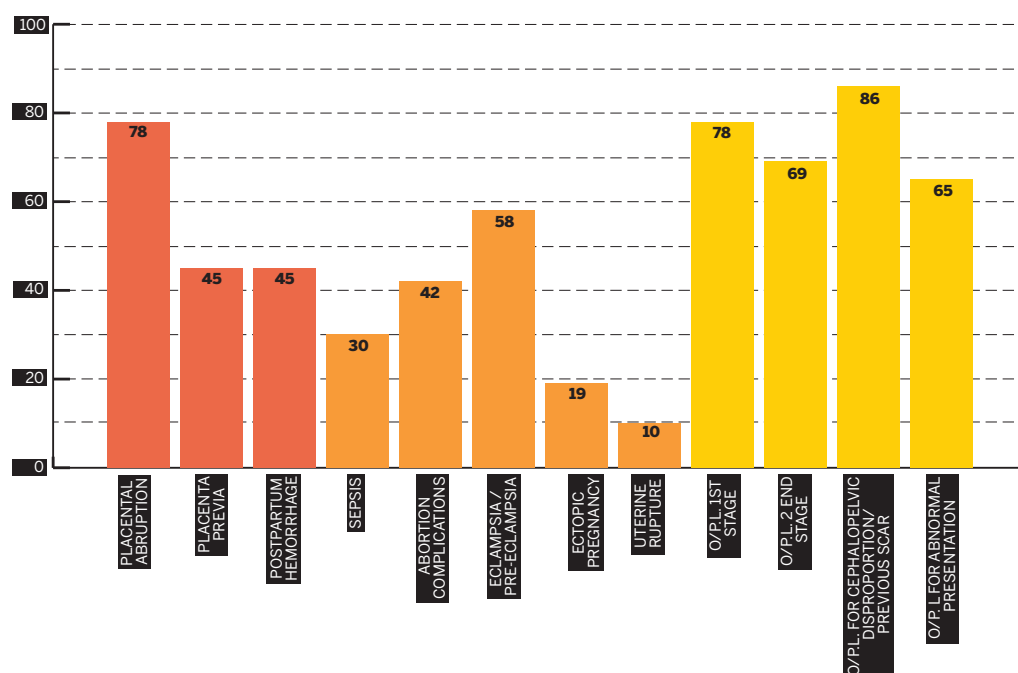
progress of EmOC policies, programs and activities. They address the following questions:

- Are there enough facilities providing EmOC?
- Are the facilities well distributed?
- Are enough women using the facilities?
- Are the right women – i.e. women with obstetric complications – using the facilities?
- Are enough critical services being provided?
- Is the quality of the services adequate?

Parameters are then provided to help interpret the values collected, as described here below. **Table 1** shows seven of the eight indicators and the Pujehun assessment for each of them. Overall, we saw positive progress in terms of all of the indicators vis-à-vis the previous year. The only targets that have yet to be achieved are those related to “Met need for EmOC” and “Cesarean sections as a proportion of all births”, but here too there was some improvement vis-à-vis last year.

Doctors with Africa CUAMM felt it would be helpful to include an additional indicator, “Unmet obstetric need” – a particularly important one as it quantifies to what extent EmOC has been provided, estimating the number of women in need of a major obstetric intervention for life-threatening complications who did not have access to appropriate care. This indicator is especially helpful for identifying geographical or social inequities in access to hospital care. Although no reference data are currently available for it, we can affirm that Pujehun District kept the level of unmet obstetric need under 35%, thereby achieving a relatively good level of care.

FIGURE 1 / DISTRIBUTION OF MAIN MDOCS IN PUJEHUN DISTRICT (2015)



CONCLUSION

Based on Doctors with Africa CUAMM's experience in Pujehun District and the data presented above, it seems clear that our decision to invest both in the referral system and in secondary care, which plays a strategic role in reducing maternal mortality, was of key importance in achieving these improvements. In terms of planning, we believe it is crucial to take into account geographical peculiarities, pay special attention to especially vulnerable communities such as teenagers, and monitor obstetric emergencies with good statistics.

Reducing the MMR in a high-burden country like Sierra Leone is a major challenge that can be met only if all stakeholders – health institutions, communities, NGOs and aid agencies – share a strong commitment to doing so.

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TAKING A CLOSER LOOK

SOUTH SUDAN: WAR, DROUGHT AND ECONOMIC CRISIS

War, drought, the oil crisis: together, these factors have brought about a situation of extreme vulnerability in South Sudan. Five million individuals require humanitarian assistance and 2.4 million have fled from their homes. The impact on people's health has been severe, and malnutrition is on the rise. This is where CUAMM has stepped in to help, with a special focus on mothers and children.

TEXT BY / CHIARA SCANAGATTA / DOCTORS WITH AFRICA CUAMM

South Sudan's two-year-long civil war has left the country deeply scarred. The consequences of the conflict are not only political; they have also had a heavy impact on people's quality of life and the overall society, underscoring the interconnections between health, development, politics and the economy. Environmental and climate-related factors have only exacerbated the country's current vulnerability. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) has estimated that it will be able to provide 5 million people with humanitarian assistance this year¹, including both those who continue to reside in their places of origin or habitual residence and the displaced. By May 2016, in fact, some 2.4 million people had been forced to flee from their homes, 712,000 of whom have sought refuge in neighboring countries. The main factors driving people to this drastic decision are physical and food insecurity. In February 2016, UNICEF, the Food and Agriculture Organization (FAO) and the World Food Programme (WFP) sounded the alarm, stating that 2.8 million people – nearly 25 percent of the country's population – were "in urgent need of food assistance" because of insufficient access to staple foods, and at least 40,000 were "on the brink of catastrophe".² The situation is the result of a combination of environmental, political and economic factors³ that has impacted not just the areas where the conflict is underway, but the entire country. In addition, in 2015 a prolonged dry spell negatively affected agricultural activities, already under strain due to looting and continued insecurity. Local market systems have become increasingly dysfunctional and inaccessible, due both to the global decline in the price of oil, which accounts for 98% of government revenues, and to the devaluation of the local currency. Less than one fifth of the country's total population is receiving food aid, a number that is far too low given the vast scope of the problem⁴. The result is a rise in acute malnutrition that has surpassed the emergency threshold⁵: at the end of 2015, OCHA estimated that 1 out of every 4 children under the age of 5 and 1 out of every 3 pregnant women were malnourished⁶, and the situation may worsen. The United Nations agencies responsible for responding to humanitarian emergencies have repeatedly underscored the importance of integrating the response to malnutrition, which is usually carried out based on a vertical approach, into broader health-related interventions. This is precisely what Doctors with Africa CUAMM, which has been active in South Sudan since 2006, is doing. Although we do not work in the most conflict-ridden areas of the country, we are present in counties where the situation is very critical. Adverse climatic conditions, the insecurity that has disrupted farming and harvesting activities, and the constant flow of internally displaced migrants mean that today, most families eat just one meal a day. Doctors with Africa CUAMM's response, which has been planned and implemented in cooperation with local health authorities and the United Nations agencies responsible for providing nutritional supplements, such as UNICEF and WFP, focuses on preventing and treating moderate and severe acute malnutrition in children under five years of age and in pregnant or breastfeeding women. The activities being carried out include:

- health and nutrition education;
 - monitoring of nutritional status and provision of micronutrients to anyone who comes for a prenatal or pediatric visit or a vaccination;
 - hospitalization and/or provision of nutritional supplements for the treatment of moderate or severe acute malnutrition.
- Prevention activities are being carried out in 81 peripheral health facilities in 7 counties and treatment is being provided in 18 such facilities in 3 counties, including 3 hospitals.

This work was begun only recently, but in the first three months of 2016 we have already achieved the following results:

- 6,059 children under the age of 5 and 525 pregnant or breastfeeding women have had their nutritional status monitored;
- 179 children under the age of 5 and 105 pregnant or breastfeeding women have been enrolled in a treatment program for moderate acute malnutrition;
- 361 children under the age of 5 have been enrolled in a treatment program for severe acute malnutrition.

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REPORT

CLIMATE REFUGEES: A PHENOMENON ON THE RISE

There is no consensus on the exact figures: UNHCR estimates that there could be anywhere from 25 to 250 million climate refugees by 2050. The effects of drought and flooding are undermining the dignity of people's lives and forcing them to flee their homes.

TEXT BY / CLARISSA DE NARDI AND ELENA CAPELLI / ITALIAN MEDICAL STUDENTS' ASSOCIATION (SISM)

According to the UNHCR, in 2014 some 22 million people migrated from one region or country to another in order to escape from famine or drought. Such individuals are called "climate refugees" because they are driven from their homes by the poverty and hardships that ensue from climatic phenomena. And difficult as it is to quantify their exact numbers, some estimate that by the year 2050, the number of people fleeing from their places of origin as a result of climate change could be anywhere from 25 million to 250 million.

One of the reasons that it is so tricky to make a reliable forecast is that there is no clear-cut definition of the terms "climate refugee" or "environmental refugee". The latter was first coined by the environmental pioneer Lester Brown in 1976, but today other similar terms are also used to describe this type of migrant, including "forced environmental migrants" and "disaster refugees".

What's more, it is often a myriad of factors acting in concert that shapes people's decision to migrate. Most experts see climate change as an underlying driver of the deterioration of people's socio-economic status, with events such as drought, flooding and hurricanes bringing already vulnerable communities to their knees and creating situations that make it extremely difficult to live a life of dignity. And environmental disasters are not just devastating in themselves; the way they are dealt with by institutions, communities and individuals, the promptness with which they are reacted to, the amount of resources that is made available to manage their consequences – these factors, too, are of critical importance in determining the final outcome of such events, particularly when they are sudden ones such as floods, major storms and earthquakes.

WHO ARE CLIMATE REFUGEES, AND WHAT KIND OF FUTURE AWAITS THEM?

When they are not faced with attendant problems such as ongoing conflicts that endanger their security, climate refugees are much more likely to migrate internally within their own countries than to other countries. People often move alone or in small groups with other family members, and frequently they make their way towards large urban centers, often the nearest to the place hit by the disaster. The phenomenon has a significant impact both on the areas the migrants have left behind and on the residential areas to which they flee, thereby increasing levels of urbanization.

THE REASONS FOR AND IMPACT OF CLIMATE MIGRATION

Low-income countries are the most hard-hit by the effects of climate change, as their economies are highly dependent on the agricultural sector, whose output is directly affected by adverse weather events. Soil erosion, desertification and rising sea levels eat away at arable land, while changes in seasonal rainfall patterns, drought and devastating storms damage crops, forcing the people living in these areas to migrate to more fertile areas or to cities in the hope of better job opportunities and therefore greater chances of survival.

Not only are people and land impoverished; tax revenues and productivity also fall in these areas, a situation that is exacerbated if people decide to migrate abroad. Migratory phenomena have therefore become a matter of top concern for national governments; and it makes sense for them to try to manage the situation in order to avoid draining their countries of precious human resources, creating new employment strategies that could positively impact their respective economies and thereby also providing incentives for their citizens to stay in, and contribute to the overall wealth of, their countries of origin. However, many governments lack the tools for handling domestic economic crises, and have few welfare policies in place.

CLIMATE REFUGEES AND INTERNATIONAL CONVENTIONS

The protection of climate refugees is a contentious issue. In fact, at present such individuals have no legal rights to protection, in part because it is no easy matter to separate environmental factors out from all the other possible ones driving the decision to leave one's home. Until the law recognizes climate change as a valid factor for refugee status, it is going to be very difficult to ensure that the rights of such individuals are protected. Thus far, there has been only one successful case of an application for asylum on climate-related grounds, but the judge presiding over the case granted residency abroad on "humanitarian" grounds, thus avoiding opening the floodgates to other climate change refugee claims. The international community cannot turn a blind eye to migration flow projections over the next few decades. It is appropriate to point out to governments everywhere the need to focus on this type of migration as well, since doing so is key to understanding and at least partially preventing the economic and social crises it can leave in its wake. Establishing legal protections would be a first step towards investing in the security of citizens who find themselves in grave difficulty due to climate change, and thus also investing in the growth of lower-income countries.

NARRATIVE MEDICINE: LETTING PATIENTS BE SEEN AND HEARD

Sandro Spinsanti's recent book on narrative medicine¹ offers a complementary approach to precision medicine in order to help healthcare professionals put in practice a more holistic conception of health – a way both to humanize Western-style healthcare and to counterbalance the lack of means in low-income settings.

TEXT BY / SANDRO SPINSANTI / DIRECTOR, GIANO INSTITUTE FOR THE MEDICAL HUMANITIES

"Let's go back to the old ways: that will be progress". While Giuseppe Verdi's celebrated exhortation was adopted mainly in the world of art, perhaps we can now find the courage to apply it in the medical field as well. At a time when medical progress is identified with scientific and technological advances, where even the scientific validity of evidence-based medicine (EBM) is seen as inadequate and the emerging approach is that of so-called "precision medicine", the recommendation to healthcare professionals to rethink their usual *modus operandi* and rediscover the importance of engaging patients in a dialogue – that most plain and "lowly" of tools in the therapeutic arsenal – may seem somewhat provocative. Some might view narrative as a tool to be used with those who have not yet achieved a sufficient level of economic and social development to be able to afford the medical treatment that the rich have available to them, almost as if in the absence of more "serious" treatments, one may as well fall back on the spoken word. The most open-minded individuals may deem narrative medicine appropriate for use in multicultural settings alone. Instead, it challenges us to break down such false barriers, making a forceful case that if healthcare professionals want to provide their patients with truly good care, narratives are of fundamental importance in any setting. Just because a country is among the world's least technologically-advanced does not mean that the medical care offered there is lacking from a relationship and communications standpoint. On the contrary, people would rightfully be taken aback if the suggestion were made to practice medicine in the African context paying little attention to the relationship and communication between healthcare provider and patient, as we do in Europe. Thus narrative medicine is not a "product" to be exported to the world's poorer countries, but rather a proposal for tackling some of the negative aspects of Western healthcare practices.

The first step to be taken towards embracing this approach is to acknowledge that some of the recent developments in medicine have



La medicina vestita di narrazione, Sandro Spinsanti, Il Pensiero Scientifico Editore, February 2016

led us down blind alleys. In a relatively short period of time, the medical field has introduced significant changes to the kind of therapeutic relationship that predominated for centuries. Doctors then did not discuss diagnoses and prognoses with their patients, nor attempt to learn what the unwell person's priorities were in order to decide on the course of treatment together. Good doctors made decisions on behalf of their patients, at times sharing them with family members. This model – which is seen, with good reason, as a paternalistic one, since it involved a doctor-patient relationship similar to that between a parent and a child perceived as incapable of understanding or expressing his or her own best interest – was replaced with the current one, which obliges doctors to inform patients of a proposed treatment and obtain their explicit consent to it. Narrative medicine takes us a step further, at the same time correcting some of the more

problematic issues of the informed consent model.

Perhaps narrative medicine could serve as a kind of handy label for advancing an idea that people have long aspired to: that healthcare providers and recipients come together first and foremost as human beings. "Humanized" healthcare, an oft-invoked concept, does not come about through good intentions alone. Empathy and sharing are important, of course, but the ability to communicate verbally is the most defining characteristic and function of human beings. Yet even while medicine today provides an excess of information, good listening skills are noticeably absent; and when care providers fail to listen, decisions regarding patients always come from above, regardless of how many informed consent forms they have signed. The life and soul of narrative medicine is a dialogue between the individual in need of care and the health professional with the ability to provide it – not a friendly chat, but a mutual exchange of knowledge and values that takes into account the ineluctably different roles of each. This is how we can reach truly shared decisions, i.e. decisions that are customized to a specific patient like a tailor-made outfit would be.

NOTES

¹ Sandro Spinsanti, *La medicina vestita di narrazione*, Il Pensiero Scientifico Editore, Rome, 2016



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 access to quality health care even in emergency situations.

HISTORY

In our **65-year history**:

- o **1,569** individuals have worked on our projects abroad; 422 of them have gone on to repeat the experience at least once
- o **1,053** students have lodged at CUAMM's university college
- o **163** major programs have been carried out by CUAMM in cooperation with the Italian Foreign Ministry and various international agencies
- o **217** hospitals have been served
- o **41** countries have been the beneficiaries of CUAMM's work
- o **5,021** years of service have been provided, with each CUAMM worker serving for an average of three years.

IN AFRICA

Today, Doctors with Africa CUAMM works with local communities in Angola, Ethiopia, Mozambique, Sierra Leone, South Sudan, Tanzania and Uganda, implementing **42 major development projects** and around one hundred smaller related ones. Through this work we provide support to:

- 16 hospitals;
- 34 local districts (with activities focused on public health, maternal and child health care, the fight against AIDS, tuberculosis and malaria, and training);
- 3 nursing schools;
- 2 universities (in Mozambique and Ethiopia).

180 International professionals:

- 125 doctors;
- 12 health workers;
- 3 nursing schools;
- 23 administrative workers;
- 7 logisticians.

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 91 H 05018 12101 000000107890 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.

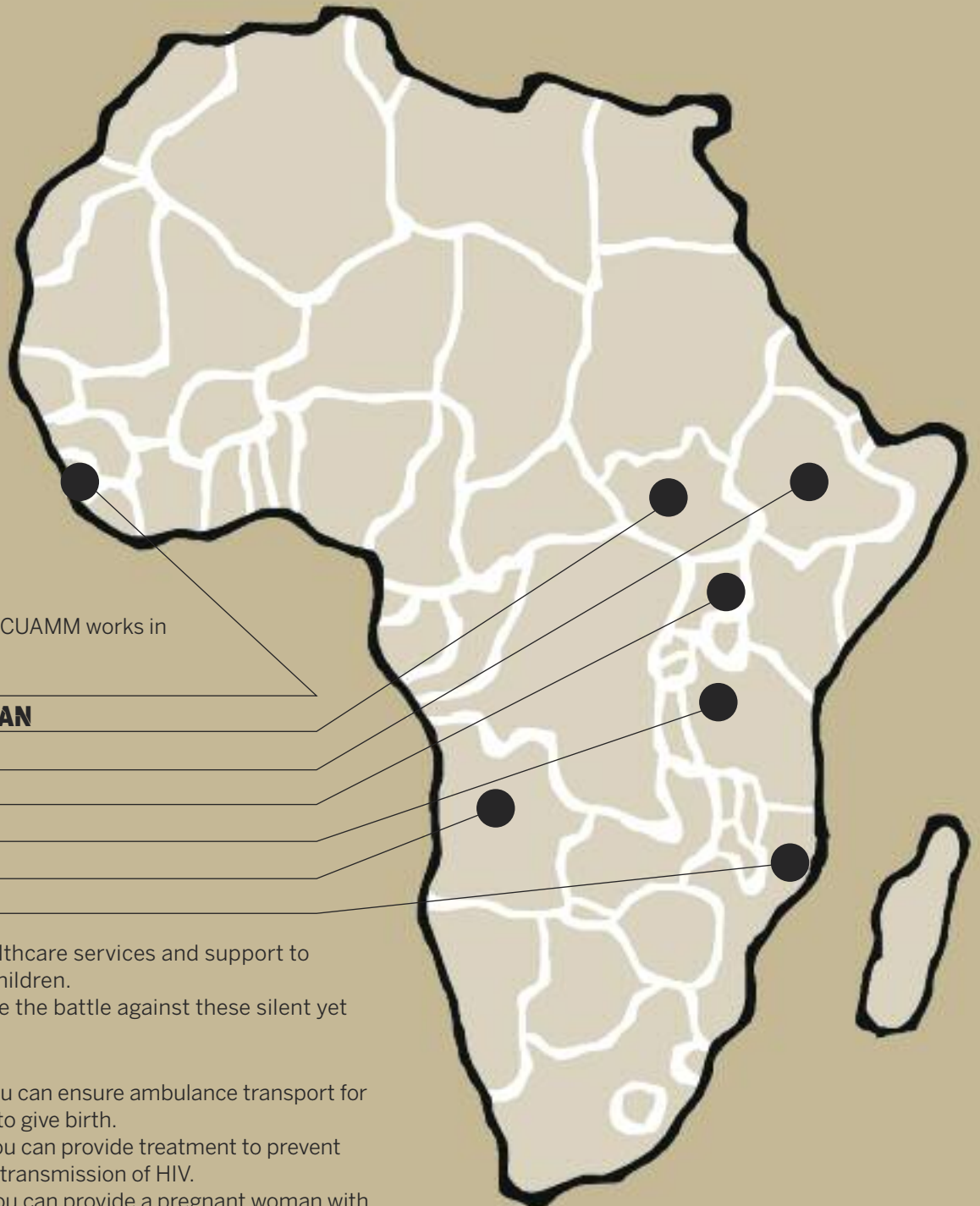
In **Health and Development** you will find studies, research and other articles which are unique to the Italian editorial world. Our publication needs the support of every reader and friend of Doctors with Africa CUAMM.



AFRICA IN NEED

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children under the age of 5 die from preventable diseases that could be treated inexpensively;
- 1.2 million infants die in their first month of life due to lack of treatment;
- 265 thousand women die from pregnancy- or childbirth-related complications.



Doctors with Africa CUAMM works in

SIERRA LEONE
SOUTHERN SUDAN
ETHIOPIA
UGANDA
TANZANIA
ANGOLA
MOZAMBIQUE

where we offer healthcare services and support to such women and children.
 Please help us wage the battle against these silent yet deadly scourges.

- With 15 euros you can ensure ambulance transport for a woman about to give birth.
- With 25 euros you can provide treatment to prevent mother-to-child transmission of HIV.
- With 40 euros you can provide a pregnant woman with an assisted delivery.
- With 80 euros you can fund a week-long training course for a midwife.



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