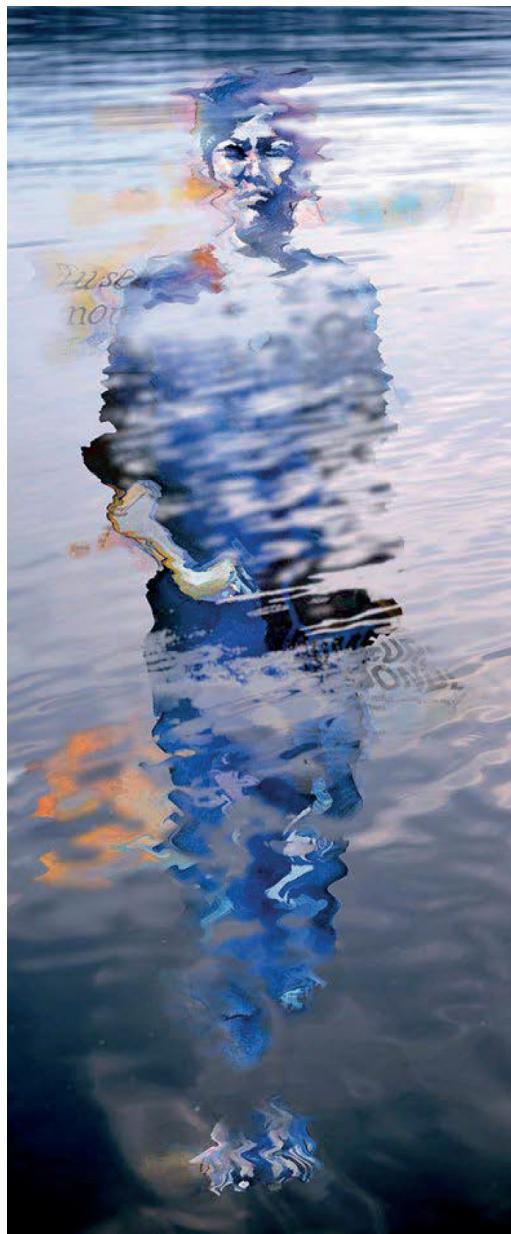


Health right across the Mediterranean tackling inequalities and building capacities

Edited by
Emilio Di Maria



Health Pathways

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Edited by
Emilio Di Maria



is the bookmark of the University of Genoa



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Publisher

GENOVA UNIVERSITY PRESS

Piazza della Nunziata, 6 - 16124 Genova - Italy

Tel. +39 010 20951558

Fax +39 010 20951552

e-mail: ce-press@liste.unige.it

e-mail: labgup@arch.unige.it

<http://gup.unige.it>

ISBN: 978-88-94943-50-4 (printed version)



(e-Book)

ISBN: 978-88-94943-51-1 (e-Book)

Printed in June 2019



Print
Centro Stampa
Università degli Studi di Genova - Via Balbi 5, 16126 Genova
e-mail: centrostampa@unige.it

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Forewords

Marina Rui, Riccardo Spinelli

This foreword stemmed from the introductory address given at workshop *Health right across the Mediterranean: tackling inequalities and building capacities*, held at the University of Genova on April, 2017.

The event took place within the framework of the initiatives of the International Year of Global Understanding (IYGU) and represented another valuable contribution by the University of Genova to this celebration.

The IYGU Initiative focussed its activity on the co-operation of over 30 Regional Action Centers (RACs), with offices in five continents. The University of Genova had set up a Regional Action Center for the whole of Italy with the purpose of promoting actions in the field of research, education and communication, in line with the IYGU objectives.

International cooperation for development is a fairly new area of activity for Universities, but is progressively gaining importance within the framework of academic public engagement. This holds particularly true here, in Italy, where the new legal framework on international cooperation gives Universities an important role in the overall national cooperation system.

Consistently with the University's mission, the workshop focussed on a very relevant topic, on which the scientific competence of academic scholars profitably balanced the experiences of supranational institutions and other actors such as Non-Governmental Organisations.

Health issues – and in particular, health inequalities – associated with the migration phenomenon in the Mediterranean area are known to everyone. Notably, the thread that connects the structure of the workshop, which is built around the juxtaposition of the concepts of global and local and properly highlights the complexity of the issues that were subsequently addressed in this book.

On the one hand – from global to local – a high critical mass is certainly needed to face these problems on a global scale, as health issues are quite often global

issues by their very nature. Hence, the key role of supranational institutions such as WHO, that can contribute to the worldwide diffusion of good practices and the coordination of global interventions.

On the other hand – from local to global – the importance of all the activities, projects, experiences that are implemented by local actors and researchers cannot be forgotten. They often generated good practices that are then leveraged on the largest possible scale. Hence, the importance of sharing the body of knowledge that is locally generated, to turn it into a common toolbox to apply very far away from where these ideas have born.

Consequently, efficient and effective action against health inequalities cannot do without a continuous dialogue between the local and the global dimension. The workshop gave ample space to both dimensions, with a multidisciplinary perspective that further enhances the value of the contributions.

Riccardo Spinelli, PhD, Rector's Delegate for International Cooperation for Development,

and

Marina Rui, PhD, Rector's Delegate for eLearning, University of Genova, Italy

The International Year of Global Understanding (IYGU)

Franco Montanari

Knowledge is the factor that leads us to change our way of thinking. However, it is the understanding that leads to change attitudes.

Dr. Eliezer Batista (Pioneer of the concept of sustainability and key figure of the Rio 1992 Summit)

The year 2016 had been declared International Year of Global Understanding (IYGU) by the three leading global sciences organizations of the natural, social, and human sciences: International Council for Science (ICSU), International Social Science Council (ISSC), and International Council for Philosophy and Human Sciences (CIPSH). These three non-governmental organizations cooperate with UNESCO and federate hundreds of societies in the different fields of knowledge. The initiative was promoted by the International Geographical Union and originated from the Friedrich Schiller University of Jena in Germany, under the Presidency of Professor Benno Werlen (<http://www.global-understanding.info>).

The International Year of Global Understanding (IYGU) has been a huge and ambitious enterprise. It was meant to address with an interdisciplinary approach the most crucial challenges of our time. Nowadays, we are confronted with the radically changing geography of a globalized world, an unprecedented situation, in which we have to face incumbent threats such as environmental changes, climate change, pollution, exploitation of natural resources, hazards to biodiversity.

IYGU was intended not only to enrich the scientific debate on such fundamental questions, but also to support and encourage concrete, everyday projects, and ultimately to call attention to the fact that changing the world is everyone's business, addressing cultural institutions as well as governments of various countries.

The keyword to address the challenges in the emerging global reality is ‘understanding’, that is to say, knowledge and awareness of the different socio-cultural contexts of everyday actions, and interaction between science and decision-making in order to translate knowledge into action strategies and fill the gap between global challenges and national politics.

IYGU was structured into a network of roughly forty Regional Actions Centers (RACs) all over the world, one of which is based here in Genova and is coordinating the Italian area (<http://www.dafist.unige.it/iygu>). Each Regional Action Center has proposed several activities with the common objective of a Global Understanding.

The first step is to understand how local everyday actions and global sustainability are interconnected and recognize that everyday actions are rooted in specific socio-cultural contexts. That is to say that in order to be effective we have to work on differentiated ways to achieve global sustainability. It is patent that a truly interdisciplinary cooperation between hard sciences and humanistic studies is much needed to achieve such a goal. We have to know societies and cultures, because they shape the ways we live and interact with nature, and affect how we perceive the global effects of our actions.

Yet, a further step is necessary: knowledge is not enough. We have to translate knowledge into operational policies, and generate bottom-up solutions to global-socio-ecological problems, thus complementing existing top-down measures. This can be achieved only by enhancing everyone’s awareness of the individual capacity and responsibility for everyday-decision-making. There is a dire need to understand and make people understand that individual everyday choices, practices and actions have a global reach and can lead to sustainable change.

In other words, IYGU has been working to build a bridge between local and global dimensions, as well as social and natural approaches, and everyday decisions and scientific knowledge.

In order to move towards these lofty goals, the IYGU network has been working along three main action areas: 1) research, bringing together social and natural scientists as well as the humanities to gain an understanding of the global impact of everyday activities and show culturally differentiated pathways towards global sustainability; 2) education, encouraging teaching institutions at all educational levels to engage in interdisciplinary teaching for global sustainability and use the relevant research results; 3) information, increasing public awareness by using different media platforms.

The activities in these three interconnected action areas, research, education and information, ranged over six main themes, identified as central topics:

- Eating/Drinking//Surviving;
- Moving/Staying//Belonging;
- Working/Housing//Urbanizing;
- Wasting/Recycling//Preserving;
- Communicating/Networking//Interacting;
- Sports/Entertaining//Recovering.

It is patent that health and health right are closely linked to all these six themes. Health is precisely related to the ways we survive, belong, urbanize, preserve, interact and recover. It is one of the most important worldwide challenges. Addressing this challenge means just build bridges between local and global perspectives, nature and society, science and everyday action. This is an arduous challenge indeed. The first step to face it, and to face it effectively, needs to be understood.

ADDENDUM (January 2018)

The IYGU closing ceremony took place on November 21st, 2017, in Jena. In 2016 and 2017, more than 1000 major IYGU events were staged around the globe and other ones are going to take place after the closing ceremony, thanks to the activities of the Regional Action Centers (RACs): a first overview of the IYGU events is available at <http://www.dafist.unige.it/iygu> (*Report degli eventi IYGU*).

The IYGU President, Professor Benno Werlen, wrote to the chairs of the IYGU Regional Action Centers on November 21st, 2017:

On June 8th, the day the American President, Donald Trump, announced the United States were leaving the Paris climate agreement, I wrote to the presidents and executive directors of the proclaiming Science Councils, stating that with this decision the IYGU's programme was becoming more important than ever; therefore, I suggested the proclamation of a Science Decade of Global Understanding (SDGU). The responses of the executive directors of ICSU, ISSC, and CIPSH on June 12th were very positive and suggested that a detailed programme be submitted until the end of September. I submitted such a proposal to the three Councils, in-

cluding an action programme, a tentative draft of the declaration, and the organizational structure.

And on December 22nd, 2017:

The current state of the world is showing that the end of the IYGU should not be the end of the efforts to make the global condition of our life better understandable. Therefore, we should continue our efforts. In a world where a push for national interests and increasing isolation from the international community are becoming yet again an invogue political strategy, understanding the links between the global and the local is crucially important to move forward on many important issues. In this context, the communication with the general public, the work at the interface of everyday life and science is of the highest relevance. With a ‘post-truth’ world on the horizon, in which ‘alternative facts’ stand on an equal footing with scientifically assessed and validated information and knowledge, it is all the more important to make scientific insights accessible as a public good. As already communicated, we are on the way to prepare the proposal for the declaration of the 2020s as Science Decade of Global Understanding (SDGU) by the sciences councils, and as mentioned in the several messages for the closing ceremony, hopefully this will be in cooperation with UNESCO and perhaps the UN. This decade will build upon the achievements of the International Year of Global Understanding and continue to deal with the three interfaces of science/ everyday life, society and culture/nature, and local/global in the fields of research, education, and information.

After official contacts, I can confirm that the Italian RAC of the University of Genova is ready and willing to continue its activity within the Science Decade of Global Understanding.

Franco Montanari

Coordinator of the IYGU Regional Action Center - UNIGE

Introduction:

Health right across the Mediterranean, from evidence to equity – a challenge for public engagement

*Emilio Di Maria**

On April 2017, the University of Genoa hosted an international workshop named “Health Right across the Mediterranean – tackling inequalities and building capacities”¹. The workplan of the present volume stemmed from the contributions given at the workshop and the related discussion².

The international meeting was aimed at stimulating reflections and dialogues about the current challenges for health right access and provision connected with the stream of refugees from Africa and the Middle East. However, this was just the incidental reason to embark on the organisation of the workshop. In 2016, approximately 200,000 individuals landed in Italy. They came from the shores of the Mediterranean. Most were escaping from war, terrorism, Libyan prisons, unemployment, starvation. All were looking for a better life, for themselves and their family. Thousands died, across the Mediterranean.

We soon identified a thread linking several, seemingly heterogenous, themes. This book tries to retrace a path by means of a few landmarks, with no ambition to exhaustively cover, as a whole, the extremely complex subject of health right for people on the move.

As a beginning for our conversation, we had to set the scene and posit a framework made up of a few robust facts and principles.

“Health right” is the first term of the statement introducing this book. Health as a fundamental human right, recognised as such by international treaties as well as the Constitutions of democratic states. We chose the fundamental paradigm, which envisages “the highest attainable standard of health as a fundamental right of every human being” [WHO Constitution, 1946].

* correspondence to: emilio.dimaria@unige.it

¹ The programme of the workshop is available on the website of the University of Genoa: https://unige.it/notizie/documents/mediterranea_060417.pdf

² The playlist with individual recording of presentations given is available at: https://www.youtube.com/playlist?list=PLbF0BXX_6CPKb51V6zS4aeBVwrX0L0jqV

Assuming health as an individual's right (as stated in the Constitution of the Italian Republic, article 32: "The Republic shall safeguard health as a fundamental right of the individual and as a collective interest...") [Constitution of the Italian Republic]) implies an obligation to ensure access to appropriate, acceptable, and affordable health care as well as to act on determinants of health. Using the lenses of health care, without a social justice perspective, gives a partial view of health promotion which, in turn, runs the risk of increasing inequalities.

An awareness of the health gap, as defined by Michael Marmot, is the introductory part of this book.

Access to health care is an undeniable determinant of the course of illnesses but does not ensure effective results if not framed in a plan for social justice and positive actions to improve equity. The transcript of Michael Marmot's talk, which opens this book, provides an overview of grounded evidence demonstrating the effects of social variables in determining individual health across different national contexts.

After our conversation, Michael Marmot completed his effort with the Pan-American Health Organisation and launched the final report in September 2018 [Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas, 2018]. The report is not a mere update on health inequalities in the American continent. It has been an opportunity to reinterpret the connection between social justice and health in a novel conceptual framework, more adherent to the contemporary complexity and interrelations between many variables. "It is an important moment to publish this report", Marmot says in his editorial [Marmot, 2018], as "Too much inequality damages social cohesion, leads to unfair distribution of life chances, and to health inequalities".

Consistently with this statement, the Regional Office for Europe of the World Health Organisation recently launched a series of key publications grouped under the title "Driving forward health equity – the role of accountability, policy coherence, social participation and empowerment" [see WHO, 2019a and citations therein]. This leads to another pillar of evidence which strengthens the first part of the book: by stating that migration is at the core of public health, Santino Severoni helps us to reframe migrants' health within a global scenario of countless routes: between continents, northbound and westbound, between countries in the same continent, within the same country – migration occurs at any geographical scale. Again, providing access to health care is a stringent duty for vulnerable persons such as asylum seekers and undocumented migrants. Local

crises, of course, heavily unbalance the migration patterns. The current figures, summarised by Severoni, underline that the majority of families who were forced to leave the Syrian battlefields are displaced in Middle East: in Lebanon, Jordan, Syria itself – the Eastern coast of the Mediterranean.

Therefore, “across the Mediterranean” is the term which links the global facts with our responsibility to act at the local level.

Migration is a global phenomenon of unparalleled size. It is worth to recall, however, that the seemingly huge number of displaced individuals corresponds to approximately 3% of the human population, as it was since the first groups of *homo sapiens* left their homeland in Africa and started moving. They were but a few, out of a few thousands of individuals. They were – they are – pushed by need and supported by hope. Here, now, more than seven billion individuals live on Earth. This is unprecedented, in fact, and not sufficiently taken into consideration when migration is seen through local lenses.

Global overpopulation is a pivotal element of the context which made urgent the elaboration of the seventeen Sustainable Development Goals (SDGs). Grammenos Mastrojeni outlines the SDGs framework and the focus on health as one of the interconnected elements of a matrix, in which each item depends on and influences the others with no obvious hierarchy.

Also central is the ability to interpret the local phenomena and operate on vulnerable individuals, recognising the principles learned from the global level. The second section of the book addresses the role and responsibility for health professionals to promote health equity by acting at the local level.

Among the innumerable possible topics, we chose to discuss interlinguistic and intercultural mediation as an emblematic field that essentially encompasses different disciplines and professions. Although it is widely acknowledged that meeting the need for effective communication is a paramount process in provision of health care for recently arrived migrants, the model currently adopted – in Europe, at least – still lacks a robust base of evidence in favour of its effectiveness.

Two back-to-back papers discuss the issue. Raga Gimeno discusses the experience of interlinguistic and intercultural mediation in the healthcare context, according to a model which is widely used with patients of foreign origin. The experiences described in the paper shed light on limitations of the current practice, concluding that a new model of concerted actions should be shared among health professionals and institutions. De Luise and Morelli speculate about the development of new knowledge-based models. The lessons

learned from interlinguistic communication in health care and mediation in multilingual communities may provide the ground to build new models of effective communication aimed at improving the health system's response in the evolving landscape of migration across the Mediterranean. Dell'Aversana and Bruno explored the current provision of culturally competent health services in Italy. They provide a piece of evidence demonstrating, as a conclusion, the lack of a reliable governance level in the process of development and organisation of services. The paper by Giacobbe and Viscoli is an example of how a locally observed phenomenon, that is the antibiotic resistance, should be interpreted on the basis of evidence and be addressed through the implementation of consistent plans elaborated and shared by both health professionals and decision makers.

Once postulated that people's health is at the core of our interests, the focus has moved away from health care in isolation. Yet, assuming the paradigms of appropriateness and sustainability, tackling health inequalities poses an obligation to develop pathways of care for vulnerable and deprived individuals.

The last part of the book reports few examples reconnecting the fundamental principles and the base of knowledge outlined in the first section with the actions that should be implemented to improve the capacity of fighting against health inequalities.

In her chapter, Ferrelli highlights the role of international cooperation combined with research on public health. She reports on the results from several action-research initiatives involving public authorities and private organizations and their favourable effect on local development and community empowerment, thus reinforcing a model of co-development which recognises the role of the resident communities as active protagonists.

Assuming, as we do, that each individual should have access to the best attainable standard of care, whether the health services are sustainable depends on a responsible use of resources. In other words, responsible governance of investments and disinvestments is mandatory to guarantee that what is needed is affordable and what is affordable is equally provided. The chapter by Flego and Cardinale introduces the principles of health technology assessment (HTA) as a tool for equity in health care. HTA is an instrument in the toolbox of clinical governance potentially able to improve the proper allocation of resources.

The last chapter is not a reflection on health right across the Mediterranean – it is just action. Luciano Griso reports the experience of the humanitarian corridors organised between Lebanon to Italy to rescue families of refugees escaping from

the Syrian crisis. The programme, named Medical Hope, is still active at the time of publication of this book with an increasing number of families hosted in Italy.

The multifaceted conversation reported in the present volume deals with an evolving scenario. As an obvious consequence, any reflection, any piece of evidence, is destined to be overcome by new facts and figures. I propose as a humble suggestion that the readers approach the contributions in dialogue with the latest evidence and recommendations published after our workshop.

The need for evidence in humanitarian crises has been illuminated in the online series of papers released by The Lancet in 2017 [see Samarekera and Horton, 2017 and citations therein]. Subsequently, a few comprehensive and undoubtedly authoritative reports were released. It is worth to quote one line from the “Report on the health of refugees and migrants in the WHO European Region” [WHO, 2019b], which serves as subtitle: “No public health without refugee and migrant health”.

As summary of some conclusions, I will make reference to the exhaustive report prepared by the UCL-*Lancet* Commission on migration and health [Abubakar, 2018]. Governance at the level of national and multilateral agencies is beyond the attributions of most of our readers, I guess; however, the part played by civil society in leadership and accountability should be kept in mind. Governance at its every level is under the responsibility of us all as citizens, irrespectively of whether we are health professionals, academics, or end users of services. The report calls also health leaders and practitioners to fully engage in dialogue with decision makers and participate in programme planning for migrants’ health. “Racism and prejudice should be confronted with a zero tolerance approach” deserves to be cited verbatim from the key messages.

What is such a call for engagement for? Universal and equitable access to health services and to the determinants of the highest attainable standards of health is the goal to be achieved. Actions should target migrants, victims of disasters or conflicts, as well as deprived individuals and communities.

For those who are willing to read this book and examine its content with reference to their own experience, the Authors and I hope that a few basic keywords will be remembered: *evidence, equity, engagement*.

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First section:

From global phenomena to individual health

The health gap: social determinants and health equity

*Sir Michael Marmot**

[Note: this paper is the transcript of the lecture given at the workshop, edited and approved by the Author]

The previous presentation¹ revolved around the issue of migrants: it is indeed an important issue for Europe as a whole and for individual countries. Dr Severoni highlighted difficulties in access to health services. I will focus on the conditions that make people sick, not simply on access to services. In my book, *The Health Gap*², my opening line is: «What good is it to treat people and to send them back to the conditions that made them sick?». When we talk about migrants, it is quite obvious that the drivers of migration, the reasons which push people to flee, can make them sick, but also the conditions in the countries of destination make people sick. That was not always the case. In the past, we referred to a healthy migrant effect³ - today, many of the people trying to make their way to Europe come from and end up in appalling circumstances.

My theme is inequalities in health, specifically the social gradient in health: the fact that the lower you are in the social hierarchy, the more adverse the social conditions in which you are born, grow, live, work and age and hence, the worse the consequences for health and health inequalities. Although I'm not going to talk about migrants specifically, what I am going to say does indeed apply to the issue of migrants. You only had to look at those tents in Turkey to realise that if I talk about housing, then think of what it means to live in a tent; if I talk about

* correspondence to: m.marmot@ucl.ac.uk

¹ The speech that Santino Severoni (World Health Organization) gave at the same conference went by the title «Migration at the Core of Public Health».

² Marmot, M. (2015). *The Health Gap*. London: Bloomsbury.

³ Marmot, M., Adelstein, A., Bulusu, L. (1984). «Lessons from the study of immigrant mortality», *Lancet*, 1:1455-8.

education, think what it means to live deprived of schooling; if I talk about employment, think what it means to be one of the two million Syrian migrants officially living in Turkey - there may be many, many more examples. Everything that I'm going to say applies to migrants, only more so.

Parenthetically, I was charmed if embarrassed by the Italian edition of *The Health Gap* (*La salute disuguale. La sfida di un mondo ingiusto*, 2016) which has a photo of me on the cover, holding forth and declaiming.

In the first chapter of *The Health Gap*, I talk about health in the US city of Baltimore. I was giving a lecture in the US, based on *The Health Gap*. A few months before my lecture, Baltimore had erupted in civil unrest: violence, uprising in the streets. The precipitant of the uprising was the killing of a Black man by the police. That was the precipitant; the underlying cause was inequality. Because when I say that Baltimore rioted, it wasn't in fact the whole of Baltimore: it was Upton Druid, a deprived neighbourhood in Baltimore's inner city. It wasn't the people of Roland Park, the leafy, beautiful area where the rich people live. The life expectancy gap between Upton Druid and Roland Park is 20 years for men: 63 years in Upton Druid versus 83 years in Roland Park.

If you live in Roland Park and you want to see what it is like to live in an area with a life expectancy twenty years shorter than you, you could fly to Ethiopia... Or if you, unlike me, are worried about your green footprint, you could just go a few miles across town and you can see it. In fact, I was in a meeting at Johns Hopkins, in Baltimore, and a couple of young doctors kidnapped me and said: «You cannot sit in this ... lovely meeting hall, we are going to take you and show you Baltimore!».

We started in Upton Druid. I was shown a street where every second house had a diagonal red cross on the door. That house was condemned as unfit for human habitation. If there was an emergency, the emergency services would not enter; fire and rescue services, the police, would not go in there. Condemned as unfit: can you imagine what it is like to live in a street where every second house is condemned as unfit for human habitation?

Imagine a typical young man growing up in Upton Druid. Half of the families are single-parent families. In 2010, the median household income was 17,000 dollars, a figure I'm going to come back to. The kids do poorly in school; there is a high rate of truancy, of missing school, and 90% did not go on to college. Each year, one third of young people aged 10 to 17 were arrested for juvenile disorder. One third each year: it means the chance of getting to 17 without having been arrested is quite slim.

There is more: over a five-year period, 2005 to 2009, there were 100 non-fatal shootings for every 10.000 residents and 40 homicides.

Then, these young doctors took me to Roland Park: a lovely, leafy area, with trees, nice lawns, where the Johns Hopkins professors live. I did see one person of colour: he was working in the garden, tending the lawns. But otherwise, it was white; 93% two-parent families; the median family income was not 17,000 dollars but 90,000 dollars; the kids do well in school, they don't drop out. Three quarters complete college. Juvenile arrests are not one third each year, but one in fifty! And there were no non-fatal shootings, and 4 homicides, which is huge, but it is not 40. It is one tenth of Upton Druid. The two areas are dramatically different, and the life expectancy gap is 20 years.

| Years of education | White women | Black women | White men | Black men |
|--------------------|-------------|-------------|-----------|-----------|
| < 12 | 73 | 73 | 67 | 66 |
| 12 | 78 | 74 | 72 | 68 |
| 13-15 | 82 | 80 | 79 | 74 |
| 16+ | 83 | 81 | 81 | 75 |

Fig. 1 Life expectancy at birth for men and women in the US, 2008

My theme has been the social gradient, not just the differences between the poor and the rich. If we keep on focussing on the US, we see a gradient in life expectancy by years of education for each of white women, Black women, white men and Black men: the more years of education for each race and sex group, the longer the life expectancy⁴. It is not only the poor who have worse health. When discussing health inequalities, I do get asked commonly: «Are you talking about the poor? I'm not poor, and what you're talking about has nothing to do with me!». It does: it has everything to do with you, and with me; because what the gradient means is that everybody below the very top gets affected.

⁴ Olshansky S.J., Antonucci T., Berkman L., Binstock R.H., Boersch-Supan A., Cacioppo J.T., *et al.* (2012). «Differences in life expectancy due to race and educational differences are widening, and many may not catch up» in «Health affairs» 31(8):1803-13.

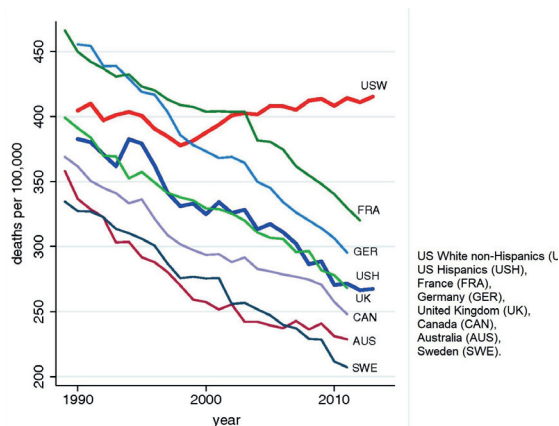


Fig. 2 All-cause mortality, ages 45-54 for US White non-Hispanics, US Hispanics and 6 comparison countries

The importance of social determinants of health for everybody is shown by the analyses of all-cause mortality for men and women aged 45 to 54 as shown in a paper published at the end of 2015 by Anne Case and Angus Deaton⁵. Between 1990 and 2012, mortality rates went down consistently in France, Germany, the UK, Canada, Australia, and Sweden. There were big differences between France and Sweden, much lower mortality in Sweden, but mortality rates have been declining in all of the countries listed, as it has in U.S. Hispanics. But in U.S. non-Hispanic whites, the mortality rate has been rising. We see that the fewer the years of education, the steeper the rise. The social gradient in mortality is getting steeper, but even among the middle classes, mortality is not falling. The causes of death that are responsible for this rise in mortality in non-Hispanic whites contain a telling message. The main cause of death are poisonings, due to drugs and alcohol, and opioids play a big role here. The second: suicide. The third: alcoholic liver disease.

Then, of course, there is violent deaths. These causes are psychosocial in origin. I call it a crisis of disempowerment. Anne Case and Angus Deaton talk about an epidemic of despair. Parenthetically, when crack cocaine was killing Black people, it was seen as a criminal issue and they were locked up: prisons are full

⁵ Case A., Deaton, A. (2015). «Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century», Proceedings of the National Academy of Sciences of the United States of America, 112(49):15078-83.

of Black people for drug use. When opioids are killing white people, it is seen as a health issue... Racism runs very deep.

It is a health but not a healthcare issue. In the US, much of the discussion is about improving access to healthcare. Obamacare did increase health insurance coverage.

Whatever impact access to healthcare has on health, it does other things, too: good health insurance coverage stops people going bankrupt when they get sick; it removes the stress of wondering: «Can I have healthcare or can I pay the rent?». It's a terrible situation: to spend 17% of GDP on healthcare but deprive people of access.

In Europe, we mostly see access to healthcare as a fundamental tenet of a civilized society. What's going on in the US? I don't want to be political, yet the initial proposal that went to Congress, from the Republican Party and President Trump, to strip back Medicare was actually a proposal to redistribute income from the poor to the rich dressed up as a healthcare plan. They proposed depriving 24 million people of healthcare so they can redistribute money upwards.

We should remember that it is not lack of access to healthcare that accounts for the inequalities in health. People don't kill themselves, they don't commit suicide, they don't poison themselves with opioids or alcohol because they lack access to healthcare. The high mortality in middle-aged men and women in the US relates to the conditions in which people are born, grow, live, work, and age: the social determinants of health. But when they get sick, they do need access.

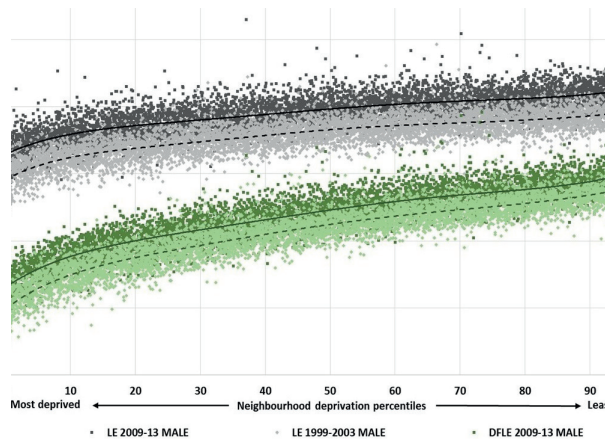


Fig. 3 Life expectancy and disability-free life expectancy (DFLE) at birth for males, ranked by neighborhood deprivation, England, 1999–2003 and 2009–2013

The graph below, appearing also in *The Health Gap*, shows clearly the gradient in health in England. Each point in the top graph represents life expectancy for each neighbourhood in the country, classified by level of deprivation and affluence. People near the bottom socioeconomically have shorter life expectancy than those at the top. The gradient in life expectancy runs all the way from top to bottom, from the most affluent neighbourhood to the most deprived.

The following graph shows disability-free life expectancy. The gradient is steeper. We are confronted with the problem not only of diminution in length of life, but in quality of life as well.

We may focus now on the issue of morbidity and mortality. This is not primarily a healthcare issue. For example, going back to the US and the debate about repealing Obamacare, a recent analysis that I saw claimed that improving access to health insurance probably does not affect life expectancy. That’s not a very radical statement. As I said, this is not primarily an access issue: the people near the top in the previous graph have access to our National Health Service. It is not lack of access that causes the problem.

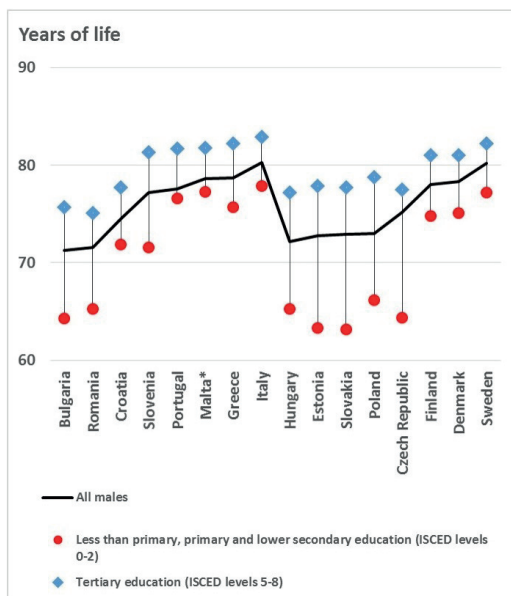


Fig. 4 Life expectancy for males living in EU Member States ranked by education, 2014

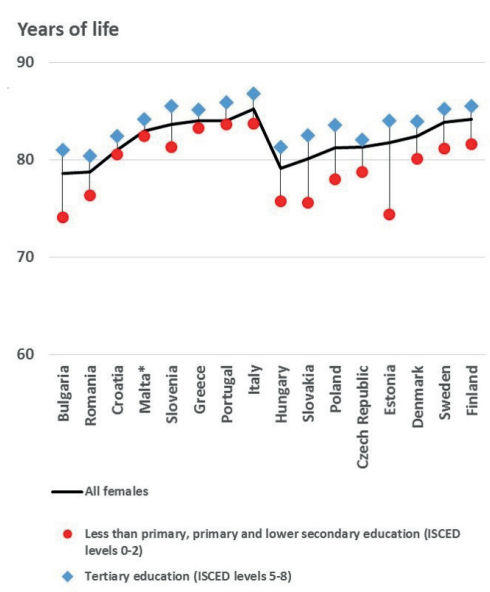


Fig. 5 Life expectancy for females living in EU Member States ranked by education, 2014

We also see that the life expectancy gap varies across Europe. Looking at the life expectancy by education for male citizens of EU member states (of which Britain is still one, until, unfortunately, Brexit), we are confronted with this sort of scenario: the red dots are people having less than primary education, and the blue triangles are people with tertiary education. In every country, people with fewer years of education have a shorter life expectancy than those with more years of education. Sweden has among the longest life expectancy in Europe and a relatively narrow gap; Hungary, Estonia, Slovakia, Poland, Bulgaria, and Romania have a relatively short life expectancy and a huge gap. Interestingly, the Mediterranean countries look quite good: is it the sunshine, is it the sea, is it the diet, is it the lifestyle? People may have all sorts of different views about Mediterranean lifestyle; all the same, the Mediterranean countries look quite good. That said, Sweden, which looks equally good to Italy or Greece and other Mediterranean countries, is very active on my social determinants of health agenda. There are Marmot Reviews springing up in all Sweden: in Malmö, in Linköping, in Nyköping, in Göteborg, in Östersund, and now there is a national Commission on Health Inequalities.

So, Sweden looks quite good and it is really active: it embodies the phrase that I used in *The Health Gap*: «Do something, do more, do better». If you are doing well, you want to do even better.

When talking about women, in general we see that the inequalities in health are smaller than in men, but the pattern is similar. And again, the Mediterranean countries look, on the whole, quite good. But remember: «Do something, do more, do better».

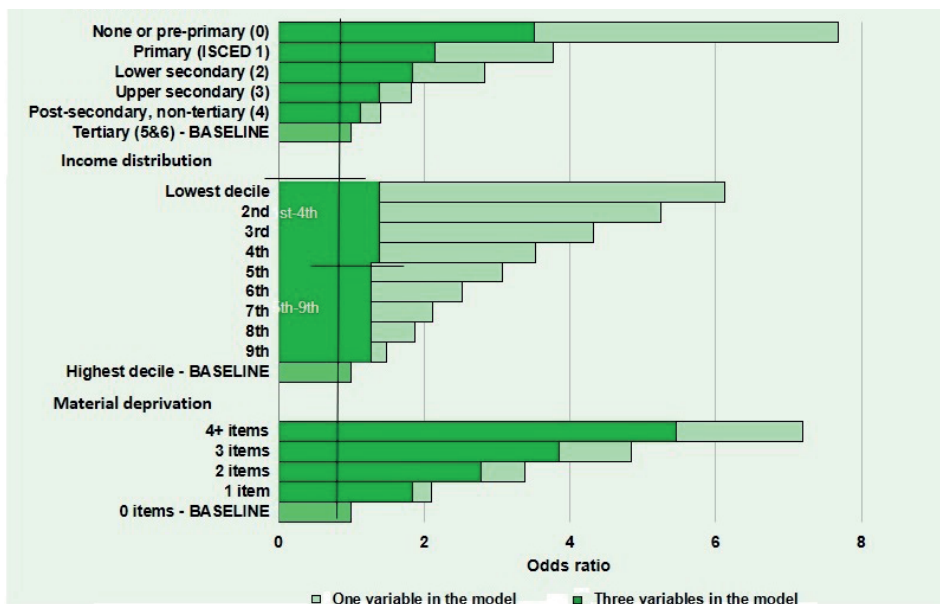


Fig. 6 Estimated odds of reporting poor or very poor general health by socioeconomic characteristics in 25 EU Member States, 2010⁶

Even though it is a slightly technical issue, we may want to ask ourselves what's the best predictor. The following graph shows self-reported health and the odds of being in poor health, according to education, income, and a measure of material deprivation. The pale green line, which runs the full length of the graph, is a unit of variant analysis. It shows the gradient: the more years of education, the lower the likelihood of reporting poor health. The higher the income, the lower the likelihood of reporting poor health. The lower the material deprivation, the lower the likelihood of reporting poor health. These measures - education,

⁶ Source: Health inequalities in the EU.

income, and material deprivation - are highly correlated. When we put them into a multi-varied model, we see that education is still important; material deprivation is still important; but income disappears: I don't want to put too much emphasis on it, but it is possible that education stays in, and it is a cause of income - how much education you have is a key determinant of your income - while material deprivation, which stays in as well, is a consequence of income. So, when we put the cause of income and the consequence of income in the model, income becomes less important; that doesn't mean that income is unimportant, because if you haven't got enough money to buy food, or shelter, or clothing, then your health will suffer. That's why the material deprivation measure is still in it.

What do I say to my American colleagues who say: «Why should I care about all of that? I'm not poor, it is nothing to do with me»? I say, if you are a fifteen-year old boy, going to a typical American school, and you count a hundred boys just like you, thirteen of you will fail to reach your sixtieth birthday. Is thirteen out of a hundred a lot? It's double the Swedish figure. It's higher than in 49 other countries: the US ranks 50th on this particular measure.

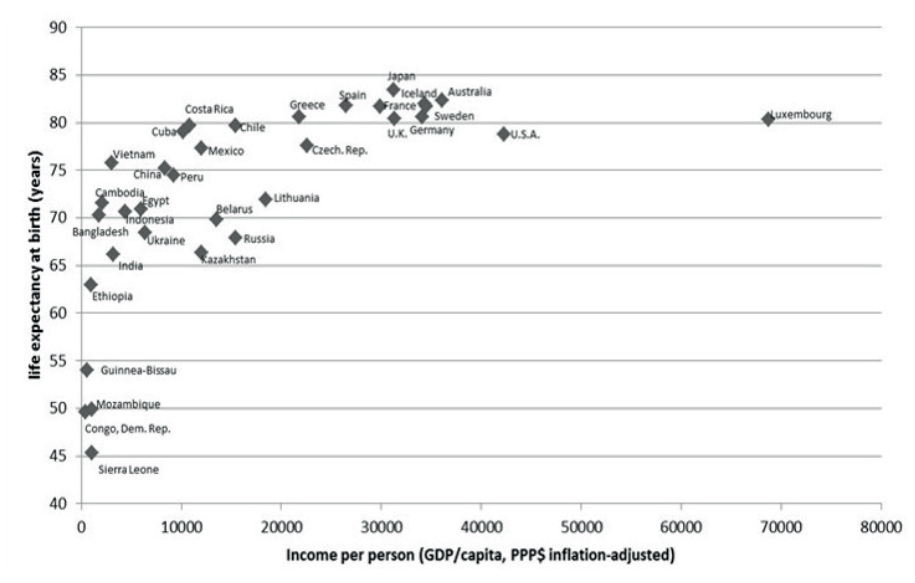


Fig. 7 The relationship between wealth and health, 2012⁷

⁷ Source: Data from Gapminder.

If we look on the global scale at national income, at purchasing power parity adjusted to the US dollar, we may see is a low level of national income. A slow rise in national income is correlated with a big rise in life expectancy. If we start from a figure of around 2,000 dollars of countries like Costa Rica, Cuba, Chile, all the way out to Luxembourg, we see that there is no relation between national income and life expectancy. The poor of Baltimore, whose purchasing power is 17,000 dollars, are richer than the average in Costa Rica, but their life expectancy is about 15 years shorter. It's not just about how much money you have. Going to the poor part of Baltimore, you would have no trouble saying: «These people are poor». But compared with the poor in Africa or in Columbia, then they are not poor at all: they have housing, they have enough to eat, there is also quite a lot of obesity, but they are poor relatively to the standards of their society: it is not just what you have, but what you can do with what you have.

In the US, the bottom 10% spend about 40% of household income running a car, because there is no public transport. That makes it impossible without a car to get to work or take your children to hospital if they need care.

I was in New Orleans, after hurricane Katrina, in the Lower Ninth Ward, which was flooded; around 60% of people living there didn't have a car. To get out when it flooded, they had to wait for the bus, which in the US is not an activity that I would recommend.

Having said that, what we need to do is to take a life course approach. In the report of the WHO Commission on social determinants of health (2005-2008), I drew attention to the life expectancy gap in Scotland. In Scotland, in the poorest part of Glasgow, Calton, life expectancy for men at that time was 54 and in Lenzie, a few kilometres away, was 82. A twenty-eight-year gap in their life expectancy in Scotland. And the question is, what is it like, growing up in Calton?

Imagine a young boy called Jimmy, living in Calton. Jimmy had a single mother, she had a succession of male partners, each of whom beat Jimmy physically, if not sexually; they moved house every year or eighteen months; by the time he got to school, he had behavioural problems.

As soon as he was old enough, he was known to the police for delinquency, got into trouble with gangs, and then, violence. He never had a proper job. Any money he gets goes into drink and drugs.

His diet is pub food, fast food, and alcohol. He abuses his girlfriends. And his life expectancy is 8 years shorter than the Indian average.

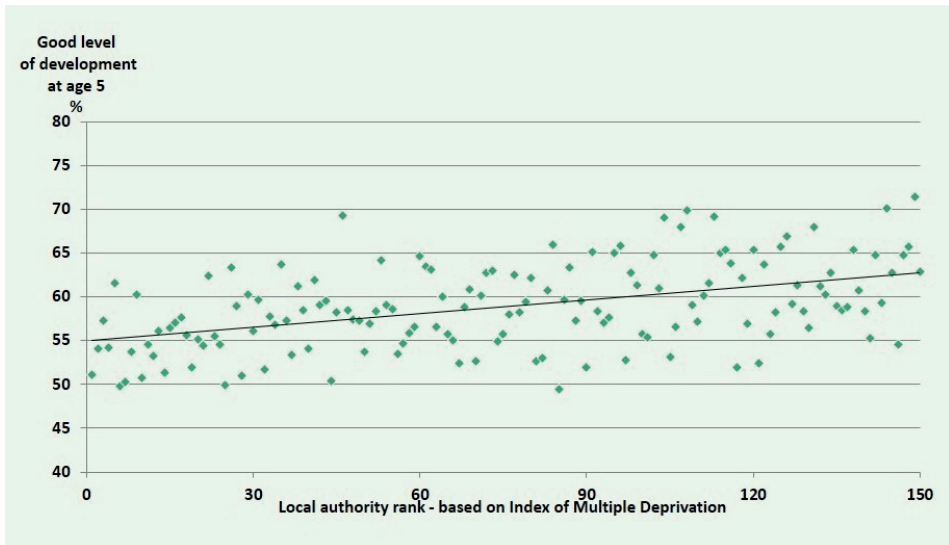


Fig. 8 Children achieving a good level of development at age five, local authorities rank, 2011, England⁸

At the London Health Observatory, we've been interested in monitoring the quality of early child development. We had thirteen measures of what constitutes good development at age 5, and we looked at the proportion of children aged 5 who have a good level of development in each local authority in the country. The local authorities in this graph are classified by their level of deprivation. On the right, you have the more affluent local authorities, on the left you've got the more deprived.

The more affluent the local authority, the higher the proportion of children aged 5 that have a good level of development. They're scattered down the line.

I've made a little test to pick out people's political attitudes: people on the right say, it is poor parenting, and people on the left say, it is poverty. And I say, they are both correct: the circumstances in which you are trying to raise your children have an impact on the quality of care that the children get. If you go to somebody in some of those tents in Turkey and say: «You really should be reading bedtime stories to your children», they might say: «Yeah, I would... if I had a bed, let alone a book!».

⁸ Source: LHO (2012)

The quality of environment impacts on your ability to be a ‘good parent’. I suggest two strategies: first, reduce deprivation - make better the conditions in which people are trying to be parents - and, secondly, support parent and families.

| Rank | Early 2000s | Rank | Late 2000s | Change in rank |
|------|----------------|------|----------------|----------------|
| 1 | Sweden | 1 | Netherlands | +2 |
| 2 | Finland | 2 | Norway | +2 |
| 3 | Netherlands | 3 | Finland | -1 |
| 4= | Denmark | 4 | Sweden | -3 |
| 4= | Norway | 5 | Germany | +2 |
| 6 | France | 6 | Denmark | -2 |
| 7 | Germany | 7 | Belgium | +1 |
| 8 | Belgium | 8= | France | -2 |
| 9= | Czech Republic | 8= | Ireland | +4 |
| 9= | Poland | 8= | Switzerland | +3 |
| 11 | Switzerland | 11 | Portugal | +5 |
| 12 | Ireland | 12 | Poland | -3 |
| 13 | Spain | 13 | Czech Republic | -4 |
| 14= | Canada | 14= | Canada | no change |
| 14= | Italy | 14= | Italy | no change |
| 16= | Greece | 16 | United Kingdom | +4 |
| 16= | Portugal | 17 | Austria | +1 |
| 18 | Austria | 18= | Greece | -2 |
| 19 | Hungary | 18= | Hungary | +1 |
| 20= | United Kingdom | 18= | Spain | -5 |
| 20= | United States | 21 | United States | -1 |

Fig. 9 Country comparison on average rank in four dimensions of child wellbeing – material, health, education, behaviours & risks – in early 2000s and late 2000s⁹

The Unicef Report Card on the quality of early childhood shows a country comparison on average rank on four dimensions of child well-being. The USA and the UK in the early 2000s were bumping along on the bottom of these 21 rich countries. Italy is alright, not terrific. Sweden and Finland are. In the late 2000s, we see the Netherlands, Norway, and Finland at the top, while Sweden dropped a bit. The UK zoomed up to 16th, but the US are still bumping along at the bottom. If you want to start building up an explanation for the failure of mortality to decline, start with early child development, which doesn't look good in the US.

⁹ Source: UNICEF, 2013.

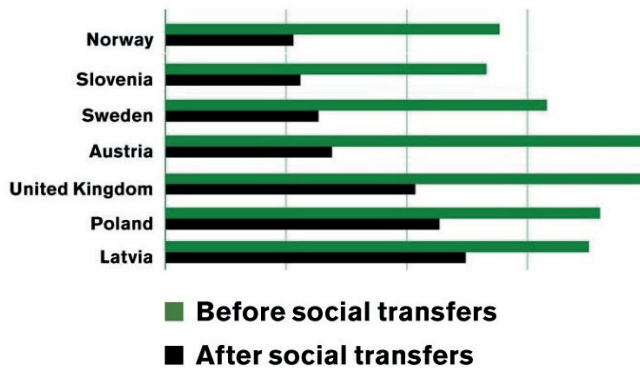


Fig. 10 Child poverty rates before and after transfers, ranked by after-transfers rate, EU-SILC, 2009

One way to deal with the problem is to reduce poverty and deprivation. This graph shows child poverty, where poverty is defined as a relative measure, less than 60% of median income, before and after taxes and transfers.

If we compare Latvia and Sweden, we may see that, before taxes and transfers, child poverty in Latvia was 35% and in Sweden was 32%. After taxes and transfers, child poverty in Latvia was still 25% and in Sweden was now 12%. In Sweden it is just somehow taken for granted that you wouldn't organize your affairs so that children languish in poverty: if there is enough money, you just share it about a bit.

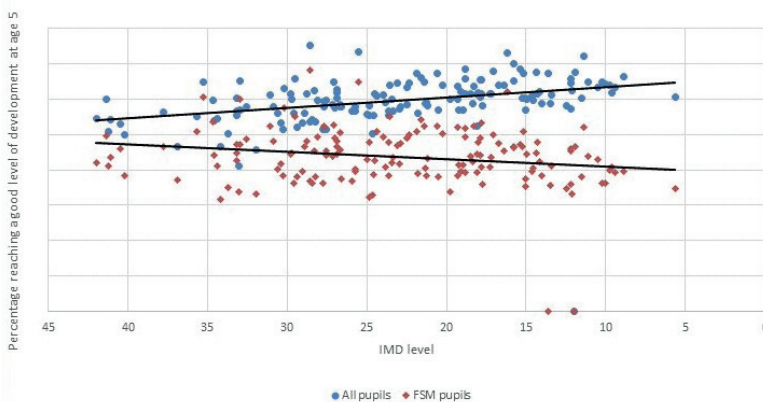


Fig. 11 The percentage of children achieving a good level of development at the end of reception, 2013/2014, IMD 2015

In our monitoring with the London Health Organization, we found this very interesting thing: as we've already seen, the more affluent the area, the higher the proportion of children at age 5 that have a good level of development. A standard way to look at poverty in Britain is child eligibility for free school meals, which is a means-tested benefit. If you are below a certain income, then children are eligible for free school meals. In this graph, the red is the children eligible for free school meals. As you would expect, they have a lower proportion with a good level of development at age 5. Yet, in our monitoring we found that the more deprived the area, the better the poor children do. Poor children do better in a poor area than they do in a rich area. Rich children, or average children, do better in rich areas, but poor children do better in poor areas.

| England and selected local authority areas | Level of development at age 5, 2013/14 | | |
|--|--|----------------|---|
| | All pupils (%) | FSM pupils (%) | Gap between all and FSM pupils (percentage point) |
| England | 60.4 | 44.8 | 15.6 |
| Hackney | 64.9 | 60.7 | 4.2 |
| Bath and North East Somerset | 62.5 | 33 | 29.5 |

Fig. 12 Level of development at the end of reception

The English average of children with a good level of development at age 5 is 60%; while for the whole of England, the children qualifying for free school meals (FSMs) who have a good level of development at the same age are just under 45%. The gap in the level of development between FSM and non-FSM children is 15.6%.

Yet, I'd like to show you an example. Hackney is a poor area of East London: the average of children who have a good level of development is 64.9%. The poor children having a good level of development are just under 61%. The gap between FSM and non FSM-children in Hackney is under 4%! The poor children of Hackney are doing as well as the national average, something that should prove that poverty is not destiny.

Let's look at another example: Bath is a beautiful and wealthy Georgian town in Somerset, and the poor kids are doing really badly. My guess is, if you go to Bath and ask what they are doing for poor children, the answer might be: «Do we have any poor children here? We didn't know we had any!». But if I'd ask

that same question in Hackney, I'd get a completely different answer. There are so many poor children in Hackney that if you won't focus on them, why ever get out of bed in the morning?

What it shows is that if you focus on the problem, you can make a difference.

An article that I recently wrote for the *The Lancet*¹⁰ shows evidence supporting the fact that you can actually make a difference.

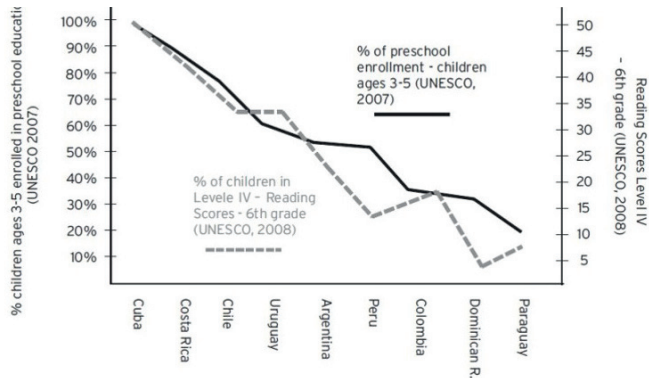


Fig. 13 Enrolment in preschool (ages 3-5) and reading scores in 6th grade in selected countries of Latin America¹¹

I'm now chairing a Commission on Equity and Health Inequalities in the Americas, set up by the Pan-American Health Organization. If we look at the enrolment in preschool for nine Latin America countries, we can see that in Cuba, nearly 100% of children are enrolled in preschool; in Costa Rica, the number of children enrolled in preschool is very high, as it is in Chile. At the other end of the scale, in Paraguay, Dominican Republic, and Columbia, the figure is very low. The reading scores in the 6th grade are high in Cuba, Costa Rica, and Chile; low in Paraguay, Dominican Republic and Columbia. This maps onto the life expectancy: the highest life expectancy among these countries is in Cuba, Costa Rica, and Chile and the lowest is in Paraguay, Dominican Republic, and Columbia. It is consistent with the life course approach according to which enrolling in preschool, good performance in school, better conditions in adulthood and longer life expectancy are all correlated.

¹⁰ Marmot, M. (2017). «Post-truth and Science», «The Lancet», 389, 10068, 497–498.

¹¹ Source: Tinajero, 2010.

Good levels of development are among the good things that can happen to children, always bearing in mind that the lower the position in the hierarchy, the fewer the good things that would happen. The problem is that at the other side of the good things are the bad things, the adverse child experiences (ACEs). They include physical abuse, sexual abuse, violence, mental illness in parents, divorce and separation, and other unfavourable events. Contrary to my expectations, the frequency of adverse child experiences in Britain is as high as in the United States.

Let’s look at the consequences of ACEs: if you could eliminate adverse childhood experiences, you could reduce the frequency of early sex before 16 by one third, unintended teen pregnancy by one third, smoking, binge drinking, cannabis use would all decrease, violence perpetration by half.

Fifty-two percent of perpetrators of domestic violence were themselves subject to adverse child experiences. And even more chilling, if we look at the victims of domestic violence, we see that at least half the victims of domestic violence were themselves subject to adverse child experiences earlier in their lives. And you could think of various reasons why that might be the case. Globally, one third of women had been abused by a domestic partner. Globally, two thirds of women who are murdered are murdered by their domestic partner. For men, only 6% of murder victims were murdered by their domestic partner. So, not just promoting good early child development, but preventing adverse childhood experiences, a psycho-social issue related to the social environment, would have a dramatic impact on public health.

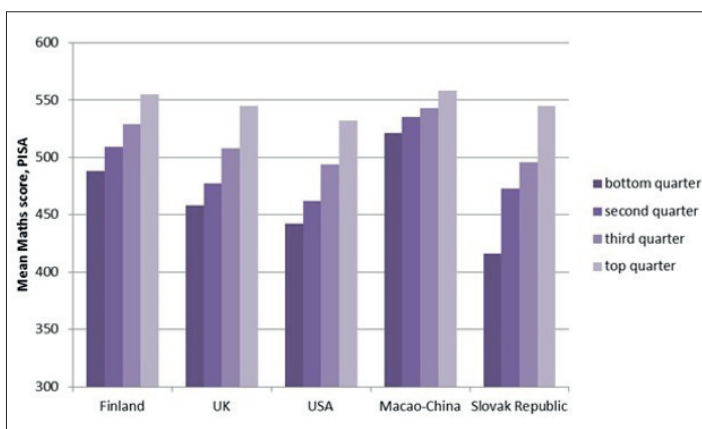


Fig. 14 Within country Maths results by quarters of ESCS (Economic Social and Cultural Status), PISA, 2013

Early childhood development is also a predictor of education: children with a better early childhood development at age 5 perform better in school. PISA is a programme of international student assessment, a global study measuring mathematics, literacy, and science knowledge at age 15. The graph shows the mathematics results by economic and social classification, which is a socio-economic measure. Finland always does the best in Europe. The higher the socio-economic position, the better the performance. But it is a gradient: the top quartile in the UK doesn't do as well as the top quartile in Finland. The bottom quartile does a lot worse. The USA do worse overall and at a much steeper gradient. Worse scores on early child development correlate with a worse performance on education, and a steeper gradient. The median income in the US has not risen over the last three decades. With recovery from the global financial crisis in the US, out of every dollar of income growth in the US, 92 cents went to the top 1%.

Maybe you are trying to build up a picture of what's happened to the middle income people in the US, let alone the poor: low rates of early child development, poor school performance, resulting in jobs where incomes are low and not improving.

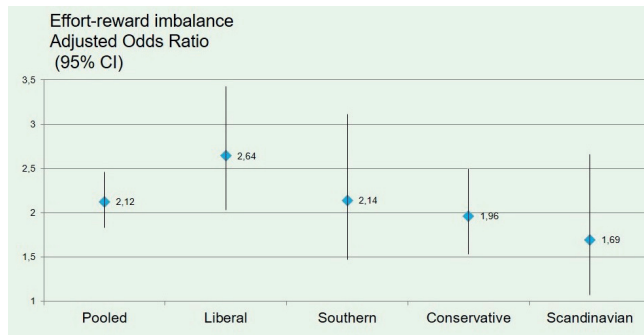


Fig. 15 Association between work stress and depressive symptoms varies by welfare regime: baseline¹²

We have also been interested in stress at work. One way of measuring that is the imbalance between effort and reward. A job with high effort and low reward is a stressful job. The vice-director has high reward, mere professors low reward, and so a job with high effort and low reward is a stressful job and increases not only the risk of depressive symptoms, but also of physical illness.

¹² Source: Dragano et al, 2010.

Interestingly, the relation between imbalance and good health varies by country, depending also on the different welfare regimes. In a liberal model such as the British one, jobs characterised by effort-reward imbalance have a strong association with depressive symptoms; Mediterranean countries have a quite strong association with those kinds of symptoms as well; the Conservative-German Bismarck type of system and the Scandinavian one show a bit weaker association. So, being in a stressful job is bad everywhere, but how bad it is for your health varies by where you are.

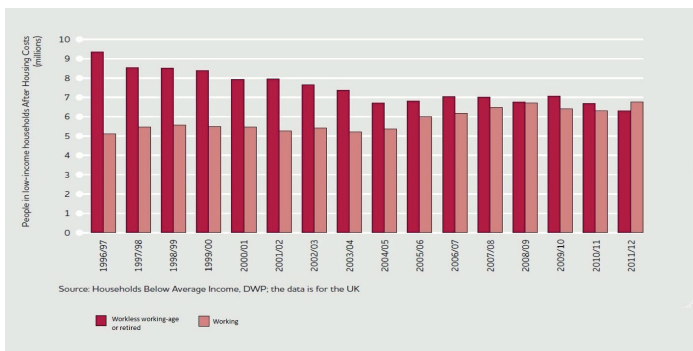


Fig. 16 6.7 million of the 13 million people in poverty are in working households, UK 2011/12¹³

One of the things we want work to do is to step people out of poverty. The following graph shows the UK figures for people below the minimum income threshold - that is, poverty indicating also whether they are in a household where someone is working or in a household where no one is working. In 2011-12, more people are in households where someone is working than in workless households. Politicians say that people in poverty are somehow morally worthless. There is a real implication that if you are a good person, you wouldn't be in poverty. It's somehow your fault, you are making bad choices, and it's your fault.

What this shows is that assertion is contradicted by the facts: people are not in poverty because they are morally worthless, they are in poverty because they are lowly paid. They're working, but they are still in poverty: they are not paid enough to live, and that, in a rich country like Britain. That relates to ensuring a healthy standard of living.

¹³ Source: (JRF 2013 using DWP data).

I'm not in the least bit political, but I'd like to point something out. You had got to be some sort of nerd to look up at the International Labour Organization Global Wage Database and look at the figures for 2007 shown below in the Average Real Wage Index, from developed G20 countries.

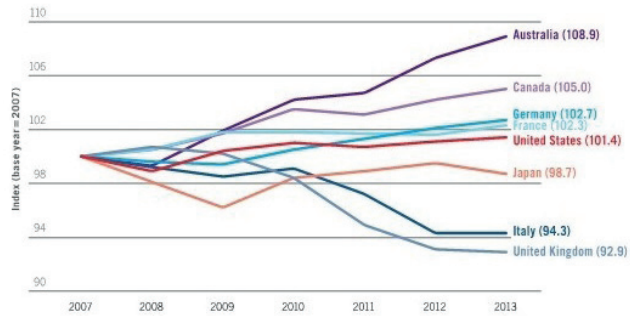


Fig. 17 Average real wage index for developed G20 countries, 2007-13 ¹⁴

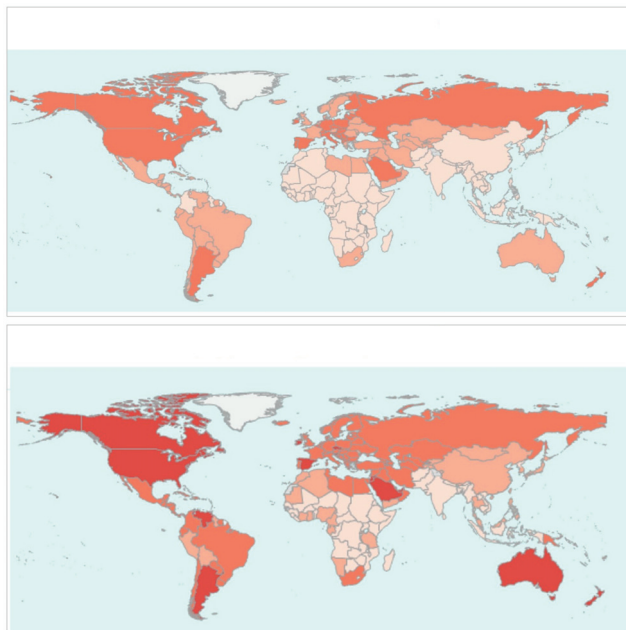


Fig. 18 Global mean BMI, male ages 20+, 1980 (up) and 2008 (down) ¹⁵

¹⁴ ILO Global Wage Database.

¹⁵ Source: WHO, 2014.

Talking about ill-health prevention, if we look at the mean Body Mass Index (BMI) for men, globally, in 1980, and we compare it to the figures for 2008, we see that the world’s waistline is remarkably expanding. We’re not going to knock down this global obesity epidemic simply by telling people to eat sensibly or jog around the block.

The following graph shows the US figures for 1985. The pale blue is less than 10% obesity, the slightly darker blue is 10 to 13% obesity, and the yellow is more than 20%. The data are organised by state.

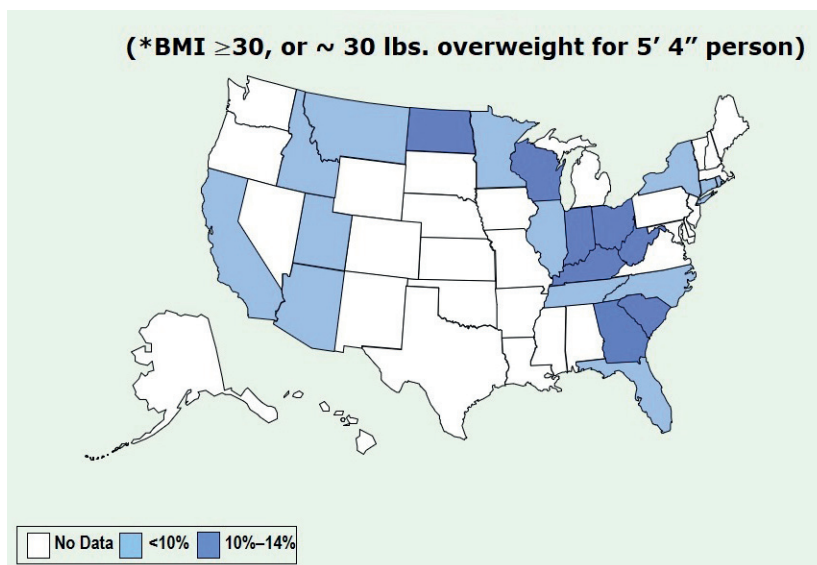


Fig. 19 Obesity Trends Among U.S. Adults, BRFSS, 1985¹⁶

We may then look at the following graphs with figures for 1997 and 2010. If you think that obesity is genetic, it is amazing how rapidly the genome can change in the US.

¹⁶ Source: CDC, 2010.

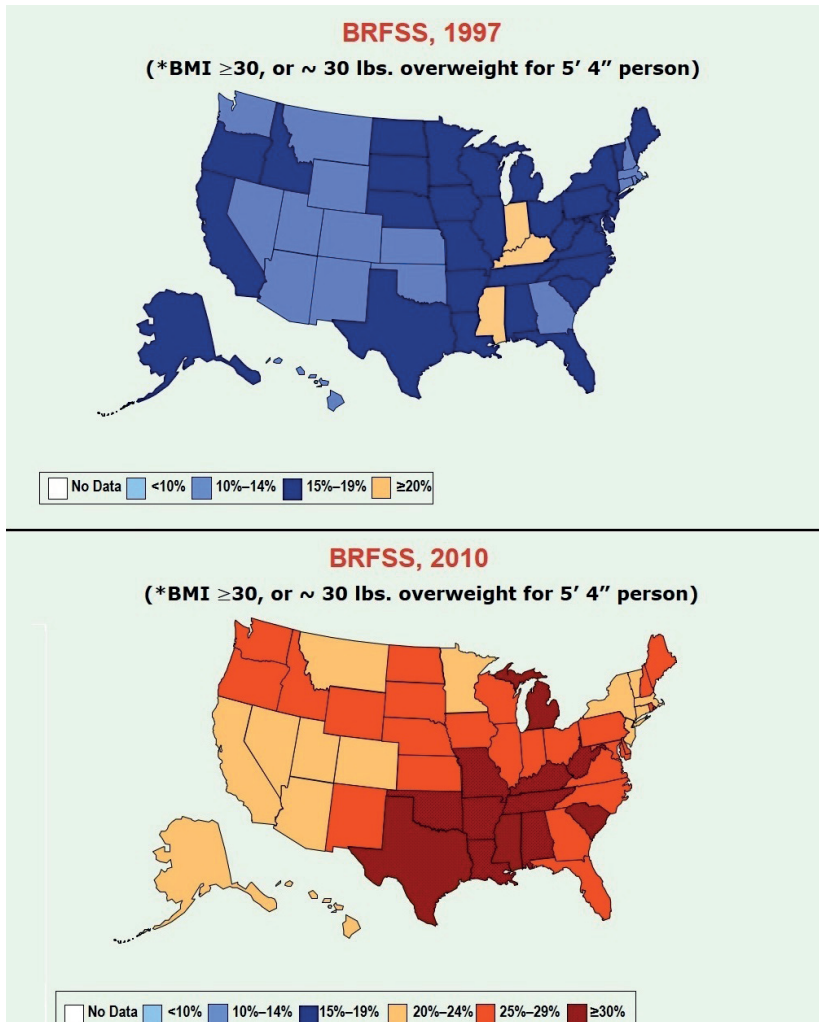


Fig. 20 Obesity Trends* Among U.S. Adults, BRFSS, 1997 and 2010¹⁷

And if you think that is going to be solved by telling somebody to eat a slightly smaller McDonald's hamburger, you are kidding yourself. I debated with a Chicago economist who said: «Obesity is a rational choice: the utility of having a Big Mac and fries and a large Coke now is greater than the utility of not getting diabetes thirty years from now. It's entirely rational».

¹⁷ Source: CDC 2010.

I said to him: «How does your account explain why Americans are getting fatter? Why are they now making the rational choice in greater proportions to get fat than they were thirty years ago? And why are Americans fatter than French? Why are more Americans making the rational choice to get obese than French men and women?».

I went on and said: «That doesn't explain anything. You're just stating your ideology of free market economics, but it doesn't explain anything: all the interesting things are completely outweighed in this framework!».

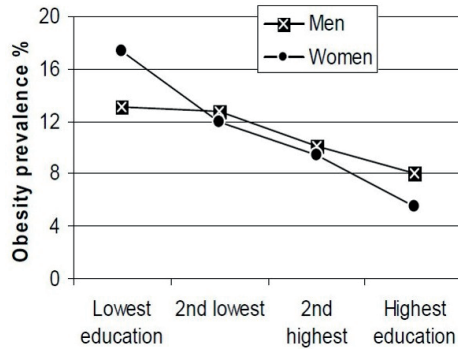


Fig. 21 Obesity prevalence according to educational attainment, averaged across 19 EU Member States¹⁸

Indeed, we know that the obesity epidemic follows the social gradient: this is data from nineteen EU member states. The greater the education, the lower the likelihood of being obese, for men and for women.

The following graph shows the English data and the index of deprivation for children age 10 to 11. The social gradient is very clearly highlighted here: the more deprived the children, the greater the level of obesity. Each of those histograms is a year, from 2006-7 to 2012-13; if you look at the most affluent, the least deprived, it is flat: the rise in childhood obesity has stopped for the higher social groups, but it is continuing to rise for the lower social groups, so the inequalities in obesity are increasing: if you want to do something about the obesity problem, we have to do something about the inequality problem.

¹⁸ Source: Eurothine 2007 reported in Robertson et al 2007.

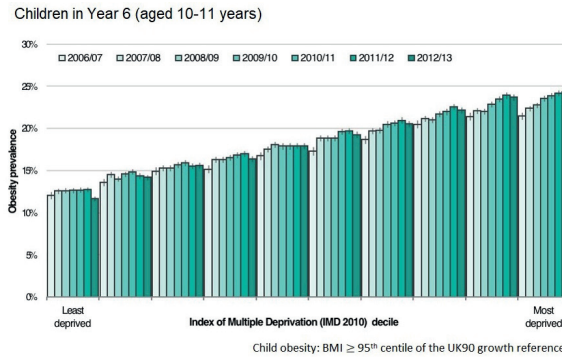


Fig. 22 Inequalities in childhood obesity are increasing in England: Obesity prevalence by deprivation decile 2006/2007 to 2012/2013 ¹⁹

I wanted to call my book, *The Health Gap*, «The Organization of Hope». And the publisher said: «You can't do that, nobody would buy a book called «The Organization of Hope». Actually, I wanted to call it «The Organization of Misery». The reason I wanted to call it «The Organization of Misery» is because I quoted from a Pablo Neruda poem that said: «Rise up with me against the organization of misery!», and that is what I want people to do: to rise up with me against the organization of misery.

I sometimes describe myself as an evidence-based optimist: evidence proving that we can make a difference, such as this:

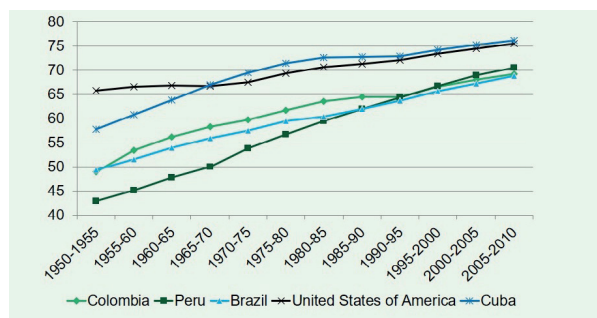


Fig. 23 Male life expectancy at birth in Colombia, Peru, Brazil, USA, Cuba ²⁰

¹⁹ Source: National Child Measurement Programme 2006/2007 to 2012/2013.

²⁰ Source: UN World Population Prospects: The 2012 Revision.

If we look at the countries from the Americas shown in the table above, we see that in the 1950s Peru's life expectancy for men was 43, while in the US it was 66: a 23-year gap in life expectancy between these two countries.

Following it through to 2005 to 2010, we see the life expectancy for the best-off. The USA is slightly behind Cuba, and is now significantly behind Costa Rica, not shown in the graph. We've got 76, and for the worst-off is 69. A seven-year gap. A 23-year gap has fallen to a 7-year gap, not by making the best-off countries worse, but by improving the worst-off countries at a more rapid pace. That's the kind of thing that fuels my evidence-based optimism.

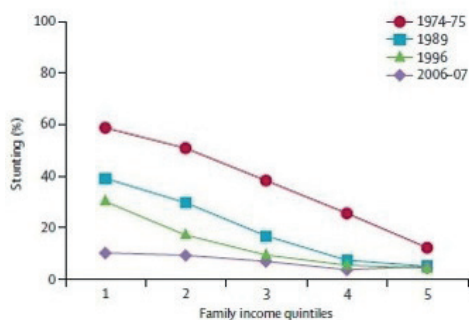


Fig. 24 Prevalence of stunting by family income and year of survey in Brazil²¹

In Brazil, if you look at stunting, that is, slow growth in the first year of life, you see a clear social gradient by family income quintile: in 1974-75, the gradient is steep, and over time, the gradient's got shallower and shallower. So that, by 2006-7, there is almost no gradient in slow growth in the first year of life. You can make a huge difference! Cesar Victora, who is a member of the Commission on Equity in the Americas and who did all of this, told me how they did it. Partly, they have 'bolsa familia', a conditional cash transfer programme, getting money to poor women. About 25% of the Brazilian population are covered by that. They've improved services, they've done a great deal: and you can do it really quickly!

I'd like to come back to the subject of post-truth and science. We, in science and healthcare, are committed to the truth: that's what we do. We are here, in this university hall, surrounded by books. The reason we have them is because they

²¹ Source: Victora et al 2011 citing Monteiro et al 2010.

are a repository of truth. That's our mission in the university: it is to try and to uncover the truth, to educate people do research. I haven't been shy: we are not in a good place politically. But we, people in science, in the healthcare professions, are on the side of the angels, and we will win. There may be a dark phase, but we have to stay true to our principles. We believe in health for everybody, we believe in certain values of social justice, and we believe in truth and evidence:

«Do something, do more, do better».

Migration at the core of public health

*Santino Severoni**

The complex and multifaceted dynamic of migration is affecting key elements of the health sector and of the public health in a broader way.

Since 2011, the World Health Organization Regional Office for Europe is investing in setting up operations and capacities on issues related to migrants and refugees' health. During the past years, European countries have experienced unprecedented migration flows. The European region is the largest WHO Region with 53 countries. Due to its extension, there are differences in terms of country context and situation, including health. The health situation of European Region Member States has been certainly improving rapidly in the past years, but the inequity and the diversity between countries and within each country plays an important role in reaching the highest status of well-being and health. In the context of diversity and inequalities, migrants and refugees' health plays a crucial role. It was estimated that the 8.5% of the European population have been born outside the country in which they are living. Although migration is not a new phenomenon in Europe, in the past six years several crises led to forced migration. This pattern of movements, triggered by emergencies, concerns particularly countries in the Mediterranean area, which tend to deal with sudden arrivals of many irregular migrants, who come to Europe by sea along three main routes: the Western route, mainly from Morocco to Spain and from Mauritania and Senegal to the Canary Islands; the Central route, from North Africa to Italy, that became important after 2010; and the Eastern route, particularly from Turkey to Greece. It is possible to identify three types of countries: 1) countries that are defined as arrival points, and attract migrants because of their competitive welfare conditions (i.e. Scandinavian countries); 2) 'transit countries' where, despite the rapid movements of population as per definition, there is the highest concentration of fences and walls all over the world; 3) countries which probably bear the largest

* correspondence to: severonis@who.int

proportion of labour migrants (i.e. countries belonging to the Former Soviet Union): this total an estimated 15 million migrants moving from the poorest to the richest countries in the world.

Therefore, European governments and their health systems need to be flexible according to this diversity and to the different health needs of each specific group.

The profile of migrants changes throughout the Region, looking at different countries within Europe, and it constantly changes over the years within each country. In particular, looking at demographic data, in 2015 there was a big shift in the refugees and migrants' profile. The migrants were mainly economic migrants, young men, who moved in search of better working and living conditions before 2015, and became a mixed group of people on the move, with families, a good number of women and the recent phenomenon of unaccompanied or accompanied children.

A situation analysis of Turkey certainly deserves a particular attention and explains why migration is at the core of public health. The seven largest refugee populations are located in Turkey, Pakistan, Lebanon, Iran, Ethiopia, Jordan and Kenya, respectively. Together they host more than half of the world's refugees¹. Among the measures put in place in the attempt to face the emergency condition, the Turkish government established temporary protection centres managed by the Ministry of Interior for Disaster and Emergency Management Authority (AFAD), the primary healthcare provision was strengthened to reduce the patient load on secondary and tertiary healthcare and the respective costs, temporary migrants' health centres and units were established as primary care providers for Syrian refugees; services were put in place that focus on disease surveillance, sexual and reproductive health, mental health and vulnerable groups, as well as a comprehensive mid-term health care strategy which addresses health issues related to non-camp refugees and the impacted communities. With regard to the policy development, a major effort of the government was done with the integration of Syrian health professionals into the Turkish health system. Finally, a UN Regional Refugee and Resilience Plan was developed.

Turkey has put in place advanced 'people-centred' policies: close to 95 per cent of the Syrian refugees today are hosted into an urban setting, a new approach for providing healthcare to newly arrived people.

¹ United Nations High Commissioner for Refugees as of 2015. Available from: <http://www.unhcr.org/>

The challenge was to quickly set up an adaptation of the local health system capacity to reach out to these new 3 million people, but not only in terms of numbers. Any health system needs to be adapted also in terms of cultural and linguistic competences: Turkey is the first country experiencing the inclusion of Syrian doctors and nurses into the national system, to make the service more effective for this population.

So far in 2017, Europe has numbered 174,509 arrivals and among those 163,979 by sea and 10,530 by land². The Central Mediterranean route is by far the world's deadliest European border for refugees and migrants, being over 33,700 the people reported to have died or gone missing in the Mediterranean during their journeys between 2000 and 2017. Although arrivals to Greece and to Italy began to subside in 2017, unfortunately crossing the sea remains the only option for many people. The main public health issue related to the journey by sea is the different management in the EU countries in responding to different EU national legal framework, usually the first provision of healthcare happening at sea.

Large influxes of migrants into the Balkan area have challenged the capacity of the health systems of those countries to respond rapidly and effectively. The Balkans have probably the highest concentration of borders, fences and walls aiming at mitigating and controlling the unregulated influx of refugees and migrants. Nowadays, we are confronting with a new phenomenon. Migrants and refugees are now spending a longer time in an informal or temporary setting, often stranded in countries where they do not want to stay, in challenging conditions including extremes of temperature, unsanitary conditions, violence at the borders and not being able to access healthcare during their time in transit.

In this respect the relationships between population mobility, health and international political affairs have long been acknowledged; over the past few years of international and global health, migration was identified as an issue deserving special attention due to its relevance to domestic and foreign policies within and between European countries. Unfortunately, the traditional approach is to look for un-coordinated, single-country solutions instead of promoting a common response and collaborative action between countries. Since the entire discussion on the public health aspects of migration is heavily influenced by the

² MIGRATION FLOWS – EUROPE. Available from: <http://migration.iom.int/europe/>

political dimension and by the media, it is imperative to produce evidence and share knowledge, as well as to improve the availability of good quality data on public health and migration in order to develop evidence-informed policies and interventions.

Health and migration have a multi-sector agenda and working with multiple sectors may be challenging. The whole complex geopolitical situation is crucial to the public health dimension because of the immediate repercussions and issues on different sectors. Indeed, the debate on public health is indeed does not only concern the public health sector. On the contrary, the migrant health sector is influenced by non-health sectors and policies (i.e. Ministries of Interior, Labour, Social Affairs, Foreign Affairs, and Education) and the empowerment of the health sector may represent a way forward to address migration-related issues and to suggest solutions. This multi-sectoral agenda requires an everyday debate, with on the one hand the migrants and refugees' need to access the health care service and, on the other hand, the implementation of security measures. On the one hand, then, there are public health implications concerning the different definitions of migrants: these different definitions and ongoing restrictive legal framework affect migrant health. On the other hand, there is a consistent fear associated with people's movement, in relation to importation of communicable diseases and the real risk associated with people on the move. In addition, receiving countries are facing other questions posed by the resident population with regards to the national health system capability to deal with this large influx of people and to the costs linked to this situation. Those complex questions are as relevant for politicians as sensitive for the media.

If you consider one of the key issues – communicable diseases -, we observe that people's movements can spread communicable diseases around the world as per definition., nowadays we are confronting with a measles outbreak in Europe and we are exporting it to countries where the impact of measles in terms of morbidity and mortality is much higher than in Europe. Therefore, communicable diseases are associated with movement of people, but there is not a systematic association between communicable diseases and migration and refugees.

Despite the increasing burden of non-communicable diseases (NCDs), reflecting the broader global demographic transition, there is still low attention about them. One reason might be identified in the impact that communicable diseases have from the point of view of media. However, the Ministries of

Health of the receiving countries should invest on NCDs prevention among the refugee and migrant population, being those people exposed to new lifestyles and environments, something that play a very important role in exposing them to NCDs.

Health services and policies on NCDs need to be sensitive, inclusive and culturally competent.

The WHO Regional Office for Europe has been working to address the public health of migrants and refugees for over six years. There are four main strategic types of action: technical assistance to countries, health information and evidence, advocacy and communication and policy development.

In terms of technical assistance, the Regional Office sends experts to the ground, assists countries in developing contingency plans and develops technical guidance on key urgent issues. The Regional Office established in 2012 the Public Health Aspects of Migration in Europe project (PHAME) with the financial support of the Ministry of Health of Italy. Assessment missions were conducted jointly with the Ministries of Health with the aim to analyse the health-system preparedness, response and capacity to cope with the public health challenges posed by large-scale arrivals of refugees and migrants. An ad hoc toolkit to assess system's capacities has been developed in collaboration with other UN agencies, namely the UNHCR and the IOM.

Concerning health information and evidence systematic policy, review and synthesis reports for policy makers were produced in order to clarify issues related to migration health across the whole Region. Communicating correct and relevant information is one key element of the programme, being migration as an issue highly manipulated by media and politicians.

Finally, policy development aims to address key issues: reducing mortality, minimizing negative impact of migration, avoiding disparities in health status and access and ensuring refugees and migrants' health rights.

This framework was taken as the basis of the first WHO European Strategy and Action Plan for Refugee and Migrant Health, adopted by the Regional Committee last September to strengthen the capacity of countries by providing opportunities for learning and region-wide knowledge transfer and capacity building through multiple platforms.

The latest initiative launched the last year in Sicily, Italy, together with the ministry of Health of Italy is the Knowledge Hub on Health and Migration, a new critical tool to address the need for an educational institute devoted to

international migration and public health. The Knowledge Hub has a systematic approach to public aspects of health; it also aims at sharing a common strategic approach and supports policies development and country capacity building. It will equip the global migration sphere with the evidence and data necessary to inform professionals and press, as well as to back up responsible arguments with facts and numbers, disseminate data-driven information and therefore contribute to an informed discussion on health and migration and to evidence-based interventions.

Specifically, there are five macroareas of activities: biennial summits, policy dialogues, the summer school, webinars and the Knowledge Library.

The overall objective of the Knowledge Hub is to cover the gap of availability of technical handbooks, analysis and assessment and to inform the decision making and policy formulation. The beneficiaries of this network are mainly health professionals, policy makers, governments, national and local authorities, non-health actors and, of course, the migrants themselves.

Health, environment, development and peace

*Grammenos Mastrojeni**

A Global Balance Agenda

In 2016, a new era has started for development. A new Agenda, focussed on 17 goals, will set the course of international development efforts until 2030, building on the results achieved in pursuing the previous international framework, known as the Millennium Development Goals. The latter, a list of eight simple and easy to understand objectives, paved the way to a much more articulated architecture: the goals were multiplied in the 2030 Agenda, specified in 169 sub-targets, and subjected to a hopefully rigorous monitoring through a set of quantitative indicators. Yet, its more complex articulation is only the surface of a deeper revolution in perspective. The true novelty in the 2030 Development Agenda is not that it focusses on more goals in a more detailed way, but that, finally and assumingly, it fully reflects a new intuition about the world we live in: global balance.

MILLENNIUM DEVELOPMENT GOALS - 2000 to 2015



* correspondence to: grammenos.mastrojeni@esteri.it

SUSTAINABLE DEVELOPMENT GOALS – 2016 to 2030



Compared with the past, the 2030 Development Agenda is characterized by three main features:

- its development goals are qualified as sustainable;
- it shifts from the perspective of one-way development aid from the ‘rich’ to the ‘poor’, to the horizon of a shared and common interest to further and joint development in a sustainable way;
- it hints to the idea that the goals themselves are interconnected and synergic.

Another way to describe all these novelties in the 2030 Agenda is to say that it also takes care of the environment. Besides the fact that four out of seventeen goals directly refer to ecosystemic health, including the environment further affects all the advancements in the new Agenda. Indeed, introducing the environment is different from considering another supplementary set of goals for humankind to reach, rather it means that traditional development goals have to be re-defined and managed within the reactive system that surrounds us. It portrays a radical shift in perspective, as we start to look at the future of mankind not as an absolute, but within the grid of relationships and balances that shape the functioning of the broader system we belong to: one that is shared and therefore has to be managed together and one that, like a home a family shares, has to be kept in balance in all its elements, both human and physical.

Sustainability, an eye to the health of the environment, and the idea that we all have to take together the path of a better development are revolutionary advances, but they cannot be understood as three separate innovations. Instead, they are all significant – but still incomplete – symptoms of a new perception of the human condition: everyone and everything is interconnected within a biophysical system that sustains life and enables development, which needs to be protected and kept in a state of vital, just, and generous balance. In this sense, the 2030 Development Agenda unintentionally exceeded its highest ambitions: it ended up being much more than a development roadmap focussed on helping poorer communities bridge the gap, rather looking like a new economy, shaped by new values, for the whole of mankind.

A healthy balance for nature and humankind: the big picture

Leading to the innovations brought by the 2030 Agenda, towards the end of the 80s a small and visionary group of scientists began warning that mankind and the environment shared a common fate in ways that were much more complex than it was commonly thought. Well beyond the obvious – and yet then misunderstood – links between production and pollution, they started to identify an intimate connection between the state of the ecosystem and the general welfare of mankind, in the framework of a long neglected truth: we are all parts of a global balance, that interconnects everything at a planetary scale.

Their intuitions went against the tide: the common assumption was that mankind and nature were related but not ‘one’, that us were ‘above creation’ and its natural balance, entitled to model the Earth according to our vision of a never-ending expansion and progress. In that mind-set, we simply neglected balance, especially since we were thinking of a stable and predictable ecosystem: during millennia natural balance was given or taken to mankind by superior forces and we felt that it was not our concern, nor within our reach, to influence it. Furthermore, with natural balance mainly preserved and plentifully distributed by the biosphere since the last ice age and the onset of the agricultural revolution, we tended to take it for granted, forgetting the fact that without balance there is no way we can achieve our cherished objectives of growth or expansion; nor we considered that, besides enabling progress, balance provides its own specific benefits in terms of quality of life. Even worse, we tended to conceive balance as a static

condition and therefore as inhibiting change, growth and progress. In this mindset, during the last century we were seeing the environment as a wealth-limiting factor and we felt that there was a trade-off we had to come to terms with, sooner or later: since our planet's resources are finite, protecting environmental stability may well be a necessary burden in the end – if not a ‘bourgeois luxury’, as the former Soviet Bloc dubbed it – but it can only come at the expenses of development.

We have now to understand that the opposite is true: if we fine-tune them with nature – and that includes our own nature and physiology of beings that co-evolved with the rest of the system – development, well-being, and wealth are boosted by a healthy environment, not limited by it. Indeed, the 2030 Agenda finally overcomes these misperceptions and incorporates the idea that not only is balance compatible with progress and change, but also that there must be a dynamic balance between mankind and nature that acts as a propelling factor of expansion and quality of life: a propeller rather than a limit, a synergy instead of a trade-off. Our understanding is becoming deeper because we are currently coping with a game changer, globalization, that gave us the power to perceive planet Earth as a unified system, but also to alter it; and we are starting to understand the risks. It is impossible to structure a stable society and plan progress without relying on expected natural cycles which are the expression of balance, first and foremost a reliable and foreseeable cyclical climate pattern.

Progress, development, and expansion are not incompatible with balance, both human and environmental; on the contrary, they represent probably the way to ensure progressive universal sustainability, once we manage growth with the awareness of global balance. But so far we did not, and nowadays the awareness of global interconnectedness has been forced unto us by threats like climate change. We are now compelled to take into account the fact that environmental disruption is linked to food insecurity, State collapses, migrations and so on: to the point that we are now facing a serious and imminent global shift in planetary balance that threatens to take the form of a single, vast – planetary scale – and dangerous positive feedback loop where both human and natural components of the ecosystem could concur in making our mother Earth a barren garden.

It's no wonder: we forgot about it, but we are indeed part of the ecosystem and we are naturally induced to react accordingly.

As the overall rapidly degrading situation forces us to stop reasoning sector by sector, we are giving ourselves the instruments to analyse and manage our common home Earth as a global balance sustained by a collection of interlinked

sub-balances. What we are realizing is that local or sectorial unbalances, beyond critical thresholds, tend to impact on other balances and can spread at an ever accelerating pace to the whole system. Climate change and its feared tipping points – permafrost thaw and consequent methane release, ice-albedo feedback loops, etc. – are becoming more well-known to the public. Yet, fearsome as they are, they are nothing compared to the big picture that emerges once we put together the intricate series of interlinked environmental and human unbalances that we have pushed to the verge of towards catastrophically accelerating cumulative cycles.

In this global interlinking machinery, health stands as more than an element among others, one of the Goals, or a sub-balance to take into account. It provides an equivalence, a fundamental one, that acts as the very meaning of the new order we need to build: the health of the ecosystem triggers the health of mankind and the health of mankind protects the ecosystem. The case of climate change demonstrates it.

Development, environment, health, and quality of life

It has become obvious that climate change brings a threat to health in its basic and restricted meaning: if we define ‘health’ as an absence of pathologies, we are all concerned with the swift mutations of airborne pathogenic bacteria or the impact of heath waves; or we could even worry about the de-freezing of pre-historic super bugs with the accelerating thawing of permafrost. But this only represents the tip of the iceberg. If, instead, health is considered as the portrait, projection, and result of the overall well-being of a person, the link becomes fundamental.

The infinitely complex interactions network harnessed within Earth’s balance can be described in the terms of a mathematical instrument often used to account for dynamic balance systems: a matrix. Matrixes portray – in compound systems like planet Earth – how the whole situation evolves as a result of the variation of its elements. To describe system Earth, and monitor the preservation of its stability, we need a matrix that interconnects a set of sub-balances in an overarching final balance, through algorithms. It implies that a variation in one sub-balance can affect other related sub-balances and that these, in turn, can reverberate on further elements, so that if the chain effect gains enough strength, it can modify the global state of the system.

If it took into account all the causal and cyclical connections that shape the biosphere, a matrix describing this balance would be exceedingly complex and useless, since it would provide an instrument far beyond our quantitative capabilities. But such a matrix can be declined at different levels of complexity and from diverse angles, as a useful tool. And indeed, the two last development Agendas hint in this direction: probably as an intuitive consequence of a perceived but not yet rationalized truth, once environment came into the picture of development, the idea of a global-balance matrix started unintentionally to emerge. The images chosen to communicate both the Millennium Goals and the 2030 Agenda, for instance, do look like a matrix at least in the way they were shown to the public.

The two similar graphics – that ascribe each goal to a box, in a set that really reminds of a matrix – do not just depend upon the choice to market the idea that both subsequent Agendas are part of the same path: still instinctively, they seem nevertheless to spring out of a growing awareness of an organized order and balance. Since the intuition that the goals were interconnected within a planetary-wide balance was already present when the Millennium Development Goals were adopted in 2000, starting to represent them as a matrix came natural. In both tables, the difference between taking them as a matrix, instead of a mere list of goals, consists in identifying functions that connect all the different boxes, that we are only starting to explore in quantitative terms.

Especially if we look at the more elaborated 2030 Agenda in this perspective, we recognize functions that connect, for instance, ‘life on land’ with ‘quality education’ that, in turn, reflect on ‘no poverty’ and ‘zero hunger’ which, again, are factors in ‘peace, justice, and strong institutions’, the end result of which could, again in turn, reshape ‘life on land’ and ‘quality education’. In other terms, we are – still timidly – recognizing that we are coping with trans-sector local, regional, or even global feedback loops.

The 2030 matrix can be simplified in one more organic but still practical approach to describe global balance – and guide us in identifying significant interferences from the point of view of mankind’s interests – a matrix that portrays dynamically the relationships among the environment, development, human rights/social welfare, and peace:

| | |
|-------------|---------------------|
| ENVIRONMENT | PEACE AND STABILITY |
| DEVELOPMENT | HUMAN RIGHTS |

It basically says that a feedback loop connects the four dimensions, that if a land is contaminated, it will no longer sustain its owner, who can become vulnerable to abuses, prone to migrate or an easier prey to fanaticism, and so on. And, conversely, it says that if the same peasant is granted a sounder education, he can manage better his field, protect it from contamination, count on a more dignified livelihood, and therefore resist temptations to engage in conflicts, etc. No matter which term of the matrix is subjected to an initial stress or improvement factor, its consequences will cyclically reverberate on the three related dimensions and grow in scope and impact. It is the Keynesian idea of a ‘multiplier’ extended beyond traditional economy, to encompass the broader economy focussed by the Agenda: one where the common etymological roots of ‘economy’ and ‘ecology’ – the law and the science of our common house – are finally reconciled. And one that describes the ultimate goal of economy as an overall human condition of well-being and health. Our exemplified peasant’s condition, if he is prey to the first disruptive cycle, can be described as lacking most of the elements that concur to a physical, psychological and social, healthy life. Which is what the 2030 Agenda new economy aims at preventing: whereas classical economy limited its scope to the creation of material wealth, the economy/ecology encompassed in the new perspective aims at building all the conditions for individual and collective overall health.

In more pragmatic terms – and taking the environmental term of the loop as our starting point – environmental balance matters for livelihoods, dignity, development, peace and stability, the fulfilment of which is synonymous with a condition of health. The basic cause-to-effect link that has been identified is that, in the first place, some environmental modifications directly affect human beings: for instance, heat waves, water pollution, particulate matter, or the hole in the ozone layer obviously put human health at risk. Beside these, other environmental modi-

fications trigger cumulative cycles of instability when they affect socio-economic organization, even if they do not directly concern human physiological well-being. By suppressing, randomizing, or displacing ecosystem services upon which societies have organized their livelihoods, environmental modifications cause insecurity and uncertainty in planning for the future, as they reintroduce in the system a higher-than-usual dose of chaos; insecurity and uncertainty, in turn, pave the way to poverty and disputes around vanishing services, fragility, compression of human dignity and rights, possibly violent conflicts and, , this mix integrates a push factor for both voluntarily chosen or forced migrations. The resulting situation, further in turn, is likely to revert back on the initial term, eroding even more environmental and human health – because predation of nature is a way out in impoverished contexts – so that outcomes could be endlessly self-feeding.

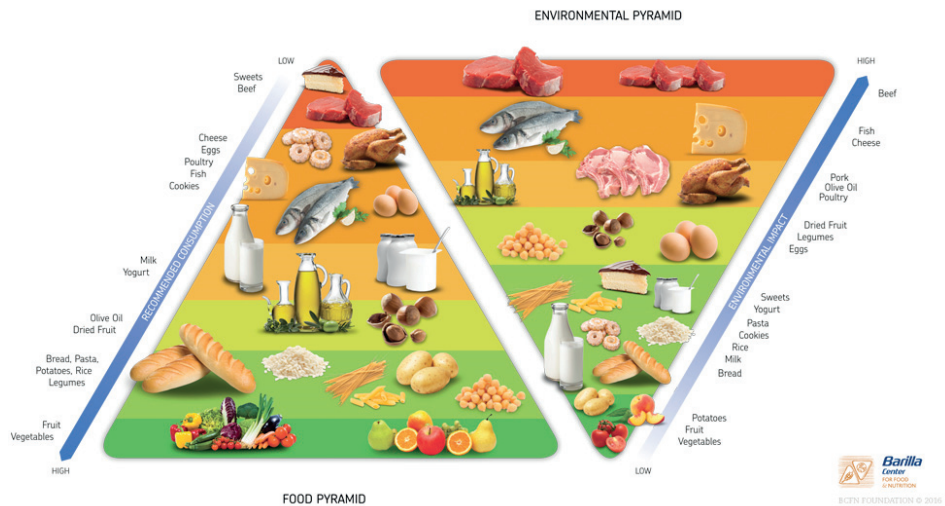
Health: the way out.

It is therefore clear that the disruptive loop between the health of the environment and human health is broader and more complex than simply a question of spreading pathogens, poisoning, or temperatures: environmental decay produces a context where public and private health are severely affected. But this same loop can be actioned in the opposite direction to leverage a quick co-recovery of the planet and its human inhabitants.

To cope with climate change, we are currently relying on treaties and public measures focussed on energy and other productive sectors. We need to, but this induces the illusion that remedies have to be orchestrated at the institutional, macroeconomic and organizational level, with individuals only passively concerned. It is an illusion indeed: no treaty or law, per se, will make a difference to the environment; all such instruments, instead, are meant to favour a change in individual and concrete community behaviour. In other words, people tend to think that the climate and environment challenge can be solved by maintaining unaltered individual behaviours that would become sustainable thanks to a more efficient extraction and management of resources. This approach is not only quantitatively insufficient to defuse the environmental crisis, but also provides a mere delay in time of the collapse threshold, and still reflects the idea of a fundamental trade-off between development and environment: technology and better organization will give us more time, but fundamentally we don't want to change our ways of life.

Reality is harsher than that: we can hope to defuse environmental tipping points only if we apply enhanced efficiency to a different lifestyle that takes a healthy nature as a context of well-being. Quantitatively, the sum of even marginal improvements in the sustainability of individual choices – if practised on a large scale – would be enough to bring back overall environmental parameters below the collapse threshold. And here emerges the fundamental dimension of health: more sustainable individual behaviours tend to coincide with healthier lifestyles. Furthermore, they have cascading systemic repercussions that tend to build justice, dignity, stability, and peace on a planetary scale, therefore solving the health-environment nexus in its broader dimension.

One paradigm of how this could work is to be found in nutrition. The now famous Double Pyramid Model – developed in 2009 by the BCFN Foundation – shows us that our food choices play a key role for our well-being and for the environment.



The model indeed shows that the foods with low environmental impact are those for which a more frequent consumption is recommended, whereas foods with a higher environmental impact are the ones that should be consumed with moderation. At the base of the pyramid, there are foods of vegetable origin, rich in nutrients and protective substances, such as vegetables, pulses, fresh and dried fruit, and cereals, half of which wholegrain. At the top of the pyramid, there are

instead foods with a growing energy density that should be consumed less frequently, including fish, white meat and dairy products, and finally, the products, such as sweets and red meat, for which a more moderate consumption is recommended. The production and consumption of food however does not only affect the well-being of people, but also the quality of the environment surrounding us.

This rather immediate relationship between personal health and the environment investigated by the Barilla Foundation, nonetheless, is only the tip of the iceberg. Actually, if everyone – especially developed countries populations – ate in a healthy way, it would also correct a global polarization between a rich world that suffers from obesity, heart diseases, diabetes etc., and a poor world where 815 million people are undernourished: the unhealthy excess given up by the rich would be quite automatically redistributed – the economics of such redistribution exceed the scope of this article – in favour of those who need it in order to be healthy. And this, in turn, will act as a powerful peacebuilding machinery, since most conflicts have roots in inequalities.

In this scenario, a better nutrition for fragile groups will also provide grounds for: access to education, active work presence and therefore empowerment, awareness in reproductive and maternal health with substantial improvements in demographic unbalances that are also creating a tangible threat to the environment, and much more. Concretely, this scenario embodies a more favourable health context for both mankind and nature, one in which health produces health and the latter resumes all the feature of that ‘sustainable development’ we are struggling to achieve.

The nutrition sector has been better investigated than others, but it is no exception. In all sectors – and in social and productive life as a whole – the rule seems to be the same: healthier behaviours are also more sustainable and distribute justice and peace. A healthier transportation behaviour – more bikes, less SUVs – acts like that. A healthier home does, renewable energies act like that: and if you give up your plastic shopping bag, you are not only saving whales and dolphins. What’s good for your planet, is good for you, what’s good for you is good for your planet!

The equivalence between human and environmental well-being, if marketed to the public, could prove an essential game changer. Awareness about the looming environmental collapse is general, but society is slow in engaging towards a necessary lifestyle change, without which we have no hope to avoid a planetary collapse. This is due to many causes, but the main obstacle seems to be that sus-

tainable choices are perceived as sacrifices in quality of life, which – coupled with the individual sensation to be but ‘an irrelevant drop in the ocean’ – is the perfect and devastating recipe for immobility. A different message could change this culture: sustainable and fair development are both a cause and a consequence of healthy lifestyles. There is no ‘sacrifice’, what’s good for your planet, is good for you. No community is more credible and entitled to spread this message than the medical one: not the media, nor the greens. If doctors took up the challenge, collectively, they could heal the planet’s fever by healing mankind’s insanity.

Second section:

Reflections on health promotion,
between global and local

Interlinguistic and intercultural mediation at a standstill: causes and effects

*Francisco Raga Gimeno**

Introduction

This study is intended as a reflection on the current status of interlinguistic and intercultural mediation within the healthcare sector (referred to from now on as MILICS, Spanish acronym for *mediación interlingüística e intercultural en el ámbito sanitario*). First, I shall very briefly present its equally brief history, and then I shall reflect on some of the factors which, in my view, have affected and continue to affect the current situation of standstill in MILICS, which, as we shall see, is not very positive or encouraging.

Historical contextualisation of interlinguistic and intercultural mediation in the healthcare context¹

Initial stage (1990–1999)

The phenomenon of intercultural mediation arose in Spain in the mid-1990s, as a result of the widespread arrival of immigrants from Asia, Africa and South America. In a few years, Spain went from being a country of emigrants to having a population of which approximately ten per cent was of foreign origin. Among other things, this considerable increase in immigration gave rise to communication problems that had been unknown up to that time and that affected not only daily communication, but above all interactions taking place in the context of public services.

* correspondence to: raga@trad.uji.es

¹ Giménez [2007: 5–9] offers a more complete and generic account of the history of intercultural mediation in Spain, coinciding, as one would expect, with some of the issues described here.

It was obvious from the very beginning that these communication problems were not limited to purely linguistic questions and that the solution did not lie exclusively in promoting (or setting up, to be more accurate) teams of translators and interpreters in public services, but in starting to develop a new professional profile, that of the interlinguistic and intercultural mediator (inspired in part, but only in part, by the figure of the conflict mediator) [Giménez, 1997; Bermúdez et al., 2002; Raga, 2008], capable not only of facilitating interpersonal communication in both its linguistic and cultural dimensions at the same time, but also of playing an active part in establishing projects for community mediation between native-born and foreign groups, with a significant impact on intercultural integration processes [Giménez, 2002].

This first stage was characterised by a certain lack of definition of the functions of intercultural mediators, due to the fact that academic studies and training (which was unregulated) were just starting to be developed, professionalization was minimal and very insecure and there was practically no specialisation in different areas of public services. In this initial phase, the profile of the intercultural mediator was a person aged between 25 and 45, who came, or whose family came, from an African, Asian or South American country, and who had spent part of their life in their country of origin, was familiar with the cultural characteristics of that country and of the host country, expressed themselves correctly in the languages of both countries (and usually in a third language as well), had completed secondary or higher education, had taken, at most, a brief course on intercultural mediation and worked in most cases as volunteers, usually through an NGO, attending police stations, courts, schools and hospitals on an equal basis².

During this first stage, the presence of mediators and interpreters in hospitals was fairly rare, not to say non-existent, and therefore patients of foreign origin who did not speak Spanish relied, at best, on ad hoc interpreters or mediators; in other words, they were accompanied by friends or relatives with some command of Spanish who ‘acted as interpreters’³.

² See also Bermúdez [2009].

³ On this subject see the studies in Valero & Raga [2006].

Development stage (2000–2010)

From the end of the 1990s to the beginning of the second decade of the present century, there took place what some authors such as Giménez [2007] defined as the boom in intercultural mediation in Spain. During this period, various research groups were consolidated, such as the Triángulo Group, the CRIT Group, the FITISPOS Group and the GRETI Group, to name just a few [Valero & Raga, 2006], working both on intercultural mediation and on translation and interpreting in public services, and sometimes (though not very often, a point we shall return to) a bridge was established between the two disciplines, combining them. Training programmes began to be developed, and although they did not reach the point of being officially integrated in the public higher education system, they showed a certain degree of systematic organisation and coherent planning, with rigorously prepared teaching materials. In other words, when assessing the profile of an intercultural mediator, their training becomes especially important, as well as their personal journey and their life story as an immigrant; and some of these courses were recognised when the first official registers of intercultural mediators were established⁴.

The position of intercultural mediator started to be professionalised to a certain extent, and mediators began to carry out their work on a more or less regular basis in schools, courts, police stations and hospitals, although in most cases this professionalization continued to be channelled through the medium of agreements with NGOs, foundations or university institutes. For example, a leading role was played in this period by Madrid City Council's social and intercultural mediation service SEMSI (now discontinued) [Giménez, 2002], which came to have around a hundred intercultural mediators in total, and the *Red de Mediadores Interculturales* (Network of Intercultural Mediators), funded by the social foundation of La Caixa bank, which also acquired a total of more than a hundred intercultural mediators attached to various NGOs all over Spain.

In this period, intercultural mediation also underwent a certain degree of specialisation (in academic, training and professional terms) in various

⁴ For example, Order 8/2011, of 19 May 2011, regulating accreditation of the position of intercultural mediator and the Register of Intercultural Mediators of the Valencian Community, was published in the *Diari Oficial de la Comunitat Valenciana* [Official Gazette of the Valencian Community] no. 6529, of 26.05.2011

areas of public services. Among these, an outstanding example was the area which interests us here, that of MILICS⁵. By the end of the first decade of this century, it had begun to be quite common for MILICS to be present in hospitals, although there were marked differences in the various regions of Spain. In 2010, for example, the *Hospital del Mar* in Barcelona⁶ had a team consisting of six intercultural mediation professionals specialising in different linguistic and cultural areas, under contract with an NGO, *Salud y Familia* (Health and Family), which had a long-term agreement with the health services of the Catalan Government.

In most cases, the intercultural mediators working in hospitals or health centres did so on an occasional and unregulated basis, were not (and are not) members of the official hospital staff, and usually worked under the authority of patient care and information services (SAIPs in Spanish). These SAIPs, in turn, served as intermediaries between mediators and health and social care staff, who were initially unaware of the precise role these professionals performed. Although getting other health and social care staff to accept interlinguistic and intercultural mediators was not proving to be an easy task, it would be fair to say that by the end of the first decade of the present century the relationship between these groups was starting to be regularised and mediators were beginning, not without difficulties, to be professionally accepted.

Moreover, the steps taken to address problems of communication between health and social care staff and patients of foreign origin were not solely confirmed to developing and consolidating the position of the interlinguistic and intercultural mediator. Some hospitals hired telephone interpreting services [Rosenberg, 2005]; computer tools were developed for translating doctor-patient conversations into a range of languages, such as UniversalDoctor, created by Jordi Serrano [García & Serrano, 2009]; various types of medical texts aimed at patients, such as information leaflets and informed consents, began to be translated; guides aimed at health and social care staff were published, containing information on the cultural characteristics of different groups of patients, such as that of the CRIT Group [2009], and training, information and awareness programmes were conducted both for members of health and social

⁵ At the Universitat Jaume I in Castellón, for example, a course was taught for several years on “Introduction to interpreting and mediation in the healthcare context”.

⁶ Catalonia has always been at the forefront of the development of intercultural mediation.

care staff and for various groups of patients, with special attention to certain specific fields, such as sexual and reproductive health [Raga, 2013].

The crisis (2011–2018...)

This promising outlook was drastically curtailed, however, at least in Spain, by the advent of the infamous economic crisis. The presence of MILICS in hospitals and health centres in Spain has returned to the levels of the early 1990s. Training courses in intercultural mediation in general, and in MILICS in particular, have also been significantly reduced, partly because they were producing large reserves of highly qualified mediation professionals with practically no prospect of finding employment. And although I am not going to go into this issue here, things have largely come to a standstill from the academic point of view as well.

The idea of MILICS: factors affecting its current state

What are the causes of this situation? I am not going to dwell on a political analysis of how the economic crisis has hit the public service sector in general and public services of a social nature in particular, nor on how certain ideological discourses have sought to saddle the immigrant population with a large part of the blame for the crisis.

In this second part of my paper, I shall briefly analyse some of the key factors underlying the situation in which MILICS found itself at the time when the economic crisis exploded, factors which can help us to understand its current state of extreme weakness in the face of a more or less exceptional socio-economic situation. I shall analyse this state of MILICS in terms of three groups directly involved in its everyday reality: managers of public healthcare institutions, members of health and social care staff, especially doctors, and research and teaching staff. These reflections are based, at least in part, on the data and impressions obtained in the course of a research action project conducted by our research group [the CRIT Group, 2014] between 2010 and 2012, in which two intercultural mediators, a team of health and social care professionals and leaders of various patient groups took an active part, in addition to the members of the research group.

Institutional managers

Although it is not difficult to find laws, regulations and white papers, at both national and regional level⁷, that refer explicitly to the need for hospitals and health centres to have professional interpreting and intercultural mediation services, the fact is that, from the institutional point of view, even in the period when MILICS was at its fullest stage of development, a certain lack of understanding, and even resistance, towards the phenomenon of MILICS, and especially towards introducing it on a regular professional basis, has always been evident. The discourse of institutional managers tends to rely, firstly, on certain expressions of public opinion (or «published opinion», as is often said) indicating that the presence of immigrants in public health centres is saturating them to a certain degree. Secondly, institutional managers have conveyed to us that in their view providing hospitals with these MILICS services would amount to a privilege, a form of positive discrimination towards immigrants that might not be well understood or accepted by native-born patients. Thirdly, we have sometimes encountered the idea that the presence of MILICS in hospitals could contribute to holding back or slowing down the process of integrating immigrants into the host culture. A fourth argument is a purely economic reason: the supposedly excessive expense involved in hiring intercultural mediators across the board in public health centres and hospitals.

The effect of all these factors together was that, even in the period when MILICS was undergoing its greatest expansion, the commitment of public institutions consisted of providing only certain hospitals with MILICS services and always doing so unofficially; in other words, as I was saying before, through agreements with NGOs, through training scholarships, or by ‘accepting’ students for internships. Obviously, this situation did little to consolidate the professional status of intercultural mediators.

As regards the arguments put forward by managers of public institutions, it must be said that the facts indicate, firstly, that far from saturating the Spanish public health system, the immigrant population has contributed significantly to maintaining it, since for various reasons, including the fact that there are not yet many elderly immigrants in Spain, foreign patients make considerably less use of health services than the native-born population, with the exception of reproductive

⁷ For example, Articles 13 and 14 of Act 15/2008 of the Valencian Regional Government, of 5 December 2008, on Integration of Immigrants in the Valencian Community.

health services [Raga, 2013].

Moreover, the very idea of regarding the presence of MILICS as a privilege or a form of positive discrimination is completely incomprehensible, especially when we consider that healthcare is a basic right and that the effectiveness of medical treatments naturally depends, among other things, but also and crucially, on proper communication between the patient and the doctor, added to the fact that however well patients of foreign origin eventually learn the Spanish language and become integrated into the Spanish culture (largely thanks to the work of empowerment performed by interlinguistic and intercultural mediators), the flows of migrants are not going to stop, and there will always be a group of foreign patients who have recently arrived in Spain and urgently need help with linguistic and cultural communication.

In general, we can say that to establish a conflict of interests between native-born patients and those of foreign origin is a complete fallacy. Any measure that leads to better healthcare for a patient, or for a group of patients, always benefits other patients. There are no native-born patients and foreign patients, there are simply patients. It is particularly significant in this respect that studies carried out especially in hospitals in the United States have demonstrated with tangible data that the presence of interpreters and mediators produces a financial saving for those hospitals [Nápoles et al., 2010: 303], since they speed up consultations with foreign patients, reduce misunderstandings, avoid medical errors that have to be rectified and save many medical tests, such as X-rays and blood tests, which doctors often ask for when they have problems in communicating with patients.

Health and social care staff

The attitudes and actions of health and social care staff, especially doctors, must also be regarded as an important factor for understanding the current state of MILICS. Clearly, it is not easy for a group such as doctors to include a new type of professional into their working practices, and moreover one whose work is to be carried out in the private space normally shared by doctor and patient, and who may sometimes try to exert some kind of influence on various aspects of how they communicate and interact with one another. The comments presented below on attitudes and opinions towards intercultural mediators are obviously not applicable to all doctors across the board. Fortunately, in conducting our research projects we have benefited from the support, collaboration and often initiative of doctors who

are particularly sensitive to the communication problems encountered by patients of foreign origin and are in many cases staunch defenders and promoters of MILICS. However, it must be said that in general terms, according to our experience, even when the development of mediation was at its height, we found a large number of medical professionals who, whether through unfamiliarity or for other reasons I shall mention, manifested their hostility towards the figure of the mediator. This hostility sometimes took the form of not requesting the presence of a mediator even when the situation required it, expressing various kinds of complaints about the actions of these professionals, particularly with regard to how active a role they played, and even sometimes openly refusing to have a mediator present when requested by the patient. In addition, with the exceptions mentioned above, it was quite striking that few doctors attended the training, information and awareness courses we regularly organised for health and social care staff on the problems of communicating with patients of foreign origin.

What were the reasons put forward by doctors, and not only doctors, to explain these attitudes? Firstly, somewhat to our surprise, we found a quite widespread view that the new group of patients they were starting to treat, patients of foreign origin with almost no knowledge of the Spanish language, Spanish culture, the workings of the Spanish healthcare system, the key elements of biomedicine and the key elements of doctor-patient interaction in Spanish culture, did not pose a particularly significant communication problem. It was more or less assumed that somehow they could cope with these patients, either through a family member or friend who spoke a bit of Spanish, or by using a third language, especially English, or through non-verbal communication, or by speaking slowly and loudly in Spanish, and ultimately by avoiding direct communicative interaction with the patient and performing various types of analytical tests.

In this respect, it is fair to point out that despite the increasing presence in medical studies of matters related to doctor-patient communication (consider, for example, the whole issue of the rights of patients to receive clear and precise information on their state of health), communication is still not as important as it should be in medical training, and above all virtually no attention is paid to interaction with patients who come from other countries, speak other languages and belong to other cultures [Watson et al., 2012].

The truth is that whether or not we are willing to recognise the fact, there are patients in Spanish hospitals on a daily basis, and not just Spanish ones, who do not receive adequate healthcare, who are sometimes indirectly expelled from the

public healthcare system and who suffer and die because of linguistic and cultural communication problems. In the research project I was referring to earlier there were several occasions on which not only we as researchers or as mediators but the healthcare staff themselves, the doctor involved, acknowledged that without the presence of the mediator the patient would most probably have died. I could cite the case of a child of Moroccan origin with particularly severe symptoms of diabetes who attended the clinic with his mother, and whose condition, to the doctors' surprise, got steadily worse, with an alarming aggravation of his disease. When they finally had the mediator present, the latter was able to determine that the mother had understood absolutely nothing about the medication she had to give her son, monitoring of blood glucose levels or diet [the CRIT Group, 2014].

Secondly, health and social care staff show a certain lack of understanding of the fact that cultural differences can adversely affect communication; in other words, it is accepted, at most, that there is some need to have translators and interpreters to solve the language problem, but not professionals who also try to solve problems related to cultural differences: intercultural mediators. Indeed, as is all too often the case, not only with health and social care staff, there is a certain tendency to identify intercultural mediators with the 'unattractive' idea of conflict. We should not be too surprised that doctors identify communication problems exclusively with language problems, since the emergence of cultural issues in communication studies is a fairly recent development. Even in the purely academic context, communication tended to be identified with language until fairly recently. Nowadays [Hall, 1959], however, we know that cultures actually function as communication systems that can give rise to misunderstandings at least as serious as those produced by language differences, and that a patient can die because of a communication problem that is not linguistic but cultural. To give just one example, in the case cited above of the Moroccan child suffering from diabetes the problem was not only that the mother did not understand any of the instructions the doctors had given her, but that she did not admit her lack of understanding in their presence. The reason for this was cultural: this woman came from a very traditional rural area of Morocco where a patient would never dare tell her doctor that she did not understand him, because this would amount to questioning his knowledge and authority.

Finally, in cases where the mediator actively intervened to resolve some misunderstanding of a cultural kind, a certain resistance could be observed to taking account, or even being aware, of the cultural features of the healthcare

systems in the patients' countries of origin, let alone to establishing any kind of intercultural dialogue between the characteristics of the biomedical system and those of the systems of traditional medicine. The idea was to 'explain to the patient how things are done here'. I shall not go further into this question, but the point needs to be made that although we may intend to promote intercultural dialogue through the work of mediators — a two-way dialogue, from the patients' culture to the Spanish healthcare system, but also in the opposite direction — the fact is that the ideology that still somehow prevails in Spanish (and not just Spanish) society is a certain assimilationist ethnocentricity, which argues that those who come from outside, especially if they come from a developing country, should totally adopt the language and culture of the host country. In this regard, it should be pointed out that it is quite normal for this ethnocentric feeling to be manifested in a marked way when one operates in a scientific field such as medicine. People who do not consider themselves ethnocentric may perfectly well hold the view that biomedicine is not only different from traditional forms of medicine but obviously better and more advanced.

Researchers and teachers

Perhaps the most important factor, the decisive one, in understanding why the professional position of the interlinguistic and intercultural mediator has not been consolidated is that the functions of mediators, and the parameters within which they should be conducted, are not clearly defined: it is very often not clear to health and social care staff and patients what they can and cannot expect of a mediator.

Researchers and teachers in this field obviously play a decisive part in this lack of definition. One of the keys to understanding can be found in the fact that for much of the academic world this professional figure we are discussing really fits two more or less distinct professional profiles: that of the interpreter, or linguistic facilitator, a responsibility lying, in principle, within the area of translation and interpreting, and that of the mediator, or cultural facilitator, which belongs, in principle, to various academic fields such as social education, social psychology or social work.

It must be said that with certain exceptions much of the research and teaching in these academic areas is devoted precisely to trying to distinguish and differentiate these two professional profiles. Although the importance of cultural

issues and the impossibility of separating them from linguistic questions are recognised in translation and interpreting, this field seeks to identify interpreters as communication professionals whose strict aim is to follow the principles laid down in the ethical codes of interpreting, focussing their activity exclusively on three-way interventions in which the interpreter acts as a linguistic link between the doctor and the patient, remaining invisible as far as possible and refraining, for example, from establishing unilateral interactions with one of the parties [the CRIT Group, 2014].

The field of intercultural mediation, in turn, does not deny the decisive value of linguistic mediation (which on many occasions has to be necessarily performed by intercultural mediators who are themselves immigrants and bilingual speakers, especially in the case of African or Asian languages), but does not pay much attention to it, seeing the function of the mediator in a broader perspective that includes interventions both in individual cases and at a community level, with greater visibility and capacity for initiative, participating more actively in intercultural dialogues [Prats & Uribe, 2009].

In my view, this kind of research, focussing on an artificial distinction between the two professional profiles and on how professionals in each field should ideally behave, actually contributes to maintaining the lack of definition of the functions of communication professionals working in hospitals and confusion among health and social care staff, patients, institutional managers and, above all, interlinguistic and intercultural mediators themselves [Raga, 2014: 7–11].

The alternative involves not only investigating how interpreters and mediators should ideally behave, but observing and analysing how the work of these communication professionals is conducted day by day in hospitals and health centres, a daily task in which communication — communicative interaction — is manifested as a complete reality that cannot be divided up into portions and is subject to endless personal, social and medical circumstances which we gradually have to systematise. Doing this requires developing research action projects with the participation of the mediators themselves, patient groups, health and social care staff and institutional managers, as well as the researchers. The problem, as mentioned previously, is that the actors involved do not always collaborate in such research action projects in the most appropriate way, as we have had occasion to confirm in our own research projects.

Conclusion

In Spain, at least, MILICS is currently locked in a vicious circle, in which a lack of institutional support and recognition, training that lacks official approval and is poorly planned, an unreceptive attitude on the part of other professionals and an obvious lack of academic definition have been feeding back into each other to the point of reaching a worrying standstill. Although it may be extremely difficult, we will have to learn to break this vicious circle if we want to guarantee the right of a large part of the population to decent and appropriate healthcare.

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Healthcare mediation: a proposal of reflection to foster understanding

Danilo De Luise, Mara Morelli*

General framework¹

In all the studies, research and work in the field of mediation that we have carried out in the past few years, as well as in the training we have organised, and in the conferences and informal meetings we have attended, we have often identified a number of common threads in the cluster of demands and offers of possible ‘solutions’. These common themes, invariably accompanied by thoughts, opinions and interpretations, are the following:

- Demand to have qualifications, professional standing and role recognized;
- Demand for fair compensation;
- Working conditions;
- Ongoing dispute on the difference between an interpreter/translator and a mediator and, as a result, between language and culture;
- Linguistic and intercultural mediation;
- Personal background of the mediator as a migrant;
- Technique/scope;
- Lack of confidence and reassurance;
- Neutrality and impartiality.

In any situation, it is inevitable to encounter a mix of all these ‘ingredients’, which are inextricably linked on so many levels that any attempt at analysing them in any depth can be easily trivialised or create confusion. This is why we thought it was appropriate to try and bring some clarity to a number of situations,

*correspondence to mara.morelli@unige.it

¹ Although the paper is a result of joint design and discussion, De Luise is the author of the first three paragraphs and Morelli of the remaining part.

such as healthcare, social work, and other face-to-face interactions between, in this particular case, non-Italian speakers and Italian staff and workers. Hence, we would like to take this opportunity to share a few thoughts on some of the issues we listed above.

Intercultural mediation

In our experience, we saw that all the issues identified at the beginning of this article are present in this area of mediation. As we can see from several web sites entirely dedicated to this subject², intercultural mediation is a type of mediation that takes place between migrants and the community in which they settle. It is helpful for both parties and supports interaction and relationships between the two parties. In most cases, if not all, it is regarded as an institutional activity: it takes place in schools, hospitals, courts, etc.

If we read its definition in the Treccani Italian dictionary,

interculturale agg. [comp. di *inter-* e *cultura*]. – Relativo a rapporti culturali tra paesi diversi (o anche tra istituzioni diverse): *scambi interculturali*. [<http://www.treccani.it/vocabolario/interculturale> last consulted on 12 August 2017]³

intercultural adj [comp. Of *inter-* and *cultural*] – Relating to cultural relations between different countries (or different institutions): intercultural exchanges [<http://www.treccani.it/vocabolario/interculturale> last consulted on 12 August 2017]

we find that the choice of adjective is entirely appropriate in this context. Nevertheless, we still often see the old and incorrect phrase ‘cultural mediation’ (sometimes we even heard the expression ‘ethnic mediation’⁴) used by experts and providers in this field. On occasions, this is probably only a ‘slip of the

² For some examples, see <http://www.integrazionemigranti.gov.it/en/services/Intercultural-mediation/Pages/default.aspx> and <https://www.cies.it/mediazione-interculturale/> last consulted 11 December 2018.

³ We believe it is convenient to maintain the Italian original sources we consulted since we are going to analyse these definitions, instead of searching the equivalent word in a lexicographic source in English. The English translation is provided.

⁴ This expression reminds us of the dangerous concept of ‘race’ and its implication: «Parliamo di razze. Se ci pensate, la parola razza è una delle più indefinite e imprecise nel nostro vocabolario. Si dice razza quando qualcuno fa qualcosa che non ci piace, magari anche suo fratello ha fatto la stessa cosa, e allora si dice ‘brutta razza’» [Barbujani, 2017: 27].

tongue' but sometimes it is a deliberate choice or the two phrases are even considered synonyms. We do not believe that highlighting this means being pedantic or excessively fussy. When people who are very knowledgeable in the field and have often attended countless training sessions repeatedly use the wrong term (it is a common occurrence, another example of this is the difference between 'of no fixed abode' and 'homeless'), this shows a certain reluctance to cast aside an acquired concept. We are deliberately using the term 'concept' to highlight the learning curve which is defined by the speaker's approach to training or by the assumptions on which the training itself is based. In either case, there is a risk that the learner is not prepared to reflect on the contents of the training, digest them or make them his/her own. The reason for this can be a training content based on a mix of information that does not encourage independent thinking as well as little or no attention to maieutics combined with an inability of the learner to apply critical thinking. This inability often stems from educational choices and experiences which have very little to do with 'education' in the real sense, because they failed to help the learner to question what he/she was being taught and to develop his/her own individual thinking, even if at odds with the mainstream view.

If we go back to the 'contentious' term, intercultural mediation, we can try and reflect on why, for us, it is not correct to just say 'cultural'. As we said earlier, it is obvious that, by definition, the adjective describes situations in which people from different countries have to interact with systems and services in the country they have relocated to.

Let's now attempt a very simple exercise using a definition of culture, a word forming part of the adjective itself, listed in an Italian dictionary:

1. L'insieme delle cognizioni intellettuali che una persona ha acquisito attraverso lo studio e l'esperienza, rielaborandole peraltro con un personale e profondo ripensamento così da convertire le nozioni da semplice erudizione in elemento costitutivo della sua personalità morale, della sua spiritualità e del suo gusto estetico, e, in breve, nella consapevolezza di sé e del proprio mondo: [...].
2. In etnologia, sociologia e antropologia culturale, l'insieme dei valori, simboli, concezioni, credenze, modelli di comportamento, e anche delle attività materiali, che caratterizzano il modo di vita di un gruppo sociale: [...].
3. Con ulteriore ampliamento della semantica, e conseguentemente degli usi

lessicali, del termine e della connessa fraseologia (ampliamento dovuto principalmente allo sviluppo degli studi di sociologia e al crescente interesse per i problemi sociali), il termine stesso è passato a indicare genericamente, nella letteratura, nella pubblicistica e nella comunicazione di questi ultimi anni, l'idealizzazione, e nello stesso tempo la scelta consapevole, l'adozione pratica di un sistema di vita, di un costume, di un comportamento, o, anche, l'attribuzione di un particolare valore a determinate concezioni o realtà, l'acquisizione di una sensibilità e coscienza collettiva di fronte a problemi umani e sociali che non possono essere ignorati o trascurati. [...] [Treccani: online dictionary <http://www.treccani.it/vocabolario/cultura/> last consulted on 12 August 2017].

1. The entire mass of knowledge acquired by a person through studying and experience and which a person has individually processed in such a deep and personal way to convert the learned notions from simple erudition into an integral part of his/her moral persona, spirituality, aesthetic taste and, in short, of his/her own self-awareness as well as his/her awareness of the surrounding world.: [...].
2. In ethnology, sociology and cultural anthropology, the collective set of values, symbols, beliefs, general customs and actions that characterize the way of living a particular social group: [...].
3. By applying a wider semantic definition and consequently a wider lexical usage of the term and its collocations (a widening of scope mainly due to the development of sociological studies and the growing interest in social issues), the term today generically indicates the conceptualization, but also the deliberate adoption of a certain lifestyle or certain customs and behaviours as seen in the literature, published works and communication of the last few years. It also indicates assigning a special value to certain beliefs or situations and acquiring a collective awareness or ethical stance on a number of human and social issues which cannot be ignored or neglected. [...] [Treccani: online dictionary <http://www.treccani.it/vocabolario/cultura/> last consulted on 12 August 2017].

In our case, the meaning of the adjective is closer, both in terms of definition and everyday use, to the explanation given in 2, rather than the definition and meaning given in 1. However, this opens the door to a much more complex sce-

nario. Every single individual is the result of the sum of a number of life experiences and more or less significant relationships which, as a whole, shape his/her culture, according to the meaning given in 1. These two aspects obviously closely complement each other and this is why, if we want to talk about culture, we cannot just focus on the definition given in 2. Here we have a dynamic, whereby anything that identifies the way of living of a certain social group is the result of interactions and relationships with a host of social subgroups, which also interact with each other and are part of the group itself. Another important role is played by the relationships among the individuals that are part of the group, as they also often belong to social subgroups straddling across several ‘main’ groups. If we then add all of this together, we have something that fits in with the definition given in 4. This illustrates that the situation is a lot more complex than the definition suggests.

If we start from the assumption that what we call reality is in fact a cultural representation of what is around us⁵ and that ‘Earth’ and ‘world’ are two very different things (the Earth exists regardless of us whereas the world exists as an expression of our cultural ability)⁶, then we can understand how important it is to refer to these roots right from the start if we want to find a definition. In this way, a definition becomes much more than a couple of sentences and turns into food for thought, an idea for learning and research which naturally leads to a complex analysis of relationships and interactions.

If we apply this reasoning, then we can say that there are as many realities and as many worlds (more or less similar or more or less different from each other) as there are people on Earth at any given time. As a result of this, every time two human beings meet there is also a meeting of cultures (again, more or less similar or different from each other).

It may appear to be a specious argument, but it made us reflect in the past, and it still does. This leads us to question whether sometimes certain titles and definitions are more useful for the market than for scientific research.

⁵ Bateson (1984) still remains a very useful source for us.

⁶ «La terra esisterebbe senza di noi, perché è una realtà fisica. Il mondo, no, perché è una creazione verbale. E il mondo non sarebbe mondo senza le parole». Taken from Carlos Fuente’s speech during the III Congreso Internacional de la Lengua Española. Argentina, November 2004. <http://congresosdelalengua.es/rosario/inauguracion/default.htm>, last consulted on October 2017 (our translation).

However, we are going to cast aside our opinion, which some may regard as ‘jurassic’, and move forward, or rather backwards, to the noun mediation. We are again going to resort to a dictionary to find a shared definition which we will use as a starting point.

mediazióne s. f. [dal lat. tardo *mediatio -onis*, der. di *mediare*; v. mediatore]. – **1. a.** Azione esercitata da una persona (o anche da un ente, un’associazione, una collettività, una nazione) per favorire accordi fra altre o per far loro superare i contrasti che le dividono: [...]. [Treccani: online dictionary <http://www.treccani.it/vocabolario/cultura/> last consulted on 12 August 2017].

mediation s. f. [from late Latin *mediatio -onis*, der. from *mediare*; v. mediator]. – **1. a.** Action performed by an individual (but also by a public body, an association, a group of people, a nation) to help other parties reach an agreement or resolve disputes between them: [...]. [Treccani: online dictionary <http://www.treccani.it/vocabolario/cultura/> last consulted on 12 August 2017].

Anyone that works in the field of mediation knows that mediation is not limited to the actions, techniques and tools needed to perform it. All of them stem from a cultural approach to human conflict which is aligned to the definition of ‘cultural’ given at point 4 of the dictionary definition we discussed earlier.

This cultural approach, dynamic and continuously evolving by definition, acknowledges the existence of a number of shared features, constantly benchmarked, which could be called ‘essential’ and which cannot be ignored. They include the voluntary nature of the process, the transparency and the confidentiality, which all mediation ‘schools’ recognize as a *conditio sine qua non*. Without them, there is no mediation.

At the start of the paragraph, we saw that intercultural mediation nearly always refers to institutional environments such as hospitals, schools, courts, etc...

However, we cannot be sure that, when an institution engages the services of an intercultural mediator, it does so on a voluntary basis. At the very least, in many cases, it would be fairer to regard it as a sort of ‘coercion’. There can be different reasons for this, including statutory requirements, time constraints, need to communicate to complete a task, delegation of an issue, fear, etc. A voluntary act is performed regardless of any obligation or external coercion and is the result of a free and spontaneous decision. We could even go as far as saying that volunteering happens when there is an awareness that acting in such a way is necessary to express ourselves and increase our self-fulfilment (not necessarily in a positive sense). If we cast a look around us and we browse through any newspaper, how-

ever, we cannot say that this is what happens and has been happening within our communities or in the interactions with the institutions. This is true even though said institutions uphold, or rather should uphold, the fundamental values that we consider our own and we strive to live by.

It must also be said that the representatives of the institutions which should be responsible for upholding these values, whether they be physicians, judges, lawyers, teachers or others (they are, after all, human beings), are not always able to express the institution's wish, assuming such wish genuinely exists, to make use of mediation facilities.

We also cannot say that many of the people who, for a variety of reasons, interact with these institutions and resort to intercultural mediation, do so voluntarily. Because of the circumstances they find themselves in, it would be fair to say that, in their case too, they are coerced to do so.

When we talk about mediation, however, this concept of 'volunteering' does not apply, or only partially applies, to certain areas of mediation in criminal, civil or commercial courts where there is a statutory requirement for mediation in a number of specific situations. These situations are listed in detail in many countries. Nevertheless, the international debate on this statutory requirement remains open.

The same reasoning can be applied to the concept of transparency, defined as a demonstration of loyalty and honesty of intents. Too often, internal procedures within institutions and intents remain difficult to understand and are not clearly aimed at the objectives they should pursue. Once again, the human variable can add to the general confusion, both when it applies to the institutions' representatives and the people that are forced to resort to intercultural mediation because of their interaction with institutions.

Confidentiality is possibly the pre-requisite which is guaranteed in most cases. This is obviously true in court, where it is appropriate and also necessary to abide by rules set by higher entities. However, even there, confidentiality cannot be totally guaranteed because of the public nature of many hearings and deeds.

The mediator in charge is the only person who finds him-/herself in an optimum position to comply with all three of these pre-requisites. In the case of transparency and confidentiality, they are also deontological requirements. This is probably why, in general, the fact that these pre-requisites apply to all stakeholders in the mediation process is often not properly understood. All stakeholders throw their hat in the ring, get involved and come out of the process having grown

up and matured. This is true also for the mediator. All parties have voluntarily undertaken a transformation process which has changed them for the better, i.e. has improved their quality of life.

Having said this, we struggle to find evidence of any of this in many of the real-life situations or ‘case studies’ we have experienced or reviewed (including the positive examples). In many cases, perhaps, they could have been more correctly described as facilitating communication rather than mediation. When the help of an intercultural mediator is required in a school, in court, at a doctor’s surgery etc., his/her contribution does not always fulfil all the requirements of mediation. Most of the examples we have come across do not involve mediation as such but could rather be described as a number of actions which are part of a community mediation process⁷. In this case, the voluntary nature of mediation applies to the community, which is aware of the value and the importance of choosing a cultural approach based on the idea that the dignity of a human being is safeguarded if he/she can express his/her full potential in harmony with others and the environment. This is because we need human interaction, we need to live ‘with’ each other and not simply to co-exist ‘next’ to each other to develop and grow from an individual into a real person. This is the purpose of mediation: its aim is not eliminating or, worse still, hiding conflict but rather to experience it with full awareness, in a peaceful and non-violent way, taking full advantage of the growth opportunity it represents. Our colleagues who work as mediators in an intercultural environment, therefore, are faced with a ‘mission impossible’. They are asked to perform their role without any of the essential conditions being in place, including, above all, the cultural option we discussed above.

Unfortunately, community mediation is generally considered an alternative to other techniques and tools and not as a collective process which can, sometimes but not always, pre-empt situations. To achieve the idea of human being we discussed earlier, mediation requires all the skills and tools available.

⁷ If we follow our proposal of definition of community mediation we consider that: «Community Mediation is a process consisting of various actions (cultural, social, educational, etc.) whose objective is to work for the local area to move from mere coexistence to real social intercourse. These actions should create the conditions by which communities can explore new ways of preventing, managing and transforming conflicts» [De Luise and Morelli, 2016 in Morelli, 2017: 85].

Linguistic mediation v. intercultural mediation

We have often heard in the past (and we still do) people talk about these two terms as two very distinct concepts. It is often remarked that translation and interpreting are different from mediation, and more specifically intercultural mediation, because the first term refers only to language and the second more broadly to culture.

It may be interesting, once again, to look at the dictionary:

lingua:

[...] 4. a. Sistema di suoni articolati distintivi e significanti (*fonemi*), di elementi lessicali, cioè parole e locuzioni (*lessemi* e *sintagmi*) e di forme grammaticali (*morfemi*), accettato e usato da una comunità both etnica, politica o culturale come mezzo di comunicazione per l'espressione e lo scambio di pensieri e sentimenti, con caratteri tali da costituire un organismo storicamente determinato, con proprie leggi fonetiche, morfologiche e sintattiche: [...] [Treccani: online dictionary <http://www.treccani.it/vocabolario/lingua/> last consulted on 12 August 2017].

language:

[...] 4. a. A system of perceptually distinct articulated sounds carrying a meaning (*phonemes*), of lexical units, i.e. words and phrases, (*lexemes and syntagmas*) and grammatical units (*morphemes*), shared and used by a community, whether it be an ethnic community or a political and cultural one, as means of communication to express and exchange thoughts and feelings and possessing such features that allow it to be identified as an entity with its own history, phonetic, morphologic and syntactic rules: [...] (Treccani: online dictionary <http://www.treccani.it/vocabolario/lingua/> last consulted on 12 August 2017).

culture (we already analysed this definition earlier, but we copy it here for ease of consultation):

1. The entire mass of knowledge acquired by a person through studying and experience and which a person has individually processed in such a deep and personal way to convert the learned notions from simple erudition into an integral part of his/her moral persona, spirituality, aesthetic taste and, in short, of his/her own self-awareness as well as his/her awareness of the surrounding world: [...].

2. In ethnology, sociology and cultural anthropology, the collective set of values, symbols, beliefs, general customs and actions that characterize the way of living a particular social group: [...].
3. By applying a wider semantic definition and consequently a wider lexical usage of the term and its collocations (a widening mainly due to the development of sociological studies and the growing interest in social issues), the term today generically indicates the conceptualization, but also the deliberate adoption of a certain lifestyle, or certain customs and behaviours as seen in the literature, published works and communication of the last few years. It also indicates assigning a particular value to certain beliefs or situations and acquiring a collective awareness or ethical stance on a number of human and social issues which cannot be ignored or neglected. [...] [Treccani: online dictionary <http://www.treccani.it/vocabolario/cultura/> last consulted on 12 August 2017].

Even from first cursory read, indissoluble cross-links and connections between the two aspects appear obvious. Without a language our ‘cultural abilities’ i.e. culture according to the meaning described in 1, would be shared much more slowly and, as a consequence, among a much more limited number of people. This would have a negative knock-on effect on the power and development of the other meaning, which, in turn, would negatively affect also meaning number 1.

An evolutionist would say that the most likely explanation of why the last wave of *homo sapiens* was so successful compared to its predecessors was indeed language and its ability to make our culture more powerful. As Calzolaio and Pievani remind us:

Population growth influenced social networks and generated a critical mass for novelties. In turn, cultural evolution drove the successful development of groups in the environment, fuelling a boom in innovations and a drive for people to leave the area they were born in. The theory is that one of these booms propelled a particular group that consistently displayed more advanced customs and social behaviours towards long-term success. It may have been a cultural revolution triggered by the full development of a complex language and the consequences that this had on social structure and knowledge [...] The most likely theory is that the successful group of migrants already possessed the elements of abstract intelligence. [...] This is when the *homo sapiens* managed a step change, i.e. was able to transfer knowledge through language, also thanks to a further expansion

of the time devoted to learning and improved parental care. This allowed the *homo sapiens* to achieve full physical and mental development and resulted in the naming of individuals and their ability to communicate with the other members of the group [2016: 40-41, our translation].

After reading this passage, the arguments we put forward earlier about culture appear even more comprehensive and multi-layered. Fuentes [2004, see note 5] reminded us that Earth has always been there whereas the world has only existed since the appearance of words to describe it. It is akin to saying that we shape the Earth by transforming it in a 'world' through communication. Communication means first of all communicating thoughts and feelings to ourselves (see the definition of language). Those thoughts and feelings form first of all our personal culture (see meaning 1 in the definition) and then, when we share it with others, the culture of the social group we belong to (see relevant definition of culture).

There are as many cultures as there are people on Earth. When two people meet there is also a meeting of two different cultures and, even if they speak the same language, of two different ways of using it. When several individuals form a social group, they create a shared culture, but each individual also belongs to several social sub-groups which, in turn, share their own internal culture. Belonging to a group and several subgroups enriches each individual's personal culture. This, in turn, has consequences for each group to which he/she belongs and so on in a continuous loop. Moreover, each group or subgroup will use their common language in a specific way, shared only between its members. This results in a constant exchange of idioms, phrases and expressions between all these groups.

What we are trying to say is that the situation is significantly more complex than it seems and that sharing, to a higher or lesser degree, a view of the world and an interpretation of reality based on a certain 'culture' is affected by a higher number of variables that go far beyond the geographical area(s) in which an individual is born and raised.

As we observed on many occasions, an Italian who has been homeless for decades and an Italian doctor working in A&E can encounter communication problems which are as serious or even worse than the ones between the same doctor and a 'Middle Eastern' patient. The fact that they both, at least in theory, speak the same language further complicates matters because they take for granted that the other person will attribute the same meaning to a certain word or interpret a sentence in the same way. However, we know this is not always the case. These extreme cases, which are more frequent than commonly thought, help

us to understand that in human relationships, using a language always requires getting to know and learning about the ‘other person’s world’. This process allows us to truly understand what the other person is trying to tell us with their words but also through their behaviour as well as helping us to understand them better. Different levels of awareness of or totally neglecting the importance of this process, combined with differences in attitude and approach, result in a higher or lower asymmetry of the communicative interaction which, in turn, leads to a higher or lower level of preparedness to be more compromising and accepting towards others. The higher the awareness of the effort required by both parties to learn from, understand and compromise with each other, the higher the quality of the relationship and mutual understanding that ensues.

This very complex picture is often oversimplified by those who state that a mediator deals with the culture and an interpreter/translator deals with the language. Just try to imagine what would happen if a novel was translated literally or a conference interpreter did not do any preparation work on the topic of a forthcoming conference, including the codes and internal culture shared by the group of people who will take part in that conference. And what would happen if a social worker blindly believed anything an intoxicated service user is saying?

An overview of some data and a few thoughts from our experience and research

Since the 90s, there have been many studies on meetings conducted through a mediator in a healthcare environment as well as on the role of the interpreter and the mediator in this field. These studies were often the result of research carried out in the field devoting long periods of time to observation or data collection. In particular, for Interpreting Studies the work by Angelelli [2004a, 2004b] and Pöchhacker and Shlesinger [2007] was a mandatory port of call, as well as the Cross Cultural Communications web site and the very interesting and comprehensive material it makes available and which can be downloaded from the site⁸. Despite being our reference points when we started working within the Genova healthcare system in 2007⁹ and despite the fact that we continue to follow the

⁸ For more information, see <http://www.cultureandlanguage.net/>, last consulted on 21 October 2017.

⁹ The purpose of our study was investigating the actual use of mediators/interpreters during meetings between healthcare staff and patients in A&E or in other departments where there was a

work of these authors and groups with great interest, we cannot help feeling that a huge gap has now opened between the makeshift solutions adopted in Genova public hospitals to deal with non-Italian speaking patients and the structures in place in other countries, including other European countries. It is important to add that these makeshift solutions, in our view more appropriately described as an emergency response, are not perceived as such by healthcare practitioners going about their daily work in Genova. Having observed the situation for the past decade (not continuously but we have an up-to-date view), we believe that, bar a few exceptions (for example, the introduction of telephone interpreting although not always with previous training for the staff involved and with the difficulties related with the access to its quality assessment), the funding allocated to cover the cost of hourly paid mediators in Genova hospitals does not seem to have actually improved either the quality of the service offered to non-Italian patients or the daily work of the healthcare and administrative staff dealing with them. Generally, what we perceive from both groups, and in particular from mediators, doctors and nurses, is a feeling of frustration and dissatisfaction at improvised solutions, ongoing insufficient and inconsistent investment by organisations and institutions, and a sense of being left to their own devices to cope with issues as well as the difficulty of working in inadequate conditions.

In 2015 we put forward a number of proposals¹⁰ which we believe continue to be relevant today, to try and break this stalemate. Unfortunately, these proposals have not yet had the opportunity to be tested and observed in practice nor has it been possible to collect and review any data on them.

high proportion of non-Italian patients as well as researching how healthcare staff perceived their role and everyday job. This research was followed by other similar projects, whose main outcomes can be found in the following papers: De Hériz and Morelli (2010), De Hériz et al. (2012), Morelli and De Hériz (2013).

¹⁰ «Awareness-raising and training [...]. Create opportunities for meeting, discussion and sharing, in the form of workshops, promoting dialogue and encouraging maximum involvement on the part of all players in the world of healthcare [...]. Taking into account the results of awareness-raising meetings, or the needs of a particular institution, it is possible to plan specific linguistic/cultural measures, always with a view to better integration. Here are a few examples:

- simplification, where necessary, and improvement of monolingual (Italian) materials;
- localisation of multilingual material which is already available and considered effective;
- possibly translation of ad hoc material;
- the creation or localisation of terminology material (not only word-lists, but also concepts and contextualised definitions);
- support and mentoring for activities relating to interpreting» (Morelli and De Hériz, 2015: 182-183).

This is why in this paper, for the purpose of supporting the statements contained in the initial paragraphs more effectively, we refer to two specific cases. We know both cases quite well as they are close to us, however, for us they do not risk activating the ‘wishful thinking’ effect triggered by the experiences in other countries described in some recent literature¹¹. Here, we will describe the experience of the the CRIT Group (*Comunicación y Relaciones Interculturales y Transculturales*) of the Universitat Jaume I de Castellón in Spain¹² and some projects carried out by the *Centro di Ricerca Interateneo per l’Analisi dell’Interazione e della Mediazione* (AIM)¹³.

Our objective is also to demonstrate the complexity of some aspects which are generally overlooked by many, if not all, of the parties involved in some of the situations and interactions we witnessed in a healthcare environment close to us.

For the first case we used, among others, a summary report of the project co-ordinated and managed by the CRIT Group (2014), which refers to an action research project carried out between 2010 and 2012 in a number of Valencia and Castellón hospitals and financed by the *Ministerio de Ciencia e Innovación*. The objective of the project was observing more closely, from both sides, the recruitment and role of interlinguistic and intercultural mediators (in their experience all women) within the healthcare sector (hereinafter ‘the MILICS’, Spanish acronym for *mediadores interlingüísticos e interculturales en el ámbito sanitario*) in order to promote an on-going debate and continuous feedback between healthcare providers, academics and mediators (Raga Gimeno 2014: 2).

In particular, the researchers focussed on reviewing case studies and self-assessment material provided by the mediators themselves (including the self-assessment forms where the mediators described the difficulties encountered in their work). The so-called *actitudes y aptitudes*, i.e. attitudes and aptitudes [Raga Gimeno, 2014: 5]. This three-year research project, co-ordinated by academics but constantly monitored and reviewed by both hospitals and mediators through continuous feedback and a long-term data consolidation and analysis effort, tackles some of the fundamental dilemmas MILICS are faced

¹¹ The following website can be an example: <http://www.criticallink.org/>, last consulted October 2017.

¹² <http://www.uji.es/serveis/ocit/base/grupsinvestigacio/detall?codi=095>, last consulted October 2017.

¹³ <http://www.aim.unimore.it/site/home.html>, last consulted October 2017.

with, such as impartiality, interactive communication and defining the scope of their role v. the role of other providers. Too often these sensitive issues are only dealt with in the (biased and one-sided) accounts given by mediators about their real-life experiences of being left to their own devices to cope with difficult frustrating work.

An entire chapter, based on the work carried out by Baixauli for a PHD dissertation [2012], is devoted to the thorny issue of the codes of ethics and of how *Los códigos hablan...pero nosotros decidimos* (The codes tell, but we decide). This means that quite often, in their daily work, MILICS are forced to act according to their subjective criteria and without much time to think things over if they have to justify an exception to the rule or, if appropriate, to deal with such an exception [Raga Gimeno, 2014: 6]. As in the case of other jobs based on an interaction between two individuals, we raised a much debated issue again (which we have already discussed elsewhere, since 2010, for example, in De Luise and Morelli, 2010) i.e. that it is necessary to follow a protocol, a procedure, and to be objective without losing sight of the most important part of this job, which is establishing a relationship with the other person. In the case of a mediator, he/she must also be able to form a relationship with all the other parties involved in the communication process. However, the mediator must have been trained and must possess all the necessary tools to distinguish what the two parties are saying from his/her own personal input, because the mediator has an active and not entirely neutral role in the communication process.

If the spotlight is really on the more or less satisfactory interaction taking place through the MILICS (provided we have the tools to analyse it according to objective criteria), we should not focus on the potential conflict between different professional roles (interpreter or mediator) but rather on the fact that doctor and patient should be able to understand each other as well as possible [Raga Gimeno, 2014: 11]. To clarify, ‘as well as possible’ means as effectively and as appropriately as possible but respecting each other’s differences. It is important to remember that culture is a complex and dynamic concept, which is continually evolving and is not defined only by space, geography, time or heritage. Earlier, we chose to make a thought-provoking statement when we said that, potentially, any interaction between two human beings requires mediation. Raga Gimeno [also referring to other authors such as Maalouf, 2013] takes this even further when he reminds us that the social, formative, subjective and biological variables are so numerous and fast-changing that «any individual is a culture in him-/herself and that, as is

sometimes concluded in research papers on cross-cultural communication, any communication requiring an interaction is indeed intercultural» [2014: 94].

We also referred to the essential criteria that need to be applied to evaluate the effectiveness of a doctor-patient interview. In terms of interaction control, the involvement of a third party that gives both doctor and patient a voice is necessarily based on the assumption that the healthcare professional will relinquish part of his/her power. To make this possible, all parties involved must know how interpretation works and what dynamics are at play in it (although this is essential, in our local example this was not happening because of lack of training, including lack of mediator's training). The MILICS must be acknowledged and empowered as a 'communication manager' [Baixauli, 2014: 37]. In this type of situation, the 'communication manager' cannot be neutral. In this respect, we feel that the CRIT Group has decisively overcome the (reassuring but unrealistic) assumption that the mediator/interpreter must be absolutely neutral. In the chapter *La delgada línea roja de la imparcialidad* (The thin red line of impartiality) [Sales, 2014], the author reminds us of a number of crucial aspects, which are often overlooked where mediation/interpreting is not habitually used within a structured community or entity as a whole but is instead relegated to a third party contractor paid an hourly or daily rate. In the case of mediation, the MILICS must not side with either the patient or the healthcare staff because he/she must ensure that both parties are able to make the decisions that are most appropriate for their needs and interests independently and on the basis of the existing conditions and situation. However, this does not mean that the MILICS is totally detached or unbiased, i.e. neutral. To be more precise, the MILICS should be impartial or multi-partial even though, in sensitive cases where the dignity or well-being of the patient are at stake, for example in the presence of a clearly discriminatory, sexist or xenophobic attitude, the MILICS will have to step in to support and protect the person being victimised (Sales, 2014: 56).

This is the general picture painted by the CRIT colleagues and it is also important to remember that this description is always supported by our analysis of real-life cases, similar to those we observed in hospitals over the years. Against this background, our CRIT colleagues have tried to move beyond the much discussed need for recognition of the MILICS or ISP professional profile, ISP being the Spanish acronym for Public Service Interpreter. They have instead tried to focus on communication effectiveness and have argued, according to us in a well-constructed and convincing manner, that it would be desirable to overcome this

idea of mediator neutrality (obviously still complying with the codes of ethics) and these static and crystallised mind-sets, which are defined only by a limited number of easily controllable factors.

If we then move on to the ‘meso’ level, i.e. the elements that play a decisive role in the interaction, the data collected by the CRIT Group include several cases where verbal politeness, para-language and footing of the interlocutors in space and time were closely observed. The chapter by Ortí Teruel and Sanchez Lopez [2014], aptly entitled *El (des)control de la interacción*, focuses on how the MILICS technically controls the communication interaction. The authors analyse the tools and strategies used by the MILICS to manage the communication flow and his/her relationship with the primary interlocutors as well as how (and whether) he/she influences or affects communication. They carry out a more detailed ‘micro’ analysis but do not focus exclusively on transcripts. Instead, they focus on other aspects, such as the start of a new work shift and what happens during hand over, how the MILICS manages pauses, moments of silence, overlaps and interruptions. All these elements are crucial in order to be able to effectively and accurately facilitate, but we do not think any of them are included in training and CPD courses for most of the mediators that work in our city.

The second example involves an even more detailed ‘micro’ analysis and an area geographically closer to us. We have found and analysed data collected in the Emilia-Romagna region by two authors who had not yet been involved in the creation of the previously mentioned inter-departmental AIM research centre at the time the examples, situations and comments report below took place or were made [Baraldi and Gavioli, 2008; Baraldi, 2015]. However, since then the authors have never ceased to contribute to very productive research work on mediated interaction in a healthcare environment, as shown by the many papers published by this group over the last few years (see again the AIM site for more information).

The authors were inspired, among others, by Cecilia Wadensjö’s ground-breaking work [1998], which focuses on the role of the interpreter in a healthcare environment and the interactive elements of meetings with doctors. The authors chose to analyse data by applying a typical conversation analysis approach and decided to let the data do the talking. The data in question are the transcripts of the audio recordings (made when the researcher was not present), which detail the three-party conversations and interactions between physician, patient and mediator. In their experience, the third participant in the interaction is normally a mediator with no interpreting training. They also combine different theoretical per-

spectives, not only including Conversation Analysis but also Interpreting Studies, Social Systems Theory and theories of Mediation.

The first comment we regard as very interesting for us (and it also important to remember that it was made simply on the basis of recorded and transcribed data with no ‘contamination’ by the researcher), is the conclusion reached by Baraldi and Gavioli:

The interpreter also has the role of a mediator because it is impossible to interpret without influencing the interaction. The interpreter *coordinates* the interaction, i.e. tries to make sure that the parties actually talk to each other [2008: 328 italics used in the actual text, our translation].

When they say that the interpreter «tries to make sure that the parties actually talk to each other», the authors are well aware (and we fully agree with them) that, despite the mediator’s best efforts to remain neutral or claims of using unbiased aseptic techniques, this is simply impossible because linguistic and intercultural mediation can only take place if the mediator has an active coordinator role thanks to his/her ability to interpret and to manage the physician-patient interaction. The entire process is therefore not immune from expectations about the outcome of such mediation and, in particular, the effectiveness of the interpreting [Baraldi and Gavioli, 2008: 331, our translation]. Moreover, more recently, Baraldi reminds us that:

Interpreting is reflexive coordination as long as it promotes (encourages, expands, implements, etc.) or questions production or understanding/acceptance of communication, i.e. as long as it promotes or questions participant’s contributions to communication [Baraldi, 2015: 35].

Moreover: «The achievement of reflexive coordination is not an individual mediator’s initiative, but it depends on the interplay among doctors’, mediators’ and patients’ action in communication processes» [Baraldi, 2015: 47].

To demonstrate this, it is necessary to analyse a very large quantity of data in great detail, including a thorough micro-analysis of recordings of interpreted sessions for every shift, including zero rendition, formulations, footing, hedges and adjacency pairs¹⁴.

The coordinating role of the mediator highlighted by Baraldi and Gavioli [2008, 362-367] can be explicit, by means of a dyadic action, or implicit, through

¹⁴ For more information about these basic concepts in conversation analysis, see Atkinson and Heritage, 1994; Drew and Heritage, 1993; Schegloff, 2007.

translation and interpreting. In reality, it is almost always explicit even in the case of interpreting, because the mediator decides to stop interpreting to ask for clarification or replies to questions. In doing so he/she makes a choice that affects the way the information flow and communicative interaction are managed. The authors do not believe that genuine intercultural coordination and communication take place in these cases. Instead, they can only see a type of cultural mediation which somehow regurgitates the same cultural assumptions on which the physicians' culture or the patients' culture are based, without promoting a real coming together or dialogue between the two groups and their differing expectations. The authors themselves remind us that:

The dialogue is not ensured by a mere structured approach to the handover between shifts but requires instead equal participation and involvement by the parties as well as appropriate opportunities for the parties to express themselves [2008: 372, our translation].

The research paper (or to be precise the micro-analysed data) highlights that the mediation is frequently ethnocentric, i.e. it creates a communication centred not on the patient but on the physician. In this case, the coordination by the mediators is pre-eminently cultural and not intercultural. The paper also shows that, on occasions, communication can be dialogic (and therefore promote cross-cultural coordination and adaptation) if it allows the patient to express himself and make himself heard and if it involves the physician in the process, thus promoting a patient-centred type of communication. This leads us to discuss another essential aspect of communicating through a mediator, i.e. the difference between bridging (which means exactly that, creating bridges between two cultures) and siding or gatekeeping (which mean safeguarding and protecting a particular culture). Mediators can promote one or the other through their actions. However, there is a difference but not a complete juxtaposition between the two concepts. We quote Baraldi and Gavioli again:

While the meaning of gate-keeping is made clear by the fact that we know which culture we want to protect, bridging opens the door to a change that cannot be pre-determined in advance. It is impossible to foresee the consequences of cross-fertilisation or of creating new cultural forms. Bridging cannot, therefore, be juxtaposed to gatekeeping. As a result, the difference between ethnocentric and dialogic mediation does not exactly overlap with the difference between gatekeeping/siding and bridging. Attempting to create a bridge between cultures poses a question rather than providing an answer: to what extent can a third culture,

a hybrid created by mixing the two existing cultures, be dialogic? [2008: 375, our translation].

Conclusions

The thoughts and considerations we presented in this paper, both in the first part and in the section on research projects, would undoubtedly require a more in depth analysis and more space, which unfortunately we do not have. However, despite the need to be concise, we believe we have achieved our main objective, i.e. presenting a critical analysis based on data and definitions taken from a number of serious studies and lexicographic reference material, which enabled us to define a shared language (however limited) to approach the topics we dealt with in this paper. We do not want to close this paper listing a number of crystallised unchangeable definitions but rather suggest a fairly open approach. Our aim is to encourage everybody to reflect on how we often use words (in this case specialised terminology) as if their meaning was universally understood and shared, whereas we have demonstrated that this is not always the case, one example being the word ‘mediation’ itself. Showing that some situations often presented as typical examples of intercultural mediation are in reality something completely different should not wrongly lead us to underestimate the importance of making use of our ability to understand, and especially to mutually understand each other, and to facilitate communication and dialogue in sensitive interactions, such as those taking place in a healthcare environment. On the contrary, this makes us realise how essential it is to focus not on the individual but on the whole hospital or healthcare community. These are places where community mediation, if seen as a valuable resource for the whole organisation and not just as a means to manage conflicts or language/cultural issues in an emergency situation, could be a real asset to build on with a bottom-up approach, taking into account the needs expressed by all the stakeholders in that community. For example, we could deal much more effectively with vulnerable people or people who are not fluent in the local language and are admitted to A&E because it would be possible to draft and apply treatment protocols and procedures more accurately. Using tools which strengthen and improve the operator’s communication and interaction strategies could become an integral part of the entire healthcare system. It is essential to carefully and patiently listen to the needs of those who are faced with these

situations daily in their working environment, where processes are often very well-established and require hardly any verbal exchange. This sometimes generates conflicts or misunderstandings that are then difficult to overcome.

This is what we wish for when we think of the type of medium and long term investment that institutions and organisations should make in order to be able to provide more humane and patient-centred services.

Acknowledgment

The authors would like to thank Monica Robiglio for her translation and review.

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Exploring strategies for cultural competent health services in the Italian context: a qualitative study

*Giuseppina Dell'Aversana**, *Andreina Bruno*

Introduction

Attention to the health of migrants has been drawn on the part of European health systems. Complex political, demographic, and economic dynamics are changing our societies and our health systems are confronted with a highly differentiated population. According to the International Organization for Migration, the estimated total number of international migrants reached 244 million in 2015 [IOM, 2016]. In Europe, which has seen a consistent rise in the trend of migration since 2005, migrants are 76 million and constitute almost 9% of the total European population. Furthermore, a growing literature shows health disparities in migrants' groups and ethnic minorities and demonstrates the need for health systems to become more responsive to migrant populations by establishing appropriate and accessible health services. This evidence has demanded for an international reorientation of health policies to better protect migrants' health and provision of equitable health services.

In 2008, the World Health Organization called for migrant-sensitive health policies, practices and health systems with the WHA 61.17 Resolution on the Health of Migrants and in 2017 it endorsed the Resolution on Promoting the Health of Refugees and Migrants that urges Member States to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants [WHO, 2008, 2017]. In addition, at the 2nd Global Consultation on Migrant Health, hosted by the Government of Sri Lanka, IOM and the World Health Organization, the Colombo Statement was adopted to restate the importance of previous policies [IOM, 2017].

* correspondence to: marzia124@hotmail.it

Health services have a central role to promote equity and to amplify or mitigate the impact of inequities [O'Donnell et al., 2016]. Indeed, «health care systems themselves can also be considered a social determinant of health, interacting with migrant status to perpetuate inequities in health care access» [Marmot et al., 2008, p. 1665]. Referring to international data, although few generalizations can be made, most migrants seem to be relatively healthy when they first arrive in their host country (the so-called healthy migrant effect) and they risk deteriorating to poorer health because of the conditions surrounding the migration process [Rechel et al., 2013]. Migrant health is the result of complicated, dynamic interactions of several determinants, involving various stages of migration, from pre-departure to early and late migratory status. Social exclusion, discrimination, poor living conditions and poverty in general all impact on health with greater consequences for asylum seekers and migrants with irregular status. Furthermore, migrants are confronted with barriers affecting access and quality of care when they interact with health services. The 'accessibility' of services refers to the ease with which people can make use of them when they need them. Migrants risk to underutilize care provision or access care when problems are more advanced and symptoms are more severe [WHO, 2010]. It is widely known that the recourse to health services by migrants differs from that by non-migrants, as both migrants' needs and their access to health care are affected by a number of factors related to the process of migration, including health and socioeconomic status, self-perceived needs, health beliefs, health-seeking behaviour, language barriers, cultural differences, trauma and newness [Norredam and Krasnik, 2011]. In addition, migrants face legal obstacles in most countries when accessing healthcare and may receive poorer service quality for discriminative attitudes by health staff, impacting diagnostics, medication, medical follow-up, hospital visits and admission, as well as patients' adherence to treatment.

However, many European countries have been slow to respond to the international calls for action and there remain considerable differences between countries in the extent to which their health systems have adopted «migrant-friendly» policies [Mladovsky et al., 2012]. Italy has experienced large-scale immigration only relatively recently during the second wave of European migration (in the 1980s and 1990s) but responded actively by granting migrants, including undocumented ones, access to the national health system. During the last three decades, Italy has become a popular destination for non-EU immigrants and refugees with over 5 million of foreign residents, with the majority of them settling in Central

and Northern Italy. Profile of Italian migration can currently be described as heterogeneous. In 2017 there were 3,714,137 non-EU foreigners holding a residence permit in 2017 and in 2015 there were 83,245 political asylum requests (7% of the total EU). At the same time, the influx of non-EU foreigners has been declining, and the acquisition of Italian citizenship by non-EU citizens has been increasing rapidly [Idos, 2017]. Italian legislation states that all migrants in the national territory needing urgent or essential care have the right to access to public healthcare services, such as inpatient and emergency care. Regular migrants, in line with Italian citizens, have access to services provided by the National Health Service (*Servizio Sanitario Nazionale*, SSN), while irregular migrants need to be identified as Temporarily Present Foreigner (*Straniero Temporaneamente Presente*, STP). Holders of STP status have the right to access basic medical assistance, urgent and non-urgent hospitalization and outpatient treatment [Giannoni and Mladovsky, 2007]. Furthermore, migrant-related health policy targets have been set out in the National Health Care Plan since the 1990s. However, whilst the adoption of health policies on a right-based approach is a fundamental step forward to promote equity, putting them into practice seems not to be quite so straightforward. Currently, at regional level, health plans are not uniform¹ and, particularly in the South of the country, most regions have inadequate laws on immigration. At local level, new programmes have been implemented, although these initiatives are often not integrated or coordinated. Only half of the Italian Regions pay any considerable attention to migrants' health policies and initiatives to improve data monitoring, access to services, structural or training interventions. Despite the presence of best practices, they remain mostly patchy [Rinaldi et al., 2013]. While legislation and policy may guarantee some form of entitlement to health services for migrants, they do not guarantee actual access to appropriate and quality services. Local authorities have a fundamental role to promote the effective implementation of such services [Mock-Muñoz de Luna et al., 2015]. In fact, the limited research on the Italian context attests that inequalities persist, mainly when migrants experience socio-economic disadvantage [Giannoni et al.,

¹ The Italian healthcare system is a regionally based national health service. At a national level, it is responsible for ensuring the general objectives and fundamental principles of the national healthcare system. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefits package through a network of population-based health management organizations (*Azienda Sanitaria Locale*, 'local health enterprises', ASL) and public and private accredited hospitals (Lo Scalzo et al., 2009).

2012]. Research into migrant health inequalities remains not extensive [Tognetti Bordogna, 2013]. Indeed, it was only this year that the first systematic study on migrants' health was published, reporting evidence of health risk conditions related to social inequalities for migrant groups and reaffirming the need for the health system to promote diversity responsiveness [Petrelli et al., 2017].

Reorienting health care to reduce inequities

Meeting the health needs of migrants and ethnic minorities is a challenge for healthcare services and requires a systemic reorientation of health service practices. A key concept in this field is cultural competence (CC) for professionals and organizations, defined as: «a set of congruent behaviours, attitudes and policies, that come together in a system, agency, or among professional and enable effective work in cross-cultural situations» [Cross et al., 1989, p. 28]. In the USA, National Standards for Culturally and Linguistically Appropriate Services (CLAS) were developed by the Office of Minority Health (2001, 2013) to provide a common understanding and consistent definition of culturally competent health care services. In Europe, a first set of recommendations was provided in 2004 by the Amsterdam declaration *Towards migrant friendly hospitals in an ethno-culturally diverse Europe*. These definitions expanded the scope of CC beyond the interpersonal domain of cross-cultural care in order to address multiple levels, including the important role of the whole organization. CC health care, in particular, develops organizational commitment, empirical evidence on inequalities and needs, a competent and diverse workforce, access for all users and responsiveness in care provision, patient and community participation [Seeleman et al., 2015]. Good practices in culturally competent health care often include the training of staff, diversification of the workforce, use of cultural mediators, and adaptation of protocols, procedures and treatment methods [Fernandes and Pereira Miguel, 2009].

For decades, the main aim of CC has been matching health services to the needs of migrant users, to bridge 'cultural gaps' [Ingleby, 2011]. Over time, some authors criticized CC discourse by highlighting the lack of conceptual clarity around the use of the term 'culture' in clinical encounters and the inadequate recognition of the 'culture of medicine' [Thackrah and Thompson, 2013]. Thus, using culture as a concept to reduce health inequalities for 'diverse' groups entails risks which include categorization and overestimation of cultural dimensions by

stereotyping health needs at the expense of social, political, and biographical ones [Kleinman and Benson, 2006]. Partly as a result of this criticism, the concept of culture assumed by researchers on health services has changed, emphasizing intra-variability within cultural groups, and CC definition overlapped patient-centred principles [Saha et al., 2008; Betancourt et al., 2014]. The most recent development in the concept of ‘cultural competence’ has called into doubt the very centrality of the concept of culture itself, arguing instead for the adoption of an intersectional approach. This approach calls for a more general improvement of the health system’s ‘sensitivity to diversity’, encompassing gender, age, religion, disability, sexuality and socio-economic position [Mock-Muñoz de Luna et al., 2015].

Reflecting the complexity of the definition of CC and its translation into practice, it remains unclear which are the best ways to develop and implement cultural competence interventions [Truong et al., 2014]. In 2011, a Delphi study assessed the views and values of professionals working in different healthcare contexts in various European countries (including Italy) about good practices for immigrant health care [Devillé et al., 2011]. Experts asserted the right to culturally sensitive healthcare for all immigrants and despite some disagreement, both within and between countries on some issues, nine principles of best practices were identified (Tab. 1). Best practices should guarantee easy access to healthcare resources and equal rights. Migrants should be empowered to make optimum use of culturally sensitive healthcare services. Good practice means quality individual care, provided when needed and adapted to migrants’ needs in terms of communication, attitudes, empathy and non-discrimination [Ibidem, p. 7].

Identifying good practices supports organizations in the overhauling of health services, but this is not enough. Literature suggests considering and identifying barriers and incentives for organizational change, for, as far as the Italian context is concerned, organizational CC remains heterogeneously implemented and poorly sustained among health professionals [Chiarenza et al., 2015; Seeleman et al., 2009]. Studies reported that organizational aspects of CC, such as leadership, inter-professional relationships and limited resources, are poorly considered, reducing the success of interventions [Dauvrin and Lorant, 2017; Suphanchaimat et al, 2015].

There has been little research conducted on this issue in Italy and thus it represents an interesting context to further explore the development of CC health services, as it is characterized by a relatively good health policies framework but

fragmented practices and research. Thus, this paper aims to complement the existing literature by examining the views of Italian experts on service strategies to improve equity and factors that affect efficient implementation of diversity responsiveness in health care.

Purpose

| Good Practices | |
|-----------------------|--|
| Easy and equal access | <ul style="list-style-type: none"> • Accessibility on the same terms as the general population. • Remove barriers to accessing secondary care. • Special health services should be made available in areas with high migrant populations. • Service hours should adapt to the needs of their users, including migrants. • Services should be affordable: governments should provide the necessary resources and adapt legislation to achieve this. • Inform health professionals about the legislation related to the rights to health care for migrants in their country. |
| Empowerment | <ul style="list-style-type: none"> • Provision of information for migrants in their own language <ul style="list-style-type: none"> ○ about their rights and the functioning of the health care system and social care system. ○ about health, illness and prevention. • Provide a special consultation the first time people access the health care system. • Outside the health care sector: <ul style="list-style-type: none"> ○ improving access to work as well as work and living conditions. ○ improve migrants' health providing opportunities to learn the language of the host country. • Participation of migrants and non-governmental organisations (NGOs) dealing with migrants in the organisation of health care services. |

| | |
|---|---|
| <p>Culturally sensitive care</p> | <ul style="list-style-type: none"> • Health care providers should receive specific training on cultural competencies and communication skills. • Employ cultural mediators or health care providers of migrant descent. • Develop specialised services in case of added value to regular services can be demonstrated. • Health education and health promotion messages should take into account cultural diversity. |
| <p>Quality care</p> | <ul style="list-style-type: none"> • Services should consider the patient as an individual and not stereotype them with the characteristics of the cultural group they are perceived of as belonging to. • Quality care means taking into account the individual's specific medical history and social background and giving individualised psychological support and empathy. • Health care professionals should take the time to listen to patients and check that both parties have understood each other. • Other factors mentioned: <ul style="list-style-type: none"> ○ establishing trust, ○ seeking truly informed consent, ○ guaranteeing continuity of care, ○ adapting care to the person's lifestyle and their capacity to receive and self-manage care. |
| <p>Patient-health care provider communication</p> | <ul style="list-style-type: none"> • High quality interpreter services, either in person or by telephone, should be easily accessible. • Services should take into account varying levels of both health literacy and mastery of the local language. |
| <p>Respect towards migrants</p> | <ul style="list-style-type: none"> • Practitioners should show respect, create trust, be interested and address patients without prejudice and with an open mind. • Health care providers should be motivated to deliver care for migrants with attention to their specific needs and priorities without xenophobia or any sign of racism. • A policy against acts of discrimination in health care facilities should be established and implemented. |

| | |
|---|--|
| <p>Networking in and outside health care services</p> | <ul style="list-style-type: none"> • Networking within health care services and between health and social service • Interdisciplinary is a priority within health care services. • Coordination between primary care services, or between primary care and refugee-specific health care services. • Supporting migrants to develop their social networks • Supporting migrants or persons of migrant descent who care for other migrants. |
| <p>Targeted outreach program in prevention and care</p> | <ul style="list-style-type: none"> • Outreach activities in health education, screening, prevention and promotion with difficult to reach migrant groups. |
| <p>Availability of data</p> | <ul style="list-style-type: none"> • Health care services should be provided with relevant knowledge on health and risk factors concerning the populations they are dealing with. • Health registries <ul style="list-style-type: none"> ○ should record and monitor migrant health to facilitate migrant health research. ○ should be able to integrate patient mobility with full respect of human rights |

Table 1 - Good practices - Final factor list. Adapted from: Devillé et al., 2011

The purpose of this study was to gain an understanding of the ways in which health care organizations deliver culturally competent care in the Italian context. More specifically, the investigation was guided by the following research questions: Which strategies are used and/or are considered important to reduce inequalities for migrants? Which barriers reduce the ability of health services to implement culturally competent practices?

Method

The methodological approach chosen for this study was a qualitative design with the use of semi-structured in-depth interviews. According to Creswell (2005), the exploratory nature of qualitative research makes it ideal for exploring little-known topics, as it is the case with Italian culturally competent care initiatives. In this study, a purposive sampling was used: eight experts with different backgrounds and renowned for their professional expertise in the promotion of migrants' health were interviewed. They represented different professional spheres at multiple levels, both managerial and non-managerial. The participants in the study were a psychologist, a sociologist, an anthropologist, five doctors with different specializations (psychiatry, public health and epidemiology, medical genetics, gynaecology), of which two had also an academic affiliation. In particular, five respondents were members of national and international organizations with the mission to protect migrants' health: Fanon Center, SIMM (*Società di Medicina delle Migrazioni* - Migration Medicine Society) and the International network TF MED (Task Force Migration, Equity & Diversity). The interviews were conducted between March 2015 and June 2015 and carried out in four regions of North and Central Italy. All subjects authorized and approved the use of anonymous data for publications through informed consent. An interview schedule was developed using open-ended questions. During face-to-face meetings, and in one case via Skype, participants were asked to describe the strategies implemented and those considered important in reducing health inequalities for migrants and the challenges addressed in health care provision. The average interview length was 60 minutes (min. 45 - max. 90). The interviews were transcribed verbatim and analysed according to a data-led approach to maximize discovery and exploration [Braun and Clarke, 2006]. The relevant material was selected and subsequently encoded according to themes emerging from the data set. Specifically, our analysis involved different and iterative steps: data familiarization, initial coding generation search for themes based on initial coding, review of themes, theme definition and labelling. The identified themes captured important aspects of the data in relation to the research questions. The credibility of the analysis, as a criterion for the qualitative research, was assessed through supervision sessions to check the coding strategies and to review the interpretation of the data, by discussing any reason for variation [Barbour, 2001]. Rival configurations of themes were ultimately modified [Patton, 2002] and quotes were selected that best illustrated themes from the participants' perspective.

Results

Results are presented in three different sections, which represent the three levels identified to categorize strategies and barriers. The three levels are: professional, organizational and political. Respondents reported strategies used and/or mentioned as efficient to meet migrant health needs and promote responsiveness to diversity (Tab. 2). Moreover, they recognized that becoming a CC health service is a process that faces several challenges (Tab. 3).

Professional level

Strategies

Investing in staff training is considered effective to increase health providers' competencies to deal with diversity in cross-cultural contexts. Health providers, in the respondents' view, need to develop awareness of diversity and adapt their practices to address diverse patients' health needs. For this reason, it is important to promote ad-hoc training curricula in medical and nursing schools, as well as training for health professionals. Different aspects of direct and indirect discriminatory practices and their impact on the quality of care are considered a training subject that needs to be further discussed.

Training needs to be implemented in medical education: students need to develop competences to deal with 'otherness' and considering these competences as indicators of professional quality, to produce individualised practices instead of standardised ones. (Interviewee 3)

Two training experiences were mentioned for their efficient methodology. The first is based on the simulation method, to develop awareness of barriers in access and in patient-provider communication. Graduate students simulate being migrant patients trying to access services and interact with health providers. The second one refers to an international project with the aim of developing, testing, and evaluating training packages for health professionals with the purpose of improving access to and quality of services for migrants and ethnic minorities. Positive aspects attributed to the methodology were the research-based approach and the attention to a 'difference sensitivity' approach.

Barriers

For some participants, developing strategies to increase CC may be affected by a lack of sensitivity of some front-line workers dealing with migrants’ problems and a lack of awareness of the barriers that can intervene in the clinical encounter. This subsequently creates discriminative practices and hinders collaboration among colleagues. The lack of collaboration may result in a sort of isolation of the individual health professional or in his/her overcharge.

It seems that you favour migrants, and the others treat you as a ‘migrant’: you are approached only for urgencies (...) it is always seen as a separate aspect of care. (Interviewee 1)

| PROFESSIONAL | ORGANIZATIONAL | | POLITICAL |
|---|---|--|--|
| Staff and Students’ Training and Education | Internal processes Walk-In Services Health registries Appropriate Signage In Multiple Languages Telephonic Interpretation Menu Cultural Mediator Multidisciplinary Staff Strategic plan | External processes Community Health Promotion Interventions Link Workers «Street Soccer» Networks: Hospital; Primary Care; Community Leaders; Universities; Non-Governmental Organizations; European and International Health Services and Stakeholders | Advocacy Regional Equity Network State-Region Board |

Table 2 - Cultural competent strategies mentioned by participants

Organizational Level

Participants mentioned multiple interventions as being effective for increasing equity in health services at this level. Here, we distinguish between strategies aimed at modifying the internal care processes and strategies, which imply external processes outside the health organization.

Strategies: internal processes

Strategies are aimed at eliminating mostly cultural and linguistic barriers and improving quality and access. The activities implemented to overcome cultural and linguistic difficulties are related to the service environment, such as the adaptation of signage in multiple languages. Other interventions include the translation of documents about informed consent into various languages and modifications to menus in order to provide patients with familiar food. Furthermore, to prevent miscommunication, cultural mediators and telephone interpreting services during clinical encounter are commonly cited. In one of the services, a multidisciplinary staff comprised of a transcultural psychiatrist, an anthropologist and cultural mediators is used to improve the quality of care and relationship between users and services. To overcome access barriers, one interviewee mentioned the adaptation of procedures for appointment and health registry as key strategies of the service. The importance of walk-in services for vulnerable groups is outlined:

Considering the problem immediately, avoiding other bureaucratic paths and delays... The woman who works, who has children, who is suffering... if you give her an appointment after three months, she will never come back. (Interviewee 2)

Finally, actions to establish organizational support to CC were mentioned. Organizational commitment through a strategic plan is indicated as essential to enabling implementation of CC.

Organizational change... meant to focus not only on staff behaviours, but also on changing organizational infrastructures, not in a mechanical way. It's important to engage organizational management, managers who make decisions (...). This was a turning point: developing an organizational and multilevel strategy which need resources, structures, coordination and investments. (Interviewee 4)

To produce organizational change, it is considered helpful to use equity evaluation tools. Assessment supports service delivery processes by identifying areas that can create inequalities.

Strategies: external processes

Other interventions go beyond the borders of the health organization and are intended to create a link between the service and the patients. Participants mentioned «community health promotion interventions». One service implemented a «street soccer project» funded by the municipality to promote empowerment and health care access for young migrants. Another one experienced the introduction of «link workers» placed in the interface between health systems and communities, following the logic of community-based services:

We experimented with link workers in various practices: in general preventive services, they serve as a full-range assistance. They are professional figures who can help to revise health procedures and evaluate responsiveness for the immigrant population, such as educational materials or health screening letters. They are part of the community with link functions, who know the dynamics of the neighbourhood and community well. If we want to get away from the idea of ethnic community, it works very well. We had a project for the station area, a difficult area to live. (Interviewee 4)

Finally, one participant cited meetings with religious leaders and migrants' communities as a practice to provide migrants with information about health, illness and prevention and the functioning of the health care system.

Networks and partnerships emerged as being vital resources intended to deliver health care services in a culturally-sensitive manner. Networks are established among hospitals, general practitioners, non-governmental organizations (NGOs) and community leaders to promote continuity of care; among health services, universities and NGOs to promote interventions and research; among international health services and stakeholders to improve implementation, evaluation, research and exchange of best practices.

Barriers

At an organizational level, culturally competent practices are threatened by the lack of organizational policies and organizational support needed to attract resources, to make sustainable interventions and to coordinate organizational practices.

There is the effort to make this change possible, that is to include this issue in the business plan. (...) in times of economic scarcity, these aspects of health care activities, i.e. health promotion and sensitivity to diversity, tend to be cut. (Interviewee 4)

The lack of a shared culture that values diversity and permits professional exchange is also considered a barrier to CC implementation. Some participants reported the example of cultural mediators who were overburdened by staff consultations on migrant patients' problems. For some interviewees fragmentation of CC practices is not only a problem within services or hospitals, but also among different services: «one service doesn't know what the others do» (Interviewee 2).

| PROFESSIONAL | ORGANIZATIONAL | | POLITICAL |
|--|--|---|---|
| Lack of sensitivity Lack of awareness of clinical barriers Lack of collaboration | Internal processes Lack of organizational support Lack of a shared culture Lack of organizational policies | External processes Lack of health services networks | 'Urgency politic, Fragmentation in regional policies and ambiguous accountability between central government and Regions Insufficient national data |

Table 3 - CC Barriers mentioned by participants.

Political Level

Strategies

Two participants mentioned advocacy actions aiming at influencing health policies. Some strategies consist of actions based on the collaboration and involvement of institutions for the publication of national and regional policies. For example, at a regional level, one interviewee participated in an «Equity Network» to discuss and propose health policies, such as those to standardize

practice for health care fee exemption. Further strategies consist of dissemination of evidence-based practices through scientific conferences, articles and research to attract the interest of different stakeholders on the migrant health issue.

The technical board is one of the bodies that supported State-regions consultation aimed at interpreting univocally the legislation. Furthermore, actions are needed for the extension of welfare rights. (Interviewee 3)

Barriers

The current political climate is recognised as an external barrier to CC implementation. For some interviewees, the ‘urgency politic’ which characterizes the political discourse on immigration flow can waste resources instead of creating the right conditions for long-term planning for health services. The ‘urgency politic’ seems to be rooted in the discriminative portrayal of the migrant as a ‘disease vehicle’ and hence hinders the promotion of equity for migrants, based, on the contrary, on a social vision of health which recognizes the role of social determinants.

There is a persistent demagogic use of the issue of migration and the attempt to construe the migrant as an enemy, which favours racism... I am committed to counter this. I expect there will be a constant tension between the effort for a careful comprehension of diversity and misunderstandings about diversity. (Interviewee 3)

A further barrier to developing CC services is the fragmentation of policies at regional level, due to the ambiguous accountability between central government and Regions on migrant health issues. A related barrier is the insufficient national data on migrant health.

What you are talking about is a national global vision that we do not have: maybe there are hundreds of different projects today, but it’s difficult to map these activities. Furthermore, they are usually precarious. (Interviewee 5)

In addition, there is an implementation deficit that prevents translating policies into operational practices. The most cited example concerns entitlements for

irregular migrants: the assignment of the code STP (*Straniero Temporaneamente Presente* - Temporarily Present Foreign) can be hindered by bureaucratic factors or lack of information both by professionals and migrant users. Contradicting interpretations of legislation is considered an important barrier. Entitlement policies need to be updated according to one interviewee who felt that entitlement to primary care for undocumented migrants needs to be improved, especially in regional implementation, such as the entitlement for children of irregular migrants.

There is still a gap in primary care for access to a general practitioner and paediatrician. This gap actually reflects a somewhat old legal framework based on the idea of migrants as 'healthy adult workers. (Interviewee 6)

Discussion

Findings show various perspectives on actual and potential strategies of the health services for migrants' health promotion and on the barriers that health services may face in implementing and developing CC practices. In addition, the analysis of the results allows the comparison of national trends with European ones.

As widely recognized in literature, findings outline the importance of a multilevel system to develop CC health service strategies and respond effectively to the challenges that can affect the success and sustainability of interventions [Betancourt et al., 2003; Seeleman et al., 2015]. This perspective allows the debate of different interconnections and conceives CC as the integration of practices [McCalman et al., 2017]. In fact, results show that strategies are in place at multiple levels of the health care system, i.e. professional, organizational and political, as well as both inside and outside the health service. Strategies involve the development of organizational processes of care, such as supporting access, interpretation services, cultural mediation and specialized staff, staff training, networks and partnerships with external stakeholders, including health promotion intervention and political actions. Promoting equity means not only adapting process and practices to meet migrants' health needs, but also reducing fragmentation at different levels of the health system. Indeed, developing migrant-sensitive health care is challenged on one hand by ambiguous accountability and different representations of the migrant health issue and on the other hand, within organizations, by lack of shared organizational cultures that promote diversity.

Findings confirm strategies that are reported in literature, but also point to less commonly emphasised ones. In particular, confronting these findings with those resulting from the Delphi study, the strategies covered the same nine areas, but further interventions were mentioned to increase organizational and political support.

Cultural mediation and staff training, which were indicated as privileged strategies, are common actions used to improve clinical processes and quality of care. As is the case with other European countries (e.g. Belgium, Ireland, Spain and the United Kingdom), cultural mediation seems to be a favoured approach to increase communication [Ingleby, 2011]. Moreover, staff and students' training was pointed out as a vital strategy, since in several European countries there is no explicit licensing obligation for health professionals to be culturally competent [Chiarenza et al., 2015] and lack of education is still an important factor in inequity.

However, our findings highlight that using these strategies is not sufficient to reduce inequalities. In addition, participants indicated strategies to which literature tends to pay less attention, such as practices to improve organizational infrastructure and processes, political actions as well as practices to link health services to communities and different stakeholders. Promoting CC involves organizational commitment to implement policies and congruent practices among different organizational levels, and to allocate resources. As other studies have shown, accountability to reduce inequalities is not often seen as a shared responsibility, but is articulated as the domain of specialist staff, conveying a lack of ownership and the location of responsibility to a small group [Adamson et al., 2011]. In addition, at managerial level, this condition may lead to the perception that investment in CC strategies is both a separate and a peripheral aspect of the quality of care. For this reason, equity assessment is a key strategy in order to determine whether clients are receiving culturally competent care from all facets of an organization and to highlight inequalities that it may create. Since the size and complexity of the organization may create a disconnection between decision makers and caregivers, administrators in particular need to be encouraged to assess environmental support, as well as the organizational values which sustain a shared culture for diversity responsiveness [Taylor and Alfred, 2010; Dell'Aversana and Bruno, 2017]. Furthermore, to help organizations become CC, actions to influence political factors are needed. Comparing the Italian context to other countries, it can be argued that fragmentation and the barriers to CC implemen-

tation can be partly attributed to the lack of national standards such as CLAS in the US or HSE (the first National Intercultural Health Strategy) in Ireland, which had helped to promote extensively equity and responsiveness for migrants. In the Italian political context, strategies deal with levelling out the interpretation of the health policies for migrants; advocacy to extend health rights, in particular for primary care²; disseminating evidences to orient policies and to encourage a rights-based approach. The rights-based approach, that prioritizes the special vulnerability of migrants and the associated service challenges, collides with the perception of the migrant health issue as a 'threat' to public health, a perception which is often associated with the 'urgency politic'. The latter prioritizes public health security and communicable disease control, relying heavily on monitoring and screening [Zimmerman et al., 2011]. This perspective focusses predominantly on recent migrations and tends to ignore other migrant groups that largely live in Italy. Our findings are consistent with the results of the first analytical study on migrants' health in Italy, that suggests health services shift the focus from infectious diseases and acute conditions to the problems that characterize the stable population [Petrelli et al., 2017].

Finally, contributing to the debate on the use of culture to address interventions, strategies do not target exclusively cultural and linguistic needs [Dell'Aversana and Bruno, 2018]. Following more recent definitions of CC, some participants propose a 'difference sensitivity' approach and stress intra-variability within migrants' groups, patient-centred care, and social determinants of inequalities [Cattacin et al., 2013]. In the same way, the subjects and methodology suggested for training aim not only to increase awareness of cultural differences and health conditions, but also to acknowledge discriminations. Staff and students, in the participants' view, need to be trained about the organizational barriers that can reduce the quality of care.

A similar trend can be traced comparing strategies to increase the link among health services, migrants and communities, where two different approaches can

² As for the entitlement to primary care for undocumented migrants, there has been an important evolution. In March 2017 the new LEAs (*Livelli essenziali di Assistenza* - Essential Levels of Care), a range of services to be delivered uniformly across the country, were published. They established that, like any Italian citizen, undocumented migrant children have access to services provided by the SSN, guaranteeing them access to a paediatrician [SIMM, 2017].

be noticed. In one case, the use of religious leaders was preferred to increase access and trust in health care. In the second one, professional figures (i.e. link workers) were adopted to promote health and social relations in the community. In this case, instead of focusing predominately on the cultural dimension that affects migrant health, more attention is paid to social conditions of living. Referring to a religious leader can be problematic in contexts where migrants' groups are very heterogeneous on the basis of their origins, generation and type of migration. Also, in the second kind of strategy there is a more explicit aim to empower the community, stemming from the social vision of health that recognizes that social, economic, and cultural factors influence people's health, and that interventions must address social and contextual factors [Freeman et al., 2014]. Moreover, this strategy allows health services to provide flexible responses to local needs, by considering the heterogeneity within the migrant population in Italy.

Conclusion

Italy is an increasingly diverse society. Even if important steps to promote equity for migrants have been taken, further development is needed. Promoting equity means finding innovative strategies to meet migrants' health needs and to reduce fragmentation at different levels of the health system. As already noted by Devillé et al. [2011], the highly political nature of the immigration issue has important effects on how CC is developed in the health system. Reducing inequities requires a synergy that goes from top to bottom and vice-versa, abandoning 'urgency politics' in favour of a rights-based approach. Implications for the health system mean strong policies, supported by implementation plans, and a primary care reform for taking into account changes in the profile of the Italian migrant population. Our findings suggest that, beyond training staff, there is a range of strategies that services may use to improve their responsiveness. It seems vital to adopt strategies promoting partnership and organizational commitment as well as strategies to cross the borders of health organizations using a community-based approach, which is flexible to local needs. Equity requires a shift in the health care model: reducing inequalities for migrants attests the need to address the social determinants of health that contribute to illness or health. Overall, the data recommend the importance of a research-based approach to manage health services in order to enhance quality of care, to hinder discriminative practices and to contextualize strategies to local needs.

Acknowledgments

We gratefully thank the research participants for generously sharing their perspectives and for enabling us to conduct this research.

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Global threatens by Antimicrobial Resistance: are we losing the miracle drugs?

*Daniele Roberto Giacobbe**, *Claudio Viscoli*

Antimicrobials are substances which destroy or inhibit the growth of microorganisms, like bacteria, fungi, or viruses [Davies and Davies, 2010] Since some of these organisms may be responsible for severe infections in humans, the discovery of the antimicrobial activity of natural or synthetic substances in the first half of the past century revolutionized the history of medicine [Brown and Wright, 2016]. For example, the advent of sulfonamides and penicillin has provided clinicians with ‘magic bullets’ against deadly bacteria such as *Streptococcus pneumoniae*, *Streptococcus pyogenes*, *Streptococcus agalactiae*, and *Staphylococcus aureus* [Davies and Davies; Abraham and Chain]. Suddenly, deadly infections like streptococcal pneumonia gangrene in wounded soldiers, puerperal sepsis, and ‘blood poisoning’ (technically, bacteraemia) became curable with simple injections of antimicrobials, a revolutionary result and certainly one of the major successes of modern medicine.

This was not the only way through which antimicrobials changed our history. Other remarkable successes of medicine, such as chemotherapy for cancers and autoimmune diseases, organ transplantations, and intensive care after major traumas or surgery would have been impossible without antimicrobials [Marston et al., 2016; Fauci and Marston, 2014]. Indeed, all these procedures are associated with important reductions in the ability of our immune system to prevent and counteract infections. For example, the destruction of immune cells which allows the successful treatment of leukaemia (since some immune cells are in fact neoplastic cells) is associated with an increased risk of healthcare-associated infections, so called as they take advantage of a temporary or chronic breach in our defences caused by necessary medical or surgical procedures [Viscoli et al., 2005]. These healthcare-associated infections are thus a natural but perilous consequence of modern medicine, that can only be accepted as long as we have

* correspondence to: daniele.roberto.giacobbe@gmail.com

antimicrobials, or more correctly, as long as they work. Indeed, bacteria (but not only) may become resistant to antimicrobials.

Antimicrobial resistance develops through different mechanisms, for example: changes in the bacterial targets of antimicrobials; production of enzymes that inactivate antimicrobials; decrease in the bacterial cell permeability; production of efflux pumps which extrude the antimicrobials out of the bacterial cell. All these mechanisms are generated by profitable spontaneous mutations in the bacterial genome. Subsequently, resistant bacteria might proliferate clonally, or transmit the determinants of resistance to other bacteria through conjugation or other forms of genes exchange [Davies and Davies, 2010; Marston et al., 2016]. These intimately connected and efficient ways of perpetuating antimicrobial resistance likely reflect a long evolutionary process, as confirmed by studies on bacteria in permafrost samples which document the existence of resistance genes some 30,000 years ago [D'Costa et al., 2011]. One of the function of these genes was probably that of defending bacteria from natural antimicrobials produced by other organisms. Consequently, when humans began to use antimicrobials many centuries later, bacteria already had efficient, flexible, and highly transmittable defences hidden in their genome.

Therefore, antimicrobial resistance is an inevitable natural process, and it is likely that it will never be eliminated. What is certainly unnatural, and driven by the excessive selective pressure exerted by the overuse and misuse of antimicrobials in human medicine, veterinary medicine, and agriculture, is the rapid spread of multidrug resistance (MDR). Nowadays, a non-negligible proportion of bacteria in hospitals worldwide is indeed resistant to different classes of antimicrobials, sometimes to all the magic bullets in our armamentarium¹. If the diffusion of antimicrobial resistance is not stopped, it has been estimated that in the next 35 years up to 300 million people worldwide may die prematurely because of incurable antimicrobial-resistant infections².

The situation is particularly worrisome when it comes to Gram-negative bacteria. The World Health Organization (WHO) has recently produced a global priority list of resistant bacteria, identifying the Gram-negative rods *Acinetobacter*

¹ <http://www.cdc.gov/drugresistance/pdf/ar-threats-2013-508.pdf>. Last access November 4, 2017; <https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/antimicrobial-resistance-europe-2015.pdf>. Last access November 4, 2017

² https://amr-review.org/sites/default/files/AMR%20Review%20Paper%20-%20Tackling%20a%20crisis%20for%20the%20health%20and%20wealth%20of%20nations_1.pdf. Last access November 4, 2017.

baumannii, *Pseudomonas aeruginosa*, and Enterobacteriaceae as the critical priorities for which there is an urgent need for new treatments³. This call for action has been preceded and followed by other initiatives by other international organizations and conferences (e.g., the General Assembly of the United Nations in 2016 and the G20 Summit in 2017⁴), and economic incentives providing large cash awards on new drug approvals have been introduced to promote the development of new antimicrobials [Daniel et al., 2017].

Certainly, although fundamental, new antimicrobials cannot win the war alone, since they will naturally continue to select resistance. Therefore, any successful approach to antimicrobial resistance cannot be separated from global and local initiatives aimed at ensuring, for as long as possible, the activity of antimicrobials through their responsible use. In the Global Action Plan on Antimicrobial Resistance, WHO has clearly defined five strategic objectives to achieve this goal: 1. improving awareness and understanding of antimicrobial resistance through effective communication, education and training; 2. strengthening the knowledge and evidence base through surveillance and research; 3. reducing the incidence of infection through effective sanitation, hygiene and infection prevention measures; 4. optimizing the use of antimicrobial medicines in human and animal health; 5. developing the economic case for sustainable investment addressing the needs of all countries, and increase investment in new medicines, diagnostic tools, vaccines and other interventions⁵.

As highlighted above, the first fundamental step is education. Indeed, antimicrobial resistance cannot be defeated without global awareness of the problem, which is necessary to promote and achieve a massive behavioural change. Public communication programmes and inclusion of courses in school and university curricula are critical aspects. In Italy, important communication initiatives were taken by the *Agenzia Italiana del Farmaco* (AIFA, Italian Drug Agency) which since 2008 has promoted rules for a responsible use

³ http://www.who.int/medicines/publications/WHO-PPL-Short_Summary_25Feb-ET_NM_WHO.pdf. Last access, November 4, 2017

⁴ <http://www.un.org/pga/71/2016/09/21/press-release-hl-meeting-onantimicrobial-resistance/>. Last access November 4, 2017; <http://www.oecd.org/about/secretary-general/g20-health-ministersmeeting-fighting-antimicrobial-resistance.htm>. Last access November 4, 2017.

⁵ http://apps.who.int/iris/bitstream/10665/193736/1/9789241509763_eng.pdf?ua=1. Last access November 4, 2017.

of antimicrobials⁶, and by the *Società Italiana di Terapia Antinfettiva* (SITA, Italian Anti-Infective Therapy Society), which in 2016 started a dedicated awareness-raising campaign⁷. Centerpiece of the campaign is the video spot *Il Supervampiro*. The spot is available on social media and on a dedicated website (www.antibioticilanostradifesa.it), which also includes general information on antimicrobial resistance, video interviews with experts, rules for proper use of antimicrobials, and interactive tests for measuring personal awareness of antimicrobial resistance. The importance of education on the correct use of antimicrobials are also remarked by the Italian Ministry of Health in the recently released *Piano Nazionale di Contrasto all'Antibiotico Resistenza* (PNCAR, National Counter-Action Plan on Antimicrobial Resistance) 2017-2020, which establishes the national directives for surveilling, reporting, and counteracting antimicrobial resistance in our country⁸.

A second important aspect of our fight against antimicrobial resistance is scientific research. Combatting Antibiotic Resistance in Europe (COMBACTE) is a key part of the New Drugs for Bad Bugs programme launched by the Innovative Medicines Initiative (IMI) after the European Commission's call for collaborative research efforts in 2011. Several studies promoted by the COMBACTE network are currently ongoing, and will enrich our knowledge and ability to counteract antimicrobial resistance in the forthcoming future⁹. Another example is the Antimicrobial Resistance Leadership Group (ARLG), supported by the US National Institute of Allergy and Infectious Diseases of the National Institutes of Health (NIH–NIAID), which prioritizes research on antimicrobials resistance¹⁰. In Italy, important research studies on antimicrobial resistance have been conducted in recent years by the Italian Study Group on Resistant Infections of SITA (ISGRI-SITA) [Giannella et al., 2018; Giacobbe et al., 2017; Tumbarello et al., 2015], also in collaboration with the Critically Ill Patients Study Group of the European Society of Clinical Microbiology and Infectious Disease (ESCMID) and the Hellenic Society of Chemotherapy (HSC) [Bassetti et al., 2018].

⁶ <http://www.aifa.gov.it/content/senza-regole-gli-antibiotici-non-funzionano-campagna-aifa-sul-corretto-uso-degli-antibiotici>. Last access November 4, 2017.

⁷ <http://www.antibioticilanostradifesa.it>. Last access November 4, 2017.

⁸ http://www.salute.gov.it/imgs/C_17_pubblicazioni_2660_allegato.pdf. Last access August 24, 2018.

⁹ <http://www.combacte.com>. Last access November 5, 2017.

¹⁰ <https://www.arlg.org>. Last access, November 5, 2017.

In the everyday clinical practice, the crucial measures for preventing and reducing the diffusion of resistance are infection-control and antimicrobial stewardship. The former refers to all measures aimed at preventing the transmission of resistant pathogens among patients; optimal sanitation and hand hygiene are the key factors. Notably, although hand hygiene is a simple procedure and one of the most effective measures for preventing healthcare-associated infections, adherence to this practice in hospitals worldwide has been reported to possibly be as low as 34-39% ¹¹ [Luangasanatip et al., 2015]. Against this background, initiatives such as the SAVE LIVES: Clean Your Hands Campaign, launched in 2009 by the WHO and aimed at improving hand hygiene practices worldwide, certainly plays a critical role in our war against antimicrobial resistance [Pittet et al., 2005; Tartari et al, 2017].

Antimicrobial stewardship is defined as a coherent set of actions designed to use antimicrobials responsibly [Dyar et al., 2017]. These include optimal selection, duration, and dose of treatment, and control of antimicrobial use [Barlam et al., 2016]. In Europe, guidelines for the prudent use of antimicrobials have been developed by the European Centre for Disease Prevention and Control (ECDC) ¹², and several initiatives and research on antimicrobial stewardship have been promoted by the ESCMID Study Group for Antimicrobial stewardship (ESGAP) [Pulcini et al., 2017]. Generally, antimicrobial stewardship involves different approaches variously combined: 1. education; 2. prospective audit with intervention and feedback; 3. formulary restriction and preauthorization [Barlam et al., 2016]. In our hospital (*Ospedale Policlinico San Martino - IRCCS per l'Oncologia*, based in Genoa), a mixed educational and semi-restrictive antimicrobial stewardship project was effective in reducing the use of major antibacterials and the incidence of bloodstream infections due to carbapenem-resistant *Klebsiella pneumoniae* (one of the most diffuse MDR Enterobacteriaceae) [Giacobbe et al., 2017]. Other favourable experiences with different approaches have also been reported in Italy [Murri et al., 2017; Viale et al., 2017; Tedeschi et al., 2017]. All these positive results are encouraging, and testify to the positive effect of AMS. However, what we still need in this field is sustainable funding on

¹¹ http://apps.who.int/iris/bitstream/10665/44102/1/9789241597906_eng.pdf. Last access November 5, 2017.

¹² https://ec.europa.eu/health/amr/sites/amr/files/amr_guidelines_prudent_use_en.pdf. Last access November 5, 2017.

the on hand and, on the other, global standardization of measures for monitoring and comparing the impact of our interventions [Pulcini et al., 2017].

In conclusion, there is notable commitment on the part of the scientific community to effectively address the global threat of antimicrobial resistance, which justifies a feeling of hope and optimism. However, these measures should be sustained and supported by each and every one of us in our everyday practice as healthcare professionals. Indeed, it is not because important global initiatives are being taken that we can forget to always adopt the necessary infection-control measures and use antimicrobials responsibly. If we let our guard down, resistance will find the way to elude our efforts, again and again, and it will all be for nothing.

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Third section:

From global reasoning to local actions
for health promotion

Cooperation, research and collective health practice

*Rita Ferrelli**

Aid effectiveness

The international aid system was born at the end of the Second World War, when the United States supported the reconstruction in Europe. After the end of the Cold War and the fall of the Berlin Wall in 1989, the system moved towards alleviation of poverty and the promotion of development. The conferences, that were held in Monterrey, Mexico in 2002, in Paris in 2005, in Accra, Ghana in 2008¹ and in Busan, Korea in 2011² tackled the issue of aid effectiveness. The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), bringing together the leading national economies, set forth best practices that can be applied globally to improve aid³. According to them, economic growth and good governance represent pre-requisites for aid effectiveness. The 4th High Level Forum on Aid Effectiveness held in Busan, Korea, in 2011, was expected to make recommendations on a future aid quality framework, at least covering the period up to the Millennium Development Goals date of 2015. The Forum called for the establishment of a Global Partnership for Effective Development Cooperation to boost the impact of development resources worldwide. It adopted a set of 10 indicators for monitoring aid effectiveness.

* correspondence to: rita.ferrelli@iss.it

¹ International Conference on Financing for Development Monterrey, Mexico, 18-22 March 2002. www.un.org/esa/ffd/ffdconf/ (last access February 6, 2017)

² Organization for Economic Cooperation and Development. *Fourth High Level Forum on Aid Effectiveness*. www.oecd.org/dac/effectiveness/fourthhighlevelforumonaideffectiveness.htm (last access February 6, 2017)

³ OECD/UNDP. Making Development Co-operation More Effective: 2014 Progress Report, OECD Publishing. <http://dx.doi.org/10.1787/9789264209305-en> (last access February 6, 2017)

In 2015, the international community agreed on the 2030 Agenda to improve peoples' lives⁴ and the Global Partnership for Effective Development Co-operation is supporting the achievement of the Sustainable Development Goals set in the 2030 Agenda.

In 2016, the Nairobi Conference reconfirmed the main principles ensuring aid effectiveness that were set at Busan conference⁵, namely:

1. Focus on Results: countries providing support should assist with the development and implementation of national result frameworks through a transparent, participatory and multi-stakeholder process;
2. Ownership of Development Priorities by Partner Countries Receiving Support: each country has primary responsibility for its own economic and social development and the role of national policies and development strategies cannot be overemphasised;
3. Inclusive Partnership: inclusive multi-stakeholder partnerships are necessary for the realisation of effective development co-operation and for reaching the Sustainable Development Goals;
4. Transparency and Accountability: country development strategies and processes should be developed, implemented, monitored and evaluated in a transparent and accountable manner.

A number of criticisms have been moved to the notion of development aid. They refer to several aspects:

- Difficulties in establishing significant correlations between aid and economic growth measured as Gross National Product (GNP) in developing countries [Mosley, 1987]. Actually, the use of GNP as a development indicator is questioned, since not all aid is intended to generate economic growth; e.g., the micro-macro paradox reports positive results for

⁴ United Nations General Assembly. A/RES/70/1 Resolution adopted by the General Assembly on 25 September 2015. Transforming our world: the 2030 Agenda for Sustainable Development. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (last access February 6, 2017)

⁵ Global Partnership for Effective Development Cooperation. Nairobi Outcome Document. 1 December 2016. Nairobi, Kenya. <http://effectivecooperation.org/wp-content/uploads/2016/12/OutcomeDocumentEnglish.pdf> (last access February 6, 2017)

projects and programmes carried out at a local level and aiming at improving people's standards of life;

- Governments' lack of responsibility with international aid substituting for the governmental role. Aid offers governments a way out from the contract between them and their electorate mandating the provision of public goods in exchange for taxes. Often, aid encouraged kleptocracies, corruption, and aid-dependency [Moyo, 2009];
- Top-down approach, with priorities defined at bureaucratic level, without local contextualization, nor citizens' participation or empowerment;
- The current sustainability vision that changed from an initial concept of duration in time to a focus on the beneficiary's determination and skills to self-improve: in 1992, DAC Principles for Project Appraisal defined as sustainable any project ensuring benefits for a long period of time; conversely the adoption of Western democratic values and type of governance channel resources towards capacity-building and continuous improvement projects. Using this kind of sustainability as a selection criterion risks privileging recipients already having the capacity to gain control over health and living conditions and exclude others as unworthy. It would be a paradox indeed if emphasis on sustainability ended up in preventing global equity and justice instead of promoting it [Engebretsen et al., 2016];
- In relation to the ambiguous accountability criteria of the Sustainable Development Goals (SDGs), set by the international community in 2015, Engebretsen et al. observe that the 2030 Agenda is making big promises in its determination to end poverty and hunger. At the same time, the Agenda distinguishes between "us", making the promise and "us", responsible for keeping it, launching a double-duty paradox: sustainable development is about both committing oneself to a promise and committing others to an obligation. Engebretsen et al. underline the need for a robust formative evaluation system that scrutinises accountability mechanisms and possible double-duty paradoxes embedded in the operationalisation and implementation of the SDGs [Engebretsen et al, 2017].

Critical issues of the Sustainable Development Goals

The Capability Approach

Approaches to poverty in international development and policy-making have focused on economic growth as the primary goal of development and measured quality of life simply by looking at GNP per capita. Today, a different approach is prominent: the capabilities approach on what people are actually able to do and to be [Nussbaum, 2006]. According to Martha Nussbaum (*ibidem*) and Amartya Sen (2001), personal capabilities are fundamentals for the social and economic development. They define poverty not as ‘income deprivation’, but as ‘capabilities deprivation’. The capability approach stems from the principles of social justice and ethics of the development. It inspired the creation of the UN Human Development Index as a measure of human development, capturing capabilities in health, education, and income. This approach to human well-being emphasizes the importance of freedom of choice, individual heterogeneity and the multi-dimensional nature of welfare. Functional capabilities are construed in terms of the substantive freedoms people have reason to value, i.e. as ‘substantive freedoms’, such as the ability to live to an old age, engage in economic transactions, or participate in political activities. Capability is a practical choice, ‘to achieve outcomes that people value and have reason to value’ [Sen, 2001]. It relies upon two basic concepts: functioning and opportunity freedom, i.e. freedom to achieve.

Nussbaum frames these principles in terms of 10 capabilities, i.e. actual opportunities based on personal and social circumstance [Nussbaum, 2011]:

1. Life: being able to live to the end of a human life of normal length, not dying prematurely, or before one’s life is so reduced as to be not worth living;
2. Bodily Health: being able to have good health, including reproductive health, to be adequately nourished; to have adequate shelter;
3. Bodily Integrity: being able to move freely from place to place, to be secure against violent assault, including sexual assault and domestic violence, having opportunities for sexual satisfaction and for choice in matters of reproduction;
4. Senses, Imagination, and Thought: being able to use the senses, to imagine, think, and reason – and to do these things in a ‘truly human’ way,

- a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain;
5. Emotions: being able to have attachments to things and people outside ourselves, to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.
 6. Practical Reason: being able to form a conception of the good and to engage in critical reflection about the planning of one's life. This entails protection for the liberty of conscience and religious observance;
 7. Affiliation:
 - Friendship: being able to live with and toward others, to recognize and show concern for other humans, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech);
 - Respect: having the social bases of self-respect and non-humiliation, being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non-discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national origin and species;
 8. Other Species: being able to live with concern for and in relation to animals, plants, and the world of nature;
 9. Play: being able to laugh, to play, to enjoy recreational activities;
 10. Control over one's Environment.
 - Political: being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association;

- **Material:** being able to hold property (both land and movable goods and having property rights on an equal basis with others, having the right to seek employment on an equal basis with others, having the freedom from unwarranted search and seizure. At work, being able to work as a human, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.

The capabilities provide the best bases for thinking about the goals of development. Adopting the same the theoretical grounds of this approach, a wide interdisciplinary literature developed several kinds of indicators to highlight essential determinants for human development, such as the Human Development Index, the Gender-Related Development Index, the Gender Inequality Index and the Gender Empowerment Measure.

In the 2030 Agenda for Sustainable Development, the international community set forth 17 objectives and 169 targets to be achieved by the year 2030 for the future international development. The Sustainable Development Goals (SDGs) were achieved in a collaborative and iterative process, that saw the participation of experts, politicians, and the civil society. However, the SDGs were criticized for several reasons. First, achieving the SDGs depends not only by the measures adopted, but also by the same definition of sustainable development. As a matter of fact, the capability approach is not reflected in the Agenda. On the contrary, the SDGs repeat the same conceptual framework of the Millennium Development Goals, that drew criticism for their lack of an approach based upon human rights and devoted to fight social exclusion that generates poverty. Social determinants of health find no explicit mention in SDGs, while the scientific literature recognized their role in shaping and defining not only people's health status, but also health inequalities and iniquities [World Health Organization, 2008; Organización Mundial de la Salud, 2011; Marmot, 2010; The Lancet, 2014; McGinnis et al, 2002]. Social determinants of health play a fundamental role in accessing and distributing resources, power and opportunities that are at the basis of the mechanisms of social exclusion and poverty generation.

Intergenerational equity and planet boundaries

A further relevant element that Amartya Sen places at the core of sustainability is intergenerational equity, that pays attention to the needs of future generations.

Currently, climate change, biodiversity loss, ocean acidification, chemical and air pollution are putting a heavy burden on the environment and jeopardize its health. An editorial signed by Horton in 2014 regrets the lack of an articulated vision of sustainability and underlines that indicators and targets only partially address important dimensions of sustainability, such as well-being, capabilities, intergenerational equity, externalities (both positive and negative), resilience (as survival skills, the ability to adapt and flourish in spite of hardship) and the strength of our civilization, in its meaning of solidarity, wealth, containment of inequalities and corruption, susceptibility to conflicts and quality of institutions.

Thinking of development in terms of economic growth endangers the concept of environmental sustainability, according to Rockström's and Steffen's works on planetary boundaries (PBs). The planetary boundary framework provides a science-based analysis of the risk of human perturbations destabilizing the Earth system (ES) on a planetary scale: there is increasing evidence that human activities are affecting the ES functioning to a degree that threatens the resilience of the ES itself. By combining improved scientific understanding of ES functioning with the precautionary principle, the PB framework identifies levels of anthropogenic perturbations below which the risk of destabilization of the ES is likely to remain low — a 'safe operating space' for global societal development. The PBs include climate change, stratospheric ozone depletion, ocean acidification, biodiversity, human interference in the nitrogen and phosphorus cycles, land system change, freshwater use. According to the PB framework, the boundaries in three systems (rate of biodiversity loss, climate change, and human interference in the nitrogen cycle) have already been exceeded, hampering survival of future generations. Some problems, such as ozone depletion, are undergoing a process of partial resolution due to the international commitment to reduce chlorofluorocarbons (Montreal Agreement, 1987).

Monitoring of the implementation of SDGs

The Statistics Commission of the United Nations created the Inter-Agency and Expert Group on the Sustainable Development Goal Indicators (IAEG-SDGs) with the purpose of defining indicators monitoring target achievement⁶. The IAEG-SDGs

⁶ United Nations. Economic and Social Council. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. E/CN.3/2016/2/Rev.1. Statistical Commission. 47th session. 19 February 2016. <https://unstats.un.org/unsd/statcom/47th-session/documents/2016->

identified 230 indicators, but some of them can monitor the dimensions that Horton underlined due to their importance for a sustainable and equitable development.

Moreover, the monitoring indicators reveal a utilitarian vision of economic development that is limited to economic growth and is measured by GNP. However, as Robert Kennedy highlighted at Kansas University in 1968:

Gross National Product counts air pollution and cigarette advertising, and ambulances to clear our highways of carnage. It counts special locks for our doors and the jails for the people who break them. It counts the destruction of the redwood and the loss of our natural wonder in chaotic sprawl... Yet the gross national product does not allow for the health of our children, the quality of their education or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages, the intelligence of our public debate or the integrity of our public officials. It measures neither our wit nor our courage, neither our wisdom nor our learning, neither our compassion nor our devotion to our country, it measures everything in short, except that which makes life worthwhile⁷.

GNP does not take into account distribution characteristics. Therefore, a country can enjoy a high GNP and an equally high inequality of opportunities or respect for human rights for some population groups. Moreover, GNP further underlines the lack of indicators for measuring social determinants of health and the consequent health inequalities. In this regard, the European Union Research Programme Horizon 2020 financed the LIFEPATH project with the purpose of providing updated and relevant evidence for the relationship between social disparities and healthy ageing, understanding the determinants of diverging ageing pathways. The LIFEPATH meta-analysis of a multi-cohort study involving over 1,700,000 individual highlights the role of socio-economic status on mortality and urges to monitor the role of these factors in the framework of local and global strategies and health risk surveillance aiming at reducing mortality [Stringhini, 2017].

2-IAEG-SDGs-Rev1-E.pdf (last access February 6, 2017)

⁷ Remarks at the University of Kansas, March 18, 1968. Available on <https://www.jfklibrary.org/learn/about-jfk/the-kennedy-family/robert-f-kennedy/robert-f-kennedy-speeches/remarks-at-the-university-of-kansas-march-18-1968> (last access February 6, 2017)

Interlinkages across SDGs

A further critical element is represented by the interactions among SDGs, as highlighted by Nilsson et al. in a recent publication in *Nature*, based on a project that the International Council for Science developed in order to explore an integrated and strategic approach to the implementation of the SDGs, recognizing the important interlinkages across the SDGs. The 2030 Agenda is intended as an ‘indivisible whole’, with the hidden presumption that the interactions between goals and targets are mutually supporting: in order to achieve one goal area, you also need to address the others. Implicit in the SDG logic is that goals depends on each other, but no one has specified exactly how, if the interaction is positive or negative, reversible, evidence-based nor has been studied the strength of the interaction. The Authors recognize 7 different kinds of interactions: cancelling, counteracting, constraining, consistent, enabling, reinforcing, indivisible. E.g., food production may compete with bioenergy production for the same land or water. SDGs should be contextualized and adapted to the national and local context (e.g., bioenergy production was effective in Nordic countries, while in other countries it competes with food production and food security), to the time scale (e.g., intensifying food production may end famine, but it can deprive people of food resources in the long run), and to the time and space scale (e.g., industrial development may cause pollution but at the same time it can strengthen infrastructures). Therefore, it is important to develop a corpus of scientific evidence that can describe the interactions of the different goals in the different contexts and support the decision-making process of policy makers⁸.

The role of academia, research and local action in fighting inequalities and poverty

Health policy research

Health policies are strictly related to economic, financial, social, and regional policies. Research on health policies and health systems falls in the field of interest of the European Commission, whose DG for Research and Innovation finances

⁸ International Council for Science. A Draft Framework for Understanding SDG Interactions (ICSU, 2016); available at <http://bit.ly/sdg-interactions> (last access February 6th, 2017)

the Horizon 2020 Programme and the DG for Health and Food Safety ensures that food and consumer goods sold in the EU are safe [Walshe, 2013]. However, the budget that the European Commission reserves to research on health is dominated by a biomedical approach: only 4% of 642 million Euros of the programme of cooperation in health research was allocated to the research on health systems, or public health or health policies⁹. Articulating and supporting research in public health is fundamental for health systems and for population needs that must be satisfied by health systems. In this regard, the Science in Society Programme of the European Commission financed STEPS (Strengthening Engagement in Public Health Research), a collaboration from 2009 to 2011 between the University College of London, the European Public Health Association, and twelve partner countries, with the purpose of describing public health research in European Union countries and the role of civil society organizations¹⁰. STEPS highlights that the EU Member States, which provide most of all European health research funding, show the same patterns as the European Commission, allocating just 5% of all health research funding to public health research, and the rest to biomedical and biotechnology research. While the EU promotes the leading role of industry in research and innovation in general, public health research needs greater engagement of civil society organizations, acting as not-for-profit small- and medium-sized enterprises for social innovation.

STEPS recommends that Ministries of health lead support and take leadership for public health research, and collaborate to develop a European Public Health Research Area. Namely, STEPS recommends:

1. national strategies for research on public health (including health systems and services) to meet the major health challenges, such as active and healthy ageing;
2. a minimum of 25% of all health research funding to be allocated to public health research, both by member states and the European Union;
3. coordination between Ministries of Science, Education and Finance, including use of the national Structural Funds, to develop public health

⁹ McCarthy M. et al. Public health research—Europe’s future (STEPS report). London: University College London, 2011. http://discovery.ucl.ac.uk/1329165/1/STEPS_Report.pdf (last access February 6th, 2017)

¹⁰ STEPS report: Public Health Research – Europe’s Future. Available at <http://discovery.ucl.ac.uk/1329165/>, last access December 3rd, 2017

- sciences in universities and institutes of public health;
4. better engagement with public health researchers, users and partners, especially through civil society organizations;
 5. greater coordination and leadership of public health research within the European Union research and innovation programmes.

The Ecuadorian epidemiologist and rector of the Simon Bolivar Andean University Jaime Breilh gave a speech at the International People's Health University in El Salvador¹¹. He underlined that academic excellence should be defined in agreement with society. It should identify the population's needs and carry out research and training activities in order to respond to those needs, while respecting at the same time the rules of the scientific method and the methodological values of comparison and transparency. Actually, the dominant view of academic excellence is inspired by market productivity criteria such as number of publications, peer-reviewed journals, sometimes leaving aside neutrality requisites. Breilh criticizes the capitalist economy, that is accumulating not only material resources (such as e.g., the 'land grabbing' phenomenon) and financial, but also knowledge resources and skills for dealing with technologies: just to mention biotechnologies, genomics, omics sciences and informatics, that are owned by the private sector and whose results may not be available for the whole population. Starting from these considerations, Breilh proposes the 4-S Theory as an alternative for humankind survival: Sustainability, Sovereignty, Safety, Solidarity. In such a context, the academia is a tool for intellectual growth and for the population's well-being. Otherwise, it would become functional to and an expression of that power that is hampering human survival. Therefore, it is not only matter of social justice, but of responsibility towards future generations. In other words, intergenerational equity.

In relation to the role of the academia in fighting inequalities and poverty, it is important to underline that the academia offers a knowledge base that is ensured by a broad spectrum of relevant disciplines, including epidemiologists, public health researchers, medical sociologists, health psychologists, health economists and political scientists. A wide literature is available from these disciplines and much of the current evidence is solid enough to serve as entry-points for actions

¹¹ Breilh J. La desestabilización de Gobiernos progresistas en América Latina. <https://www.youtube.com/watch?v=71uGxfgQx2Y> (last access February 6th, 2017)

aimed at reducing health inequalities and poverty. However, the current knowledge on the mechanisms underlying health inequalities should undergo scientific review in order to chart the main areas of consensus and disagreement. A further step may aspire to reach interdisciplinary consensus and may lead to identify proper methodologies to study the socio-economic mechanisms underlying health inequalities. Then, existing policy recommendations should be reviewed in the light of these new insights, since improving the scientific understanding of health inequalities is at the basis for strengthening policy-making and reducing health inequalities. Moreover, evaluating the implementation of policies based upon the available evidence represents a powerful source of knowledge for understanding the same health inequalities mechanisms.

ActionResearch Laboratory for Co-development

The Laboratory of ActionResearch of Florence University represents another example of how to put into practice research and academic efforts to tackle these problems. ActionResearch for Co-development (ARCO) works with public authorities and private organizations in promoting local development and community empowerment, by providing scientific support based on the continuous interaction between academic rigor and practical fieldwork¹². At the basis of the ARCO philosophy there is the idea that only a careful analysis of socio-cultural variables, in addition to the economic ones, can allow fine tuning in interventions to fight poverty, while at the same time strengthening the role of individuals and local communities as active protagonists of co-development.

A recent Oxfam publication¹³ describes Oxfam's and ARCO's position on the role that local governance plays on the implementation of the 2030 Agenda. In particular, they emphasize the importance of enabling local actors to lead and influence policy action and practices within a system of multilevel relations, in order to address multidimensional poverty and inequality. According to Oxfam and ARCO, it is important to have a common understanding and framework on local governance to ensure that it gains a central position within the debate on

¹² www.arcolab.org (last access February 6th, 2017)

¹³ Oxfam Italia. Dove avviene il cambiamento. La governance locale per affrontare la povertà multidimensionale e l'ineguaglianza. Oxfam, 2016. http://www.oxfamitalia.org/wp-content/uploads/2016/09/Dove_avviene_il_cambiamento_Sintesi_260916.pdf (last access February 6th, 2017)

development, and more effectively influence social change for human flourishing. The document remembers that «governance mechanisms at the local level matter, because it is where the interaction among authorities, institutions, citizens – and thus society as a whole – is most immediate, as well as where inequality, exclusion, and vulnerability are most immediately experienced by people».

The arguments that call for renewed attention to local governance in order to tackle poverty and inequality relate to:

1. The presence of wide spaces of influence and action at the local level;
2. The existence of policy areas directly related to the citizens' well-being, where central governments often have limited (or indirect) incidence;
3. The diversified territorial impact of national policies (e.g., macroeconomic policies);
4. The need for tailored implementation of development strategies according to local contexts and for institutional coherence, which depends on synergies amongst governance levels.

According to Oxfam, the search for powerful and practical responses for tackling multidimensional poverty and inequality at the local level is likely to involve at least three distinct stages:

1. The development of operational toolkits that can flexibly guide policy-makers, practitioners and activists in order to strengthen local governance mechanisms;
2. The advancement of monitoring and evaluation frameworks and tools on local governance to encourage evidence-based learning and decision-making processes;
3. Further theoretical and empirical work to advance the role of local governance and a territorial approach to development, which requires a stronger dialogue among scholars and practitioners from different disciplines and perspectives.

Local governance can also facilitate a scale-up process from the local to the international level. Nevertheless, it is important to remember that local governance contribution to a real social change towards Human Sustainable Development implies strong multi-level synergies with advocacy processes at national and

international level. Local governance is one of the *tesserae* needed to complement each other and compose the wide mosaic of the struggle against social, economic and environmental injustice. Moreover, focussing on the local level does not imply lessening the fundamental role of national governance, nor looking at territories or local communities as self-sufficient and/or isolated entities detached from the national and international context. Rather, it implies emphasizing and building on the complementarities among mechanisms at different levels of governance, notwithstanding that territorial development processes depend crucially on policies, norms and coordination rules at the national and international levels.

The Oxfam paper underlines that «it is important to recognize that discussions of local governance and territorial processes of development do not imply a technical or neutral fix, as these processes do not take place in a political vacuum. Rather, it requires dealing with formal and informal power structures, and it involves asking how local power is exercised, whether or not it is oriented towards territorial development, and to what extent such power struggles reinforce horizontal inequalities amongst social groups, classes and communities».

Local governance plays a relevant role on social determinants of health and on reducing health inequalities. The World Health Organization recognized it since the '80s with the Healthy Cities Initiative¹⁴, a global movement, with networks of cities and communities committed to health and sustainable development in all the six WHO regions. Each five-year a core priority theme is launched with a political declaration and a set of strategic goals. The overarching goal of the current Phase VI (2014–2018) is implementing Health 2020 at the local level, with the following two strategic goals:

1. improving health for all and reducing health inequities;
2. improving leadership and participatory governance for health.

Both strategic goals reinforce the long-standing commitment of the WHO to address inequalities and the social determinants of health and striving to improve governance for health and promote Health in All Policies.

The Latin American and Caribbean Network of Health Promotion Managers (REDLACPROMSA) joined the Healthy Cities Initiative in its aspiration to act

¹⁴ www.euro.who.int/en/health-topics/environment-and-health/urban-health (last access February 6th, 2017)

on social determinants of health at a local level. REDLACPROMSA is a regional technical and political cooperation network that was established in 2015 for exchange, advocacy, and mutual support among health managers of Ministries and/or Departments of Health Promotion in Latin America and the Caribbean region. It aims at placing health promotion as a key element of public policies, in order to achieve equity, welfare and social development. The principles informing REDLACPROMSA recognize the value of local experiences and social participation as basis to achieve a sustainable regional development; they acknowledge the need of advancing regional strategies of political incidence in order to put in the governments' agenda a public policy approach based on equity and socio-environmental determinants of health; they retain horizontal cooperation as a new collaborating learning model; and they promote participatory methods, and action-reflection processes for planning, implementing, and evaluating public policies aimed at reducing health inequities. The REDLACPROMSA is open to all ministries and public institutions involved in health promotion at all Government level: national, regional and local. It is currently composed by: the Ministries of Health of Argentina, Colombia, Costa Rica, Chile, Cuba, Ecuador, Guatemala, Mexico, Peru, Salvador, Venezuela and Paraguay, the Ministry of Social Development of Chile and institutions related to Latin America and the Caribbean Health Promotion, like Facultad Latinoamericana de Ciencias Sociales - FLACSO Argentina; Centro para el Desarrollo y Evaluación de Políticas y Tecnologías en Salud Pública, CEDETES, Universidad Del Valle, Colombia; Fundación para el Desarrollo de la Salud Pública, FUNDESALUD Colombia; Escuela Nacional de Salud Pública, Cuba; Consejo de Ministros de Salud de Centroamérica y República Dominicana, COMISCA; Centro de Educación Ambiental de Guarulho - CEAG, Brasil; Red de Municipios y Comunidades Saludables de Lima Metropolitana, Peru. Moreover, REDLACPROMSA counts on the technical and financial support of the Pan-American Health Organization.

The focus on social determinants of health and the principles of Health in All Policies are the theoretical framework of REDLACPROMSA and find practical implementation at a local level, being this the natural space for public policies integration. As a matter of fact, local governments play a fundamental role in the quality of life and in the health of the populations, since they can implement intersectorality and equity in local policies, with a life-course approach and a focus on citizens' empowerment and community participation.

In preparation of the ninth Ninth Global Conference on Health Promotion *Health Promotion in the Sustainable Development Goals*, that was held in Shanghai, in November 2016, REDLACPROMSA organized a pre-forum of Mayors in Santiago (Chile) in July 2016, with the purpose of strengthening the PAHO/WHO strategy of Healthy Cities, Municipalities and Communities. The pre-forum saw a network of Municipalities committed to a healthy environment and signing the Santiago Declaration, where the signatories committed:

- to focussing on social determinants of health and Health in All Policies in order to achieve sustainable development;
- to sharing leadership experiences and municipal management based on intersectoral action, resource mobilization to create healthy cities.

Social business and social business cities

Social entrepreneurship programmes, that are inspired by principles of social business and social innovation, represent a further example of implementation of local governance. The Yunus Social Business Centre University of Florence¹⁵ is the first Italian Centre offering strategic support to private enterprises willing to put in practice the principles of social business, as described by the Nobel Prize Muhammad Yunus. Social business means a sustainable enterprise that has the main objective of solving a social problem and not making profit. All potential profits can be used both to expand the enterprise or to improve the product or service. Social businesses foster the societies' well-being, starting from the real needs of people, trying to solve the problems of the communities but also taking into account the economic sustainability of the project, as a traditional enterprise would do. It combines socio-environmental objectives, as the public sector does, with the efficiency and the economic sustainability of the private sector. The Centre studies and organizes events enabling the creation of networks between different actors: business owners, designer, associations, administrators who are interested in social business. It facilitates new collaborations and projects. Social business represents a clear alternative to the crisis of the dominant economic model. Social businesses allow to improve society and life contexts. Such a notion can represent a useful strategy not only to solve specific social problems, but also

¹⁵ <http://sbflorence.org/> (last access February 6th, 2017)

to address more general problems. In this sense, the Centre works out integrated programmes in collaboration with local authorities in order to create an ecosystem enabling social businesses and social innovation. The Social Business Cities constitute a good example of this activity that is further implemented in different contexts under the supervision and evaluation of the Centre. Pistoia, Italy is currently implementing this approach.

In conclusion, cooperation, sustainability, research and action at a local level represent articulated facets and instruments of principles aiming at reducing inequalities and promoting community welfare.

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Health Technology Assessment (HTA) as a global tool for universal health coverage

*Francesco Cardinale, Gaddo Flego**

HTA definition

As defined by the International Network of Agencies for Health Technology Assessment, Health Technology Assessment (HTA) is the systematic evaluation of the properties and effects of a health technology, addressing its direct and intended effects as well as the indirect and unintended consequences. It is aimed mainly at informing decision-making about health technologies. HTA is conducted by interdisciplinary groups that use explicit analytical frameworks drawing on a variety of methods.

A health technology is defined as any intervention that may be used to promote health, to prevent, diagnose or treat acute or chronic diseases, or for rehabilitation.

The term «health technology» refers in fact not only to biomedical equipment and tools, but also to medical devices, drugs, vaccines, organizational procedures and to everything that is put in place in order to produce and promote better health. The evaluation of health technologies (HTA) is a multidisciplinary methodology that represents a bridge between research, clinical practice and decision-makers, allowing them to define the priorities for intervention and investment (or disinvestment), to make informed choices and develop a responsible approach in public health, also favouring an empowering process of the population. The effects of this approach are also evident in the fight against inequalities in health, where it directs the deployment of resources to effective and sustainable technologies.

For these reasons, in May 2014 the World Health Organization adopted a resolution that includes the following statements:

- One of the greatest challenges in achieving universal health coverage is the search for equity, quality and efficiency of health systems, which implies

* Correspondence to: gaddo.flego@oeige.org

the need to choose judiciously and manage efficiently the technologies to be adopted;

- Because of the scientific and technological complexity, not every country has the skills for Health Technology Assessment; in these cases, the construction of networks between countries and institutions is of primary necessity.

The HTA Liguria Network experience

The HTA Liguria Network has been operational since April 2011. The Liguria Regional Government has decided that a HTA pathway for the acquisition of each new technology should be adopted, following the model of Hospital-based HTA. The Network also performs evaluations on direct request from the Regional Department of Health and provides support to the Regional Purchasing Center (CRA). Given the particular importance attributed within the Network to proper allocation of resources, in order to achieve maximum equity, in May 2014 the Network promoted, with the Department of Health Sciences of the University of Genoa, the conference *Inequalities and policies for health; as a future for the right to health*.

The HTA Liguria Network is part of the RIHTA (*Rete Italiana per l'Health Technology Assessment*, Italian Network for Health Technology Assessment) and has developed, since its participation in the second WHO Global Forum on Medical Devices (Geneva - 2013), international professional interactions with some countries with transition economies (South Africa, India). An agreement was also signed with the Global Health Center of the Tuscany Region.

HTA is increasingly becoming a 'global tool' with a possible interesting development in the area of international cooperation. The need to provide experiences and skills for capacity-building was also highlighted by the WHO, through the direct solicitation of international networks; in this paper, we try to share some considerations based on the application of HTA in a public health framework.

Past, present and on-going issues

Archibald Cochrane is considered the first epidemiologist to be involved in the evaluation of a universalistic public health system, combining classical questions

about the effectiveness of health interventions on patients (“To what extent are we able to make the correct diagnosis? Are we then able to cure our patients?”) with the parameter of efficiency (“Is what we do to single patients sustainable on a population scale? Are we sure that we are using adequate resources without wasting?”). The conclusions of his evaluations are expressed in the volume *Efficiency and Efficacy* of 1972, with the subtitle *Random Reflections on Health Services*: in the book, we find a sentence that, in our opinion, already contains the concept of HTA: «It would be necessary to prevent the introduction of new drugs and therapeutic procedures, unless they are more effective (or just as effective but cheaper) than existing therapies». In fact, it’s evident that, although HTA is by definition a multidimensional evaluation process, it does not make sense to undertake this complex and articulated pathway regardless of prior verification of effectiveness. In our experience, most of the technologies that do not pass the HTA process are characterized by insufficient evidence of efficacy, and it must be clear that, in its absence, their use in a clinical routine cannot be even considered as ethically acceptable. Unfortunately, today as in Cochrane’s time, the rigorous analysis of what actually supports the effectiveness of a technology or intervention is not common practice, and it is sometimes replaced, for instance, by considerations based on pathophysiology and mechanisms of action that, although suggestive, do not say enough about the real usefulness of what is proposed to adopt. Often, elements supporting the safety of technology are also lacking, and here again very important ethical aspects are involved, especially when we take into consideration the perspective of the national health system and the not the single relationship between a doctor and patient. These two fundamental aspects (which are, not by chance, the first ‘domains’ in the HTA multi-parametric model) have received greater attention in recent years in the world of pharmaceutical production, where regulatory pathways, generally requiring experimental studies, have been implemented. The same cannot be said for other technologies: for example, in the field of medical devices (a very large one, ranging from small devices to large diagnostic equipment), efficacy is seldom approached through clinical trials, while on the safety side the assessments essentially focus on aspects concerning the instruments’ conformation (materials, electrical safety, etc.), with attention increasing with the invasiveness of the device. Therefore, for non-invasive, non-measuring devices which don’t need to be sterilized, all that is needed to enter the European market is a simple self-certification by the manufacturer attesting the respect of proper construction practices. When, during the HTA

process, the absence of clinical safety trials, defined as the assessment of a degree of certainty in medium- and long-term consequences on health, is contested, the proponent opposes the possession of the CE, which is mandatory for the use of a device outside an experimental context, but which substantially refers to the manufacturing quality of the product, an element which is certainly indispensable but not sufficient. At this point, it is important to underline that HTA is indeed a multidimensional evaluation process, but the first dimensions considered, i.e. safety and efficacy, represents an inescapable barrier before proceeding with the following dimensions. In other words, it is not possible to deal with economic or context analysis if there is no reasonable certainty about the safety and effectiveness of a technology.

HTA substantially adds elements of sustainability and, potentially, participation in decision-making to the assessments of efficacy and safety, which represent the basis on which to build all the subsequent steps. The different weight of the dimensions assessed is indirectly underlined by the fact that in the United States of America, where there is no universal health coverage or a universalistic health system, evidence of efficacy is of course produced, but above all there is a great attention to safety, in some ways also greater than in Europe. Reports, warnings and recalls from the US Food and Drug Administration (FDA) represent in our work irreplaceable sources of information. In this regard, it is interesting to note how sometimes the United States, considered in the common discourse very advanced in the adoption of innovative solutions, seems instead to adopt rear-guard policies. An example is Watchman, an implantable cardiac device useful to prevent thrombus formation in patients with atrial fibrillation, and therefore to reduce the risk of stroke, which would have a very high potential impact in patients who are not candidates for anticoagulant therapy. The Watchman was in fact authorized (CE marking) in Europe in 2005 and in the US in 2015. This story, defined as «a real saga» by the *New England Journal of Medicine*, has highlighted not only the different authorization approach, but also that current use often fails to give the answers that could instead derive from experimental trials. In fact, FDA has repeatedly stated that it is not possible to derive reasonable certainties regarding safety and efficacy from data coming from the clinical use of the device in Europe. The NEJM therefore commented that a better collection of data in clinical practice, combined with the implementation of appropriate trials, would have significantly shortened the time taken to adopt a technology impacting potentially strongly on public health.

Facing these discrepancies in the pathways of integration of innovation within the clinical routine, the European Union has adopted a new regulation on medical devices, recognizing in fact the insufficiency of current procedures. Unfortunately, however, the emphasis has been placed on post market surveillance, and not on the request for robust experimental evidence in the pre-commercialization phase. It is not exactly like saying that a device is safe and effective until proven otherwise, but almost. Since the introduction of more controls than the existing ones is a necessity, between the risk for the industry to produce devices that do not enter the market (or enter it slowly) and the parallel risk to expose patients to harm or the Health System to ineffective investments (waste), it was decided (probably in the name of economic growth and development) that it was better to take the latter. On the one hand, this is a missed opportunity; on the other hand, it is a very strong push to strengthen evaluation activities to support the National Health Systems in their decisions.

So far, we have repeatedly touched on the research topic, as assessments often stop because of the lack of experimental data on safety and efficacy. To illustrate this situation, it suffices to remember that it is not uncommon to evaluate devices already on the market that are still being tested on animal models, or that have no specific experimentation behind them, if not the description of a series of cases by the patent holder (of course, these are devices which resemble others already in use and do not absolute novelties in the approach to a health issue; precisely on the basis of this analogy, they have obtained the necessary certification to access the market). In recent years, we are actually seeing an increase in experimentations on medical devices, but they are often spontaneous studies with all the difficulties that this entails, both economically and related to the difficulty of mobilizing expert methodologists (the two are obviously connected). Being these trials not mandatory to enter the market, they risk to be considered by the industry as unnecessary costs. HTA networks, that guarantee the sharing of assessments, achieve a greater homogeneity of approach towards investments in innovative technologies, and this is a considerable boost to studies sponsored by producers, determining a kind of regulatory policy on wider territories. This is one of the positive repercussions of networks, because today independence of research does not seem to be menaced by sponsorship or impaired neutrality of the funding, but the greater bias is on the choice of where to direct the research itself. Today, then, we have sufficient guarantees that a sponsored research is conducted correctly, and also that the results will be published even though they

differ from what was expected (demonstrating, for example, less effectiveness) thanks to trial databases, but we have no certainty that the research addresses the most relevant issues in the healthcare perspective rather than those considered to be strategic by the industry. The two perspectives can legitimately diverge, and it is therefore necessary to put in place policies that support research which is really useful to the Health Systems, creating support agencies and requiring the industry to pay attention to those elements that, although not necessary for the commercialization of the product, would reduce uncertainty margins at least on safety and efficacy aspects.

Many issues are raised against an evaluation approach to the introduction of innovation in healthcare, and they are all valid, if we ignore the objectives of a universal health system, which we can summarize in guaranteeing to all the most effective and safe treatments according to the available evidence. One of these, perhaps the most philosophical, sees in innovation and in general in technological progress the capacity of human beings to find answers to the problems that beset them. Faced with a problem, people try to solve it, so they use their growing knowledge and skills and produce an exactly conforming response to the initially identified need. If this is the process, what is the point of questioning, once the desired purpose has been achieved? Unfortunately, however, this extremely rationalistic view of technology, which sees people as subjects and technologies as instruments, is largely in crisis. If we look for example into the world of computer applications, among the less evaluated in healthcare, we cannot but be amazed at how they have changed our lives in an unexpected and unwanted way, and how much we still have to explore concerning their implications. Robert Wachter, initiator of the 'hospital Medicine', in his book *The Digital Doctor* can only answer the question about the reason why we should computerize health activities by saying that today a handwritten medical record is simply out of date, even if there is no evidence that digital records are faster or safer, and he warns us about the risks of this transition (risks that each of us felt when changes in information systems and computerization processes were experienced). Atul Gawande, a cardiac surgeon and writer, in his essay *Slow Ideas*, published in the *New Yorker* a few years ago, explicitly cites the applications of electronics among the innovations that have had the fastest diffusion, and the simple hand washing for the prevention of assistance-related infections, as perhaps the slowest spreading medical discovery ever, despite its impact on health is much greater than the first. In Italy, a few years ago we witnessed the prodigious diffusion of

surgical robots in urology, absolutely fascinating from the point of view of complexity and technological elegance, but whose effectiveness and safety compared to non-robotic techniques still remain uncertain, and facing much higher costs. In this context, the conclusions of a trial published in 2016 on *The Lancet* affirm that, pending other data, «patients are encouraged to choose a surgeon of experience who they trust and with whom they have a satisfactory relationship rather than a specific surgical approach», and an editorial in the same journal generalizes the case emphasizing that a «solid scepticism towards innovation and the ability to admit that there are areas of uncertainty are the elements that will eventually lead to real improvements in healthcare».

Another issue is the short lifespan of technology, which in some ways stresses the aspect of the slow-down that experimental studies would cause to the introduction of innovative technology that, in the meantime, would already become obsolete and be replaced by another one. This objection seems to be particularly weak, as ephemeral technologies are evidently problematic investments, while unfortunately in the history of medicine there are important technologies that have not been systematically adopted due to the lack of rigorous experimentation. This is the case described, for example, by Siddhartha Mukherjee in his *The Emperor of All Maladies. A Biography of Cancer*, where he tells how doctors have been debating between radical or minimal surgery for breast cancer without axillary lymph nodes for centuries (reflections on the subject date back from the times of Hippocrates), until the Veronesi study in 1981 demonstrated the appropriateness of quadrantectomy, sparing to a large number of women the radical approach endorsed by Halsted, which was very destructive. Again, it is this issue that should push the research forward, rather than the uncontrolled introduction of new technologies.

Yet, the issue that perhaps mostly deserves our attention is the one that emphasizes equity, or rather, the inequalities that are created in different contexts, depending on the rigor with which decisions are made regarding the introduction of innovative technologies. It is an issue that, in some ways, introduces the concept of freedom of choice and funding, seeing in the latter an economic lever that is operated not so much accordingly to the theoretically existing needs and answers, but on the basis of availability of resources. It is in fact an argument that is widespread among the citizens, who tend to think that some prudential choices are oriented more by the will not to spend than by the duty to protect citizens from immature technologies.

For example, we mention the case of TAVI, cardiac valves implantable with endo-vascular procedures, much less invasive compared to classical cardiac surgery. The specific interest of these devices is that they can be used on patients with cardiac valvular pathologies that would not tolerate open-heart surgery. It is an expensive technology (we will return later on the problem of costs), which targets patients for whom there is no surgical alternative, but only medical therapy of the heart failure, and it does not imply particular technical issues. In Italy, a conservative approach to this technology has prevailed, fearing a possible inappropriate use with the consequence of exposing patients to risks greater than the benefits and, despite the differences in regional policies that we find in our country, the model that has been widely adopted is that of the Heart Teams made up of competent specialists (cardiac and anaesthetic team, cardiologists and haemodynamists), evaluating individual cases. Registers have been introduced in all countries.

At the second WHO Global Forum on Medical Devices in Geneva in 2013, during the final plenary session, a slide was projected showing data on the use of TAVI in Europe, which presented very wide variations between countries, with an average of about 33/million inhabitants (Italy was just below), but Germany had a usage rate of almost 90/million inhabitants. The image was taken from an article recently published in the prestigious *Journal of the American College of Cardiology*, whose final comment said: «despite the rapid adoption of TAVI in Europe, our data confirm that there is a considerable gap in the treatment of patients with severe aortic stenosis with high or prohibitive surgical risk. National economic parameters and funding policies are closely linked to the use of TAVI and can explain the inequalities in use in the various countries».

Faced with clear data (the differences in the use of a technology), its interpretation did not at all consider that there might be different clinical strategies, but attributed the phenomenon to the economic differences between countries, rich or poor, and the management of reimbursement, which evidently reflects the availability of resources but also the propensity to direct investments in one direction or another.

Three years later, in 2016, the *Journal of Cardiothoracic Surgery* published a systematic review and meta-analysis based on the European TAVI registers, looking for information on their use in the ‘real world’. A particularly relevant parameter, the 30-day mortality rate from the day of the intervention, showed that the data in the Italian registry were among the best, while the data in the

German register showed for all three types of valves, values about three times higher than the average, and in every case the highest in Europe. The researchers' conclusions highlighted two main aspects. The first was that mortality data in the 'real world' was higher than expected from trial data; the second was that there was significant heterogeneity between countries, indicating «the urgent need for standardization of patient selection processes and procedures, to optimize results and ensure high standards of care across Europe».

It is strange, therefore, that after three years, inequalities have somehow reversed, just as the logic of 'more is better' is overturned. Obviously, it is not important here to point the finger on the competences of the various teams, but to highlight how effectiveness and safety can be underestimated in favour of the promises of innovation and how instead the weight of economic issues in clinical and public health choices is to a certain extent overstated.

In some cases, also aspects of organizational sustainability are binding. Not infrequently, the lack of specific skills, or of professional resources *tout court*, or of a favourable context for the implementation of innovative technology, represent the main obstacles. Yet, speaking about economic resources, one of the problems consists in the correct evaluation of the real costs of innovations: we do not refer to the problem of indirect costs, but to direct costs understood as applied prices. In fact, while for drugs the prices are to a certain extent determined centrally, for everything else this is not the case. Prices, however, also vary considerably depending on quantities, methods of acquisition (purchasing centres, direct negotiations), and possible recognition of exclusivity conditions, which finally prevent competition. But not only.

Some time ago, we were very impressed by an independent study, published by *The Lancet Global Health*, on the pricing policies of manufacturers of medicines treating Hepatitis C, a truly innovative category of drugs that has had a strong impact on the Health Systems' finances. A bottle of original sofosbuvir could in fact cost from \$300 (in India and Pakistan) to \$20 590 (in Switzerland) and, not too surprisingly, it was possible to draw a correlation between the prices charged in a country and its Gross Domestic Product. Apparently, a stringent market logic was followed to push prices to the maximum sum acceptable, without exceeding it: otherwise, the marketability of the product would be affected. In effect, this has allowed the use of innovative therapies in contexts that were traditionally completely excluded by innovation. The article, however, also reported that the true cost for the producer of the drug was certainly much lower than the

lowest price (a 2014 article reported that the cost of production for a 12-week treatment was below the lowest cost of a single vial).

The difficulty regarding costs is to understand that these are not fixed, but very much linked to market logics, also because the actual production costs often constitute only a very small part of the selling price. And profits, you know, are very high. In September 2015, when a short tweet by Hillary Clinton promised to «curb the huge profits of drug corporations», this instantly provoked a collapse in stock values. So, the question is: what do we talk about when we talk about costs?

HTA to support universal health coverage

Just on these considerations, as reported by the WHO, ensuring an evidence-based culture for decision-making in health policy choices, combined with an appropriate legislative and policy framework and access to local data, especially regarding costs and resources, are considered to be key aspects in achieving universal health coverage (UHC). Effective links between all these components and policy decisions are required to make a coherent system for UHC, that includes the design of an effective reimbursement strategy with an appropriate funding model.

So, international partners should do some preliminary work on this area and it was agreed that it is important not to duplicate existing projects, but to develop them further to satisfy the requests for technical support in this area from a number of countries.

In these circumstances, developing an approach to monitor expansion and uptake of use of HTA, providing a mechanism for coordination of the work on HTA and fostering networks to combine experiences and build capacity seems a priority. The main target of this activity should be the harmonization of methods and processes to guarantee the correct approach and to homogenize the behaviour both in the assessment phase and in the appraisal and dissemination phase. In this context, the existence of networks and the capacity to work and to communicate are crucial to promote methodological standards, as well as filling some of the existing gaps in terms of methods, organizational standards or capacity building.

Despite the existence of international HTA networks, we notice that there is still limited supply to meet the increase in the use of HTA at the meso-micro level with the urgent necessity to increase the capacity of local organizations which are actually out of the major networks but have daily access to technology in terms

of use and policy question. So, the need to reach and involve the widest audience of stakeholders, clinicians and, in particular, decision makers, appears to be binding when speaking about clinical governance, accountability, homogeneity, and sustainability without inequalities.

In this HTA overview, we have touched on many topics, but if we want to understand what this approach can add to scientific evidence and a weighted decision-making approach, we must address what is the true promise of Health Technology Assessment. We believe that HTA can respond to two specific needs, which are closely linked: the accountability of decision makers and citizens' empowerment. When we consider health, both start as a common asset, something that goes beyond the rights belonging to citizenship to become a human right, a vision absolutely connected to that of universal health coverage. The first concept underlines how, although the complexity of the choices imposes the engagement of informed professionals, the context in which these decisions are made is of such importance that the decision-makers themselves must always be able to give an account of it. This not only to remove all suspicions of undue interests, but also to protect the decision-makers themselves. In fact, even if it were not always be possible to make the right choices, the basis on which they were made could at least be explained. This is a necessary step to find an agreement between the delegate and the delegator, a kind of agreement which is very much in crisis nowadays, but that is all the same necessary in order to trace a reasonable path towards the extension of rights. Accountability on the one hand, and the development of conscious, informed citizenship capable of representing one's own needs on the other, are the goals of the empowerment process. But the rationalism that belonged to Leibniz's *rector rerum publicarum* (perhaps the first description of a public manager), which hoped to reach the correct choices through mathematical calculation, once it was possible to attribute symbols capable of describing the terms of the problem, is increasingly undermined by the different sensibilities that inhabit our world with equal dignity. An example among many is that of the end-of-life debates, where we move from the discourse on palliative care or the therapeutic obstinacy (arguments on which we all more or less agree) to issues such as euthanasia or assisted suicide, on which evidently and legitimately very different visions emerge. In this situation, the main road would be to resort to the so-called 'stakeholders'. And it is precisely here that we find something that belongs to within HTA, the need for a social context to be able to deal with choices. Not surprisingly, this dimension of HTA turns out to be the least developed on

a methodological level. It is sometimes even embarrassing to note that, in the face of rigorous evaluation of efficacy, safety and cost effectiveness, the citizens' point of view appears to be represented by the inclusion in the working group of a patient or a citizens' representative, whose contribution is difficult to identify in the final product.

A recent survey on citizens' participation in the definition of public health priorities, with particular reference to HTA, has given rather bleak results on the actual involvement of the 'general public'. It is worth pointing out that what really interests us is the contribution to evaluations, not so much to decisions, which are often traced back to a 'popular will' to which the political level is very attentive, especially when it manifests itself with the visibility guaranteed by media; and it might be useful to remember that different degrees of 'involvement' exist, which classically vary from information, consultation, participation; it is equally useful to warn that, while in public speech it is the highest levels that are mostly represented, in many real situations citizens cannot even rely on the first one that should be guaranteed to them (below which, we remember, there is basically manipulation...).

Obviously, there are reasons why there is such a situation: some eminently political, others less. Among the former, we find the difficulty in recognizing health as an actual right for everybody. An argument not to be taken for granted, with countries differing greatly from one another, and with different lines of thought on opposite positions within single nations. Unfortunately, beyond the explicit positions on this divisive topic, there are some convergences to whom we should pay attention. In particular, emphasis is placed on 'stakeholder engagement', both in the production of guidelines and in HTA assessments, with the involvement of health institutions, the industry, and citizens as the key to balanced and context-sensitive approaches. From our point of view, though, this apparently democratic and participatory vision levels very different interests: supporting the equivalence of the citizen/patient's interest with that of the institutions or the industry is a way to misrepresent what is at stake. On the one hand, in fact, we should speak of a right; on the other, nothing more than an opportunity. We therefore suggest that the contributions of citizen and patients and those of who can legitimately define themselves as stakeholders be taken into consideration differently

And again, there might be a conflict between citizens and patients. Take the (real) example of the renovation project of a hospital in a suburban neighbour-

hood that has now become residential. Residents are likely to express their disagreement through the formation of neighbourhood committees, with an effect that could seem paradoxical: some citizens are opposed to a primary service, while in other areas of the city other citizens complain about the absence of a nearby hospital or even of its recent closure (or downsizing). In fact, what residents are pointing out is probably the inconvenience related of a long period of construction, citing perhaps unfinished works for years in nearby areas, or the idea that the upgraded hospital could lead to more traffic, due to ambulances, and so on. And they fear that these discomforts could also affect the value of housing. Yet, even within the same neighbourhood there would be residents who more frequently than others will have to deal with the hospital, perhaps for chronic diseases that require more accesses during the year, or perhaps because they work there, and therefore would welcome the restructuring. Taken as a number, though, there would certainly be fewer of them than the others. In these cases, do we agree that ‘one is one’, that the opinion of the healthy resident has the same importance as that of the ill one? Or perhaps we should recognize to the latter a specific and more valuable interest?

In recent times, we have witnessed several situations in which disinformation and manipulation played a substantial role. Monographic issues of important medical journals have been devoted to ‘disease mongering’, i.e. the creation of diseases – most often through the medicalization of physiological phenomena –, but perhaps even more worrying are the cases in which groups of patients have rallied to have access to therapies not only proven to be ineffective afterwards, but that had not gone through any preliminary assessment and were essentially scams made by unscrupulous charlatans. The Stamina case, where even an Ethics Committee showed the fragility of its evaluations, when carried out under the pressure of the media, came to the point of stimulating a careful examination of the incident by a special commission of the Italian Senate.

So, the issue of participatory aspects of HTA is still open, with some strong points deriving from pilot studies. Among these, we believe the most relevant is that of Bouvin *et al.*, which basically tells us that participation is possible if there is a political-institutional framework that allows and favours it. And this already seems to be a problem in Italy, where a town’s Mayor is the local health authority and represents the communities before the Local Health Unit, but experiences of consultation and, even more, participation in the decision making are extremely rare. In fact, in the National Health System there are no case-specific participa-

tory modalities, that instead exist in schools, where from the 70s an elected representation of parents and students is guaranteed. With the health field, instead, at the beginning of the 1990s, we switched from a management committee, which guaranteed representativeness but was often characterized by incompetence (and here again emerges the theme of empowerment and conscious citizenship), to a single plenipotentiary manager appointed by the Regional Government. In this sense, from a global point of view, we certainly have to learn from systems that may be less complex, but in which we find health committees, village agents, etc. that can represent the citizens' needs more adequately.

Beyond the aspects inherent to the democratic nature of the decision-making processes, the role of citizens (and in particular of patients) in evaluative pathways is crucial, because HTA means in fact mobilizing competences, and these have to be found where they are. If research on efficacy and safety has its place in the international literature (including grey one) or reports of regulatory agencies, or sometimes, in the case of safety, also in the news, patients' knowledge can only be elicited through their active involvement; in its absence, the evaluation will be incomplete. For some technologies in particular, this is something that can significantly affect the whole meaning of HTA; let's think, for example, of innovations characterized by a supposed improvement in the quality of life. Unfortunately, there is a tendency in this field to use a lot of surrogate opinions; so, we believe that it is the doctor who knows which insulin pump is best suited to one's lifestyle, or we take for granted that day surgery is certainly better than spending a night in the hospital. If we really try to investigate the preferences, though, we find that the life of the patient and of his family is also made of anxiety, ability to accept a disease, and resilience. Above all, it becomes increasingly difficult to generalize. Some patients, for example, prefer to spend an extra night at the hospital, others to use a less smart technology but one to which they are more accustomed, and not everyone would opt not to go every six months to the cardiologist to check their pacemaker and replace it instead with an app.

By putting all the dimensions of a technology into the picture, although with a hierarchy, HTA seems the ideal tool not only to facilitate communication, but, above all, to manage conflicts. We have had proof of this in our hospital-based HTA experience. This is a process in which the clinician who wants to adopt a technology must evaluate it with a multidisciplinary team by answering a questionnaire (the Mini HTA grid), which explores all the traditional domains, starting from safety and effectiveness to the patient's point of view and the various decli-

nations of sustainability (economic, organizational, technological). At the end of this path, if the proponents want to go on with their initial intent, they submit the completed grid to the evaluation of the Scientific Secretariat of the Liguria HTA Network, which evaluates its methodological quality. Although negative answers are around 50%, our experience proves that the tool is very useful for preventing conflicts (or managing potential ones). In fact, at the end the proponents can be more or less satisfied, but they will always be aware of the reasons that led to the final assessment, clearing the field from suspects (“the Administration does not correctly evaluate my work, the only reason is money”, etc.). Similar results are also achieved with citizens, with whom we have however verified that the initial prejudice (“the evaluation is only about the money, they already know what the result will be”) is much more present and tenacious. As far as the Hospital Management is concerned, we have observed two things: when you start using the HTA tool, it quickly becomes indispensable. It seems honestly difficult not to use it in a systematic way; the other reason is that it is often the Management (and what can be labelled as the political sphere) that is more irreducibly resistant and struggles to renounce to the adoption of innovative technologies that are widely debated. This is because professionals, although not insensitive to the idea of being among the first to use a new technology, move from a medium- to long-term perspective, and would not like to be linked to something that does not work or is not sustainable; patients, on the other hand, have no other interest than ensuring for themselves the best possible care. The Managers and the political level that appointed them, on the other hand, often have much shorter temporal horizons, so it might be difficult for them to renounce to the reputation, although ephemeral, of having equipped a territory with a fashionable instrument (or organizational mode, or infrastructure).

In conclusion, the languages that intersect in Health Technology Assessment have certainly global significance, at least when comparing countries that have embraced the idea of a universal Health System to guarantee universal health coverage. A prudent and participatory decision-making process in the adoption of health technologies is becoming more and more indispensable both in high-income countries, which during the recent economic crisis have faced important limitations of resources, and in countries with growing economies, which risk to be exposed to strong pressures for investments that could prove to be wrong or non-priority. The theme of a major convergence seems to be already widely relevant in this sense.

On the other hand, there are universal elements in HTA that echo the great issues of public health, and which can either be viewed as strengths or weaknesses:

- HTA works in networks, so by definition it tends to connect different realities to form a single, multi-faceted story;
- HTA is based on incremental knowledge, so even those who arrive last can safely raise on the shoulders of others and develop cutting-edge experience. In this sense, the invitation contained in the 2014 WHO Declaration towards cooperation between countries with more mature experiences should be read as a great opportunity for all;
- To be effective, HTA must be implemented within explicitly defined health policies. This is absolutely the greatest weakness and vulnerability of HTA that, by its nature, cannot coexist with ‘hidden agendas’ or wavering health policies.

Finally, we like to remember that one of the most successful elements of citizen participation in HTA evaluations is the ability to give dignity to marginal voices, often carrying with them the most valuable answers. Thus, from a global perspective, the growth of international networks, actually sharing problems and knowledge, will allow the emergence of new elements that, although evident in some situations, are much less perceptible elsewhere, and so contributing to that deep and plural vision that represents the fundamental contribution of public health to the well-being of humankind and communities.

The authors wish to thank Paolo Bruzzi for the many inspirational and challenging conversations and for having been a mentor to both.

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Humanitarian corridors: a road to life

Luciano Griso *

Migration: the size of the issue

The phenomenon of migration has always accompanied the life of humankind.

Let us just consider the great prehistoric migrations that led to the diffusion of our Homo ancestors from the savannahs to the remaining dry lands, bringing finally *Hominini Sapiens* to Europe and causing them to impose upon the other coeval species, about one hundred thousand years ago.

We might as well take into consideration, in the historical era, the migrations of the Mediterranean peoples (the Phoenicians as well as the Greeks, who colonized Southern Italy giving it the name of *Magna Graecia*), or the so-called ‘barbaric invasions’ which, it is no coincidence, are referred to as ‘migrations of peoples’ in German.

Not to mention, lastly, the emigrations that have led, over the last two centuries, millions of needy Europeans to move to the American continent or to Australia in their quest for work and fortune. These migrants were referred to as ‘economic migrants’, that is, people who have abandoned their own family and country in order to escape misery and to pursue a better future both for themselves and for their children. Not rarely, once their work cycle had finished, these people would return to their own countries in order to fulfil their lifelong dream of purchasing a house.

Among them, though, refugees were an extreme minority and they were usually people escaping from political or religious persecutions.

The phenomenology of migrations is nowadays profoundly different, and it has features of its own that distinguish it from the previous pattern. Indeed, over the last decades, Italy and Europe have been at the heart of some significant migration flows, whose composition and origin are far-removed from the traditional ones. Beneath the determinism of modern migrations, we can actually identify

* correspondence to: lgriso48@gmail.com

three contributory causes, which intertwine in many different ways for what concerns the Mediterranean area.

1. Wars: from Afghanistan to Iraq, from Libya to Syria, this new-born century has already been riddled with bloody wars, which have led to the destruction of entire territories and to the death of hundreds of thousands of people. Furthermore, we often ignore the fact that in an extremely vast geopolitical area, ranging from West Africa (Nigeria, Mali, Cameroon) through Sudan and Ethiopia up to the Horn of Africa, we are witnessing some dramatically intertwined phenomena such as endemic poverty, wars and collapsed states. In such a context, for an increasingly larger number of people the choice is no longer whether to remain in their homeland or to risk their lives emigrating, but whether to face certain death in their country or to take the fatal risk of emigrating.
2. Terrorism: fierce and ruthless it is the poisoned fruit of the same wars, affecting not only those same areas (Syria, Iraq and Afghanistan) but also Africa (with Al-Shabaab in Somalia and Kenya and Boko Haram in Nigeria).
3. Climate Change: the number of refugees ascribable to this cause has exceeded that of war refugees. Nowadays, forced migrations are not only due to wars and political persecutions, but also to climate changes and their consequences on territories. Climate change, however, is barely a 'natural' phenomenon. Of course, floods and droughts do belong to nature, but the global mutation of climatic conditions is essentially due to human activity, as it represents the ultimate outcome of the development model currently in force, which is based on inequalities, on the misappropriation of resources, and on an irresponsible exploitation of the planet. Therefore, to reflect on forced migrations induced by climate change means to contest a neo-liberal and neo-colonial economic model, aiming at the depredation of the many Southern areas of the world. The progressive desertification affecting vast areas of our planet, which is due to the intensive exploitation of their resources and fertile lands, to the greenhouse effect-related rise in the average temperature and to the lack of water resulting from the above-mentioned factors is leading to the rarefaction of usable resources, fostering and reinforcing inequalities, eventually generating conflicts and wars. Hence, the movement of millions of people in search of a chance to live and have a future.

Therefore, migration is a global phenomenon. According to the UNHCR, the refugees in the world were 21 million in 2005 and 65 million in 2015, while in Europe there were 1.031 million of refugees in 2015 and 0.362 million in 2016, among which 76,770 were unaccompanied minors.

As can be seen, if we consider the migration flows from a global perspective, Europe is only marginally touched by the phenomenon, in spite of the alarmism conveyed by some media and political campaigns.

Within this framework, it is relevant to highlight that in 2015 the Global South countries hosted 80% of the world's refugees and the 48 least developed countries offered asylum to approximately half of those people (UNHCR data). The economic impact caused by migrations is actually much stronger on Global South countries than on the Global North ones. Pakistan proves to be the country carrying the heaviest economic burden: 605 refugees per dollar of GDP per capita, whereas in Germany the figure is 15 refugees per dollar of GDP per capita (UNHCR data). Evidently, the economic impact can be minimal even where the social one is strong.

Europe's response

So far, the European Union's response to the migratory phenomenon pressing on its own borders has been completely inadequate to a challenge of such extent. There has been no attempt to analyse and comprehend its structural reasons, neither was any question raised about Europe and the Western world's responsibilities (e.g. the intervention in other countries' internal affairs – see Syria and Libya – the trade and sale of weapons, the exploitation of oil resources). Europe has reacted to such a complex situation by considering the migratory phenomenon as a danger to defend itself from, rather than an opportunity to question and modify its own policies. It has therefore responded by building walls to defend its own borders.

Frontiers and borders

A frontier is obviously not just a line separating 'us' from 'them' on a territory or on a map, neither are borders some fixed boundaries that have been set once and for all. History teaches us that they are movable. One need only consider how often the European ones have changed over the last century. The myth of their untouchability is just a myth indeed. Borders and frontiers have always

been marked by tensions, ranging from impermeability to practices of osmosis, depending on the economic and political circumstances experienced by the country concerned by immigration. One need only refer to the example of Australia, whose borders have now become impenetrable to any attempt of crossing, even though in the 50s the country welcomed millions of Europeans and Asians as back then they were essential for the country's economic system.

Frontiers and borders are therefore not mere geographical concepts. Boundaries are complex social institutions. There are actually physical boundaries and metaphorical ones. Migrants are well aware of that, as when they manage to cross the physical barriers (e.g. the desert, the sea, Coast Guards, the barbed wire walls that have been raised anew in Europe after the fall of the most emblematic one in Berlin in 1989), they find themselves facing other barriers, that can be referred to as metaphorical, although they too have their own kind of materiality.

We are referring to the walls consisting of laws, administrative measures, denial of the right of asylum, detention centres and, ultimately, to those solidly built inside people's minds: rejection, hostility, and hatred.



Fig. 1 Rescue in the Mediterranean Sea (personal shot)

However, notwithstanding this formidable defensive structure, Europe does not consider itself safe yet and has elaborated a very articulate strategy which has developed its full potential over the last months: the externalization of borders.

Externalization of borders

The essential trait of this process consists in opening negotiations with the countries being crossed by migrants on their way to the Mediterranean coasts, in order to prevent them from fulfilling their aim. This agreement, named Khartoum Process, is a migration compact that allows funds transit countries (officially justified as development aid but in fact intended for security policies and procurement of arms) in exchange for the detention and the repatriation of asylum seekers to their countries of origin. This treaty, besides disregarding the Geneva Convention's provisions for refugees, leads to the stipulation of agreements with countries such as Sudan, Niger, Chad, Libya along the same lines of those between Germany and Turkey, that is, without taking into account the state of human rights in those countries and how the migratory policies are handled by local governments.

The only element taken into consideration is the geopolitical one (they are key transit countries on the way to Europe). The agreement between the European Union and the President of Sudan, who is the subject of an arrest warrant issued by the International Criminal Court, is a good example of that.

War against NGOs

Along the same lines (i.e. for the purpose of obstructing and impeding the refugees' march), must be interpreted the frenzied political campaign targeting non-governmental organizations (NGOs); actually engaged in rescuing migrants abandoned by the traffickers on open sea, they have been accused of backroom deals with those same traffickers against all logic and without any concrete evidence.

The result was their exclusion from the rescue operations, at times even by means of firearms, carried out by the Libyan Coast Guard, notoriously dealing in business with smugglers, as well as a drop in the number of migrants who manage to arrive on the European coasts. All of the above took place in the face of a presumed 'invasion' of Europe, which is actually far from being real.

The above data, marking only 362,000 migrants arriving on our continent (which has 550 million inhabitants) in 2016, and a further decrease this year,

compared to the millions of refugees received by countries such as Uganda, Ethiopia, Pakistan, Bangladesh, illustrates how Europe, in defiance of any civil and religious value, has decided to transform itself into an unconquerable fortress.

Costs

What are the human costs of borders?

They are extremely high. A matter of thousands of dead people, we will never know exactly how many. Some dead at sea (according to the official figures, 35 thousand over the last ten years, yet the real number is certainly much higher), others, whose number is beyond imagination, dead in the desert in the attempt of crossing it. Those who survive are bound to face deprivation, blackmail, torture, physical and psychological abuse. Not to mention the ever-increasing phenomenon of abandoned minors, who make up 20% of the total number of people arriving on our coasts and who often disappear without leaving a trace, therefore arousing all kind of suspicion, even the most dreadful ones, as to their fate (victims of criminal rackets, child prostitution, organs procurement).

Humanitarian Corridors



Fig. 2 Fiumicino Airport - Rome (personal shot)

The Humanitarian Corridors project stems from reflection on the complexity of the above - situation, as well as from the verification of the ineffectiveness of the responses European authorities have given in order to address the migratory phenomenon so far. It stems from the need for new reception and integration policies, for new instruments to protect migrants' rights and, lastly, for a closer collaboration in order to effectively cope with the number of migrants.

On the wave of the emotional impact following the tragedy that occurred on October, 3rd 2013, when a boat packed with migrants foundered a few dozen meters away from the shores of the island of Lampedusa causing 386 victims; a group of Believers members of the Italian Evangelic Churches and of the Community of Sant'Egidio in Rome decided it was about time to move from a personal, individual form of commitment to the elaboration of a process that could allow a number of migrants, however small, to get to our country in a safe and legal way.

A long and thorough study was carried out in order to find the implementing instruments that could make such a project feasible.

The Schengen Agreement

The solution was finally found in the article 25 of the Schengen Agreement, which allows European countries to issue, at their own consular offices, 'humanitarian visa' to people considered as 'vulnerable'; despite only being valid in the country of issuance, these visa represent a legal access pass to Italy for people who are in urgent need of protection. Currently, the only legal way for migrants to access Europe is to apply for a residence permit, but this is possible only after having stepped on the European soil, after having paid thousands of euros to criminal organizations and after having risked their own lives.

Once the mechanism was individuated, the Federation of Evangelical Churches (FCEI, Mediterranean Hope Programme) alongside the Community of Sant'Egidio and the Waldensian Table opened a negotiation with the concerned parties of the Government (Foreign Ministry and Ministry of Interior), in order to reach an agreement. After thorough discussion, a memorandum of understanding was signed in December 2015.

The Protocol

The Italian Government undertook to issue 1000 humanitarian visas destined to refugees located in Lebanon, Morocco and Ethiopia.

The requesting Organizations, in turn, guaranteed:

- On-site selection of the beneficiaries;
- Security controls to be carried out at the Italian Embassy in Lebanon through the collection of fingerprints to be verified in cooperation with the Lebanese Security;
- Travel to Italy via air flight;
- Further security controls at Fiumicino Airport;
- Reception in Italy. The type of reception provided by Humanitarian Corridors is called *diffusa* (lit. widespread), as instead of gathering migrants in large centres, it allocates them in single accommodations scattered all over the territory in order to avoid reactions from the local population. Furthermore, it ensures board, Italian language lessons, job placement, integration into the school system for minors, healthcare and legal assistance;
- No financial burden at the expense of the State, all costs of the project are covered by the Waldensian Table through the proceeds of the eight per thousand.

The Humanitarian Corridors project was launched in 2016 and has been closed at the end of 2017, having achieved its aim of bringing one thousand ‘vulnerable’ refugees to Italy. These are people persecuted for political or religious reasons, single women or mothers, sick people, disabled people, people who cannot return to their own countries as these are either occupied areas or theatres of war.

A further agreement with the Italian Government has led to a second round of the project (2018-2019), with the same rules as the previous one.

Procedures

For reasons of urgency, the mission was started off in Syria, being it the theatre of a bloody and destructive war (hundreds of thousands of dead, one million of injured, millions of displaced).

The team working on the field is composed by few units (four or five people, among whom a doctor), in order to weigh as little as possible on the project’s balance sheet. The potential beneficiaries to establish a contact with are selected under recommendation of national or international Organizations, which are active in the field of assistance to refugees and interface with all the communities



Fig. 3 Homs, June 2017 (personal shot).

living on the Lebanese territory (the sectarian context we operate in should be borne in mind). Therefore, the criteria of vulnerability and integrability are discussed along with these Organizations.

The people recommended to us or whom we have selected during our visits to the refugee camps undergo a preliminary interview followed by successive, more thorough ones. These are aimed at uncovering their requests, illustrating the project, collecting personal and familiar anamnestic data, introducing a Contract of Commitment in which the conditions of the project are summed up (commitment to stay in Italy at least for one year, to learn the language), as well as at discussing doubts, fears and questions, at evaluating the real possibility of overcoming displacement stress and of integrating in the social and working environment of our country.

Thereafter, the selected beneficiaries undergo the above-mentioned security controls and after their arrival to Rome Fiumicino they are entrusted to the reception. Besides providing assistance to the refugees, the aim of the process

described above is to promote exchange and mutual understanding with the local community. For this purpose, we organize meetings, public dinners and other opportunities of integration along with some voluntary groups, as we are confident that mutual understanding can make the walls of fear and rejection collapse.

Conditions of Syrian Refugees

Since the beginning of the Syrian war, Lebanon has been a shelter for a large number of refugees. UNHCR data indicate about one million five hundred Syrians, but no further registration has been carried out since June 2015, so the real figure is unknown. The ratio refugees/locals is about 1:4-5, actually the highest in the world. A great number of refugees have settled down in the Bekaa Valley and in the North of the country, which are among the poorest and most deprived areas, devoid of the most basic public services; this makes the crisis even harder to bear for both communities (natives and refugees).

An outdated estimate (UNHCR-2013 data) assessed 2,4 million vulnerable people amidst refugees and Lebanese natives, although this is certainly too low a figure in the light of the current situation.

Health impact of the crisis on the host country

The Syrian crisis had a heavy impact on the economic and social conditions of the Lebanese population. The unemployment rate in the country has increased, also due to the Syrian competitors who, as it inevitably occurs in these cases, are eager to work for lower salaries, at times much lower than the average ones. Feelings of frustration and hostility towards them are on the rise indeed, even though it should be said that many categories (such as real estate and landowners, merchants, owners of businesses that employ under-qualified personnel, e.g. housebuilding companies) are gaining significant benefits from this situation.

The consequences on the healthcare level are the following:

- Increase in the global demand for healthcare, followed by a decreasing supply;
- Increase in waiting times and worsening in the quality of the Service;
- Insufficient availability of medicines in order to satisfy a highly increased demand;

- Rigidity of the system, which is unable to rapidly and effectively cope with a situation of drastic change;
- Devastating impact on the Lebanese Healthcare system, which is privatized, fragmented, and uncoordinated.

Refugees' access to Healthcare

The Lebanese Healthcare system is largely privatized and based on insurance or cash payment. The public structures provide only basic services, unevenly covering the territory, leaving important diseases such as neoplasms undertreated. The most experienced medical and nursing staff usually opt for private work as it ensures higher profits.

- Local data show that only 50% of the refugees have access to medical examinations, and among these, the half of them relies on private structures;
- Refugees in the Bekaa Valley have less chances of access to healthcare compared to those residing in other areas of the country;
- Everyone's possibility of being treated largely depends on their financial resources; indeed, high costs are the main obstacle to accessing treatments and/or follow-up therapies (sources: MSF, Amnesty International);
- Unaddressed primary healthcare needs cause unresolved issues to reach a chronic condition, leading to extremely negative long-term consequences on people's health;
- 2016 U.N. data report that about 70% of refugees live below the poverty line (3.84 dollars/day);
- As a result, food safety has drastically decreased over the last year, leading to a significant increase in the malnutrition rate in children and young teenagers

Current Healthcare situation

The data provided by UNHCR summarize the healthcare issues refugees have to cope with in these terms:

- Infectious diseases: there has been a general increase especially with regard to childhood ones, due to inadequate vaccination campaigns hence, measles, rubella, polio and also food-borne and skin infections (scabies).

- **Chronic diseases:** more than half of the refugees suffer from chronic diseases such as diabetes, arterial hypertension, heart diseases due to hypertension, valvulopathy, congenital heart cardiopathies, chronic bronchopathies. As stated above, the impossibility of providing clinical inspections and adequate treatments often turns into chronic diseases some health issues that could normally be resolvable.
- **Pregnancies:** the birth rate among refugees is higher than the Lebanese one. Financial hardships, living in refugee camps (often distant from medical centres), and the difficulty of movement make it hard for pregnant women to get adequate assistance during both the prenatal phase (screening examinations, ultrasounds, toxemia prevention), and childbirth and successive phases. Indeed, many women give birth at home, where they are subjected to any possible complication. Some of them go temporarily back to Syria in order to give birth in hospital (childbirth assistance, as well as many other health services, is free of cost in Syria)
- **Mental health:** several investigations have reported a high rate of mental disorders within the refugee population, although it is obviously impossible to obtain any incidence or prevalence data. The main symptoms are anxiety, anguish, depression, insomnia. Numerous are the subjects suffering from Post-Traumatic Stress Disorder. Furthermore, it is very common to perceive among refugees a sense of inadequacy, frustration and humiliation for the loss of financial autonomy and for their dependency on others. These latter disorders are more frequent amongst men, due to the loss of the male role, which is of utmost importance in Middle Eastern society.
- **Children** suffer primarily, perhaps many of them irremediably, from the psychological consequences of war. Loss of security due to the abandonment of their home and loved ones, traumas due to the brutalities they had to witness, death of relatives, escapes, rejections, life instability, lack of education: all of the above raises serious doubts on what the future will be like for these children/adolescents who had to undergo such terrible trials at such a fundamental age in their development.
- **Handicaps:** according to a study (HelpAge 2014), a refugee on five suffers from physical, sensorial (hearing, sight) or intellectual impairments. Some of these impairments are the direct consequence of injuries and traumas occurred during the war. Others consist of congenital diseases (endogamy is common in Syria) and failures in the embryonic development due to

the lack of adequate preventive screenings, the lack of clinical inspections during pregnancy as stated above, the exposure to toxic environments and the precarious life conditions many women experience during pregnancy.

This summarily outlined overview illustrates the dimensions of the phenomenon.

An effective intervention would theoretically require a total reorganization of the Lebanese healthcare system, which is unrealistic, since the country cannot bear the enormous financial and organizational burden that assisting such a large number of people implies. Hence, the complete taking-over of the outlined situation by the so-called International Community, by means of financing and adequate interventions on the field, much more consistently than the present ones, would be extremely urgent.

At present, though, this seems to be a very remote possibility. Many influential nations seem to be more interested in further destroying rather than in repairing the damages caused in that area.

In this respect, a precious substitute role has been played by the numerous national and international NGOs (e.g. UNHCR, MSF, IRAP, Handicap International) which, through their presence and interventions, attempt to address the above-mentioned issues, addressing both the issue of healthcare and nutrition.

Medical Hope Project

This health crisis, rapidly summarized, could not leave us indifferent. Then, before this situation, we set up a new sub-project called Medical Hope. Based on a yearly grant provided by the Italian Baptist Church Union, donation by singles and groups and campaigns in Italy, we can rely on a budget that, despite its scarcity, permits us to help some Syrian refugees to deal with their health problems. Therefore, we can intervene by providing medicines, medical examinations, specialised consultations, financial support for the payment of particular treatments (e.g. chemotherapy and radiotherapy for tumours) surgeries, hospitalizations.

Some particularly complex clinical cases especially concerning children (retinoblastoma, neuroblastoma, Cooley's anaemia, bone marrow transplant) have been addressed by relocating the young patients to Italy.

Certainly, this sub-project represents merely «a drop in the ocean of their needs». True. But is also true the old Torah's saying: «He who saves one life, saves the whole world».

A particular Issue: gender-based violence (GBV)

GBV is a term used to synthesize any kind of abuse committed by men against two specific categories of people:

1. Women and girls: violence against women is permeating our current society, traversing social classes regardless of their different economic and cultural levels, as it stems from an imbalance of power between genders. It is a gender-based type of hatred, whose aim is to submit, control, and punish women/girls. It is present, less hidden than in the West, in Middle Eastern societies and therefore also among the refugee family units and camps, where a 'natural', undeniable male chauvinism is in force. It includes sexual abuse committed by strangers or more often by a relative/partner, domestic violence, forced child marriage and so on. An extremely vulnerable target is the cluster constituted by women with no man (husband, father, brother, cousin) being him away, dead or missing. This condition deprives the woman of that social acknowledgment granted by the presence of a man, therefore exposing her to exclusion, sexual assaults and exploitation on workplace.
2. Lesbian, gay, bisexual and transgender (LGBT): the violence against these people (likewise, transversally present in any society of the world, in various degrees of visibility) is dictated by the urge to condemn what is seen as a non-adherence to the commonly accepted sexual and gender norms, and is therefore considered as 'abnormal'.

Attached to this category of people is a stigma that can expose to social exclusion and violence; what is more, violence is considered as legitimate, not only at the hand of strangers but even of family members who hold as a dishonour the fact of having such people in their household. It must be actually taken into account that in many countries, even Middle Eastern ones, belonging to this category of people and the behaviour that follows are held as a very serious crime (against nature).

This kind of vulnerability has been one of the targets of our work in the first place and numerous have been the reports we received over time. The protection measures we employed have been various and targeted to the different situations we encountered. For some people these consisted in financial support in order

to allow them to escape a hostile work environment, for others in a change of dwelling, as they were intimidated by neighbours. In some other cases (women with children who were enslaved by their employer, who was also their landlord, or women who asked for help to escape their husbands' death threats, due to the refusal to accept the application for a divorce by their wives, exhausted by years of violence and abuse), the protection measures consisted in real escapes by night towards different cities, where they would quietly wait for their visa to Italy. In all cases, the ultimate aim of our activity is to give people who are subject to different kinds of abuse, the chance to live a life in their own terms and according to their own feelings.

Conclusions

Drawing the conclusions, what is the impact of the Humanitarian Corridors both on the Syrian refugees' life conditions and the European policy on migrations?

Before responding to this question, we must underline once again that our project is run by small Organizations (Christian communities such as the Protestant Churches and the Community of S. Egidio are a real minority in Italy), with limited financial and human resources.

But, despite these limitations, I can state that we are producing important effects.

Firstly, on the lives of the refugees we meet. By bringing them to Italy, we often save their lives preventing them to rely on smugglers in order to cross the Mediterranean Sea. Although being the crucial one, this is not the only positive outcome. By bringing them to Italy, we make it possible for them to have a decent life, to live in a real house, to look for a job, to give their children food and education.

In addition, for people who are not able to come to Italy we can provide some financial aid and, thanks to the Medical Hope project, deal with their health problems.

With regard to the second point, that is, the impact of the Humanitarian Corridors on the European policy on migrations, I can say that our pilot project has achieved important results so far.

- It proved to be a feasible and sustainable project;

- It is replicable both by private and governmental organizations;
- It is submitted to Europe; presently it is under way, run by religious Organizations, in France, Belgium, Andorra);
- It shows that it is possible to rule migration flows in a safe way both for the migrants and for the host country, staying true to those so-called Christian and laic values Europe claims to advocate;
- It reopens channels of legal access, without which the mere idea of halting the pressure coming from the South of the world is unrealistic. After all, those same channels will soon be indispensable if we intend to address the demographic crisis, which is becoming more and more serious in Europe.



Fig. 4 Drawing by Francesco Piobbichi - Humanitarian Corridors, Operator; translation: We showed that sea deaths can be avoided, stop deaths, let's say it to the European Government.

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Contributors

Andreina Bruno

Andreina Bruno, PhD, has been Assistant Professor in Work and Organizational Psychology since 2001, previously in the Catholic University of Sacred Heart, Milan (Italy) and currently in the University of Genova (Italy). She holds a doctoral degree in Psychology. Her main research interests are:

Leadership models in healthcare, Cultural issues in health sciences, Service organizations and Customer orientation, Reflective practice and professional development, Qualitative and participatory methodologies, Action-research in organizations.

Francesco Cardinale

Francesco Cardinale, MD PhD, is a graduate of the University of Genova. He specialized in Hygiene and Preventive Medicine at the University of Genova and in the same University he obtained a doctorate in Epidemiology and Biostatistics. Cardinale has been interested in HTA since 2005 and since 2011 he has been a permanent member, as Head of the Scientific Secretariat, of the Ligurian HTA network, as an expert in systematic reviews, meta-analysis and HTA methodology. Cardinale worked as a researcher at the Oncology Research Institute in Genova dealing with clinical trials and is currently in service at ASL 4 in staff of Medical Director where he deals with the evaluation of innovative technologies. As well as being a lecturer at courses in HTA, he is author of several publications in the HTA field and he has also published numerous articles in the field of oncology and of infectious disease.

Giuseppina Dell'Aversana

Giuseppina Dell'Aversana is a PhD student in Social Science at the University of Genova and Graduate Teaching Assistant in Organizational Psychology. Her main area of interest is Cultural competence in health services, Leadership, and Reflective practices. On cultural competence, she authored the following original articles on peer-reviewed journals: "*Different and similar at the same time. Cultural competence through the lens of healthcare providers*", *Frontiers in Psychology*, 8, 1426, 2017; "*Servizi sanitari culturalmente competenti: prospettive emergenti nel contesto italiano*", *Psicologia della Salute*, 2, 115-13, 2018.

Danilo De Luise

Danilo De Luise is supervisor for services and cultural activities of the Associazione San Marcellino, and a member of the Board of Directors of Fondazione San Marcellino ONLUS. He holds a degree in social work (University of Bologna), is trained in systemic-family mediation and conflict management and transformation (*Nuovo Centro Studi Gregory Bateson*). For a decade, he designed and was the supervisor of the training course called *Operare con le persone senza dimora* (Operate with homeless people), organised by Fondazione San Marcellino ONLUS in cooperation with the University of Bologna.

Emilio Di Maria

Emilio Di Maria (MD, PhD) is a medical geneticist, Assistant Professor at the Department of Health Sciences, University of Genoa, Italy. Within the framework of EU-funded programmes he has been visiting professor at the University of Sousse, Tunisia, and at the Saint Joseph University, Beirut, Lebanon.

His research activity has been mainly focussed on the genetic basis of neurodegenerative disorders and genetic susceptibility to complex diseases, such as psychiatric disorders and dementia; he described novel genetic syndromes. His scientific activity includes health technology assessment, public health genomics and related applications. A major task of his clinical work has been genetic counselling for late-onset genetic disorders, namely neurodegenerative diseases and familial cancer. He received grants by National and International agencies as Principal or Associate Investigator within several research projects.

In the field of migration and health, he is committed to develop actions for migrants' health rights, mainly focussed on the legal issues related with healthcare of immigrants in Italy and on the education of health professionals.

He serves as member of the Working Group for International Cooperation and as Scientific Advisor of the UNESCO Chair on Anthropology of Health, Biosphere and Healing Systems, University of Genoa; he is member of the Steering Committee of the Ligurian HTA Network, elected Chair of the Pharmacogenomics Working Group, Italian Society of Human Genetics (2016-2019), elected member of the National board, Italian Society of Migration Medicine (2016-2020).

Di Maria is the Editor of the book series "Health pathways", Genova University Press, and Associate Editor of the Journal of Alzheimer's Disease. He authored several full-articles on indexed peer-reviewed scientific journals [see <http://orcid.org/0000-0002-8357-2658>] and published *Noi e altri: identità e differenze al con-*

fine tra scienze diverse (Genova University Press, Genova, 2017 – available as open access publication at <http://gup.unige.it/node/160>).

Rita M. Ferrelli

Rita Ferrelli, MD, is a specialist in Public Health. She holds a Master's Degree in Primary Health Care at District Level. She acquired decennial experience in primary health care and public health in Italy and Latin America. Since 1997, she has been working as a researcher at the National Institute of Health of Italy, where she was in charge of health cooperation projects in Africa, Asia, Middle East and Latin America. From 2012 to 2016, she was in charge of the thematic area of Health Equity in EUROsociAL, the European Union Programme for social cohesion in Latin America. Since 2016, she has coordinated the international cooperation working group of REDLACPROMSA, the network of Latin American health promotion managers, involving the Health Promotion General Directions of the Ministries of Health of twelve Latin American countries and the Pan American Health Organization. Since 2018, she has been a member of the Task Force for Health Inequalities Reduction at the National Institute of Health of Italy. She is also collaborating in the Joint Action on Health Equity in Europe, financed by the European Commission (CHAFEA) within the Third Public Health Programme 2014-2020, coordinated by the National Institute of Health of Italy.

Gaddo Flego

Gaddo Flego is a medical practitioner. He graduated in 1989. After a five-year working experience in Africa (Chad and Rwanda), he pursued a specialisation in Public Health at the University of Genova and started a career as Hospital and District manager in the Italian National Health System. He is currently working as Health Services Manager at the International Evangelical Hospital in Genoa; he is the Coordinator of the Liguria Health Technology Assessment Network, and a member of the National Steering Committee on Health Technology Assessment of medical devices.

Daniele Roberto Giacobbe

Daniele Roberto Giacobbe, MD, is a specialist in Tropical Medicine, a PhD Student at the Department of Health Sciences (Dipartimento di Scienze della Salute, DISSAL) of the University of Genova, and the elected national representative for young investigators of the *Società Italiana per la Terapia Antinfettiva* (SITA,

Italian Society for Anti-infective Therapy). His main fields of research are severe infections due to multidrug-resistant Gram-negative bacteria and invasive fungal diseases. Daniele Roberto Giacobbe is author of more than 50 original articles or reviews on peer-reviewed journals, and he has recently received the National Academic Qualification as Associate Professor.

Luciano Griso

Luciano Griso (MD, specialized in Haematology and Psychotherapy) worked at public hospitals, both as internist and haematologist, running haematological services. He taught Internal Medicine and Haematology at the Nurses Hospital School in Pinerolo, Turin. He established in the same Hospital a public Psychosomatic Health Centre. He has been collaborating with NGOs and Humanitarian Organizations and was in charge of the training courses for nurses and health workers in a Health, Educational, Microeconomic Cooperation Project (2004-08) at the "Indian Institute for Mother and Child" in Kolkata (Calcutta). He participated to the reception and health care of migrants at the dock in Lampedusa both with MSF and the Italian Red Cross (2007, 2011). He took part as ship's doctor in the Italian Navy Rescue Mission (Mare Nostrum) in the Mediterranean Sea (2014). Since 2016, he has been participating as medical supervisor to the "Corridoi Umanitari" Mission, a humanitarian project whose task is to bring to Italy in a safe and legal way Syrian refugees living in Lebanon.

Michael G. Marmot

Sir Michael Marmot (MBBS, MPH, PhD, FRCP, FFPHM, FMedSci, FBA) is the Director of the Institute of Health Equity (UCL Department of Epidemiology & Public Health) and Professor of Epidemiology at University College London, and President of the World Medical Association. He is the author of *The Health Gap: the challenge of an unequal world* (Bloomsbury: 2015) and *Status Syndrome: how your place on the social gradient directly affects your health* (Bloomsbury: 2004). Professor Marmot holds the Harvard Lown Professorship for 2014-2017 and is the recipient of the Prince Mahidol Award for Public Health 2015. He has been awarded honorary doctorates from 17 universities. Marmot has led research groups on health inequalities for 40 years. He chairs the Commission on Equity and Health Inequalities in the Americas, set up in 2015 by the World Health Organizations' Pan American Health Organization (PAHO/ WHO). He was Chair of the Commission on Social Determinants of Health (CSDH), which was set

up by the World Health Organization in 2005, and produced the report entitled: '*Closing the Gap in a Generation*' in August 2008. At the request of the British Government, he conducted the Strategic Review of Health Inequalities in England post-2010, which published its report '*Fair Society, Healthy Lives*' in February 2010. This was followed by the *European Review of Social Determinants of Health and the Health Divide*, for WHO Europe in 2014. He chaired the Breast Screening Review for the NHS National Cancer Action Team and was a member of *The Lancet* - University of Oslo Commission on Global Governance for Health. He set up and led a number of longitudinal cohort studies on the social gradient in health in the UCL Department of Epidemiology & Public Health (where he was head of department for 25 years): the Whitehall II Studies of British Civil Servants, investigating explanations for the striking inverse social gradient in morbidity and mortality; the English Longitudinal Study of Ageing (ELSA), and several international research efforts on the social determinants of health. He served as President of the British Medical Association (BMA) in 2010-2011, and is President of the British Lung Foundation. He is an Honorary Fellow of the American College of Epidemiology; a Fellow of the Academy of Medical Sciences; an Honorary Fellow of the British Academy, and an Honorary Fellow of the Faculty of Public Health of the Royal College of Physicians. He was a member of the Royal Commission on Environmental Pollution for six years and in 2000 he was knighted by Her Majesty The Queen, for services to epidemiology and the understanding of health inequalities. Professor Marmot is a Member of the National Academy of Medicine.

Grammenos Mastrojeni

Grammenos Mastrojeni is a diplomat, an International Environment Policy Specialist and, since 2014, the Coordinator for Environment and Science at the Italian Development Cooperation, Italian Ministry of Foreign Affairs. Mastrojeni is also Coordinator of a team of specialists, and of the environmental science-policy-finance interface, in charge of ensuring environmental coherence in all Italian development aid programs, while directly supervising and planning environmental aid programs and financing, for a yearly value of more than 200 million of Euros. Among the achievements of the interface there are: the adoption of a new comprehensive set of indexes to integrate biodiversity in social progress and the launch of a new line of aid programs integrating environment, security and migrations. Mastrojeni is the Vice Chair of the Mountain Partnership

Steering Committee, the Coordinator of the National Focal Point for Land Degradation, Mountains, and Global Islands Partnership, the Head of the Italian Delegation to UNCCD negotiations, elected EU/WEOG Representative in UNCCD CoP Bureau, Vice President and General Rapporteur of UNCCD CoP (Mandate, October 2015-October 2017). He is also a Member of the Delegations to UNFCCC, UNCBD and other environment-related European and multilateral processes (among them: United Nations Environment Assembly, OECD Environet, World Bank Safeguards, ECOSOC High Level Political Forum, UN Samoa Pathway for SIDS, EU WPEI); a Member of the national Emissions Trading Commission, of the Advisory Committee of the International Yearbook of Soil Law and Policy, of the Board of the MA in Development at the Institute of Technology (Politecnico) in Milan, of the Scientific Council of the Master in Sustainable Development at LUMSA Pontifical University (where he is also Professor of Social and Environmental Sustainability), of the Consultative Board of Ashoka Italy, of the Steering Committee of UNCCD Global Land Outlook and of the board and reviewer of the Journal of Development and University Cooperation. Mastrojeni is a Lecturer and Professor of Environment and Geostrategy at several institutions, think-tanks, and Universities and a Scientific Advisor for the Environment at the University Centre for International Solidarity of the Catholic University, Milan.

He has published extensively (also within official organizations) on the subject of human impacts of environmental degradation. He is the author of the following books: *Il negoziato e la conclusione degli accordi internazionali* (CEDAM, 2000); *Il ciclo indissolubile - Pace, ambiente, sviluppo e libertà nell'equilibrio globale* (V&P/Catholic University Press, 2002); *Il nostro turno: il semestre italiano di presidenza dell'Unione Europea* (Ministero degli Affari Esteri, 2003); *L'ecorivoluzione necessaria* (Edizioni Scientifiche Italiane, 2008); *L'Arca di Noè – Per salvarci tutti insieme* (Chiarelettere, 2014).

Mara Morelli

Mara Morelli worked as a freelance conference interpreter since 1991 until 2003. She holds a PhD in Translation and Interpreting from the University of Granada where she presented a dissertation on a study of ambiguity in simultaneous interpreting and sight translation from Spanish into Italian focussing on the concept of strategy. At the moment, she is a researcher at the Department of Education Sciences (University of Genova). She is currently carrying out research in both

domains of interpreting and mediation, in particular with an on-field project on multilingual communication, interpreting and mediation in healthcare, courts and prisons.

Francisco Raga Gimeno

Francisco Raga Gimeno holds a PhD in Hispanic Philology from the University of Valencia, and is Senior Lecturer in the Department of Translation and Communication at the Jaume I University in Castellón. He is the director of the CRIT Group, which has focused its research in intercultural communication, and, in the last few years, on how to teach — intercultural and linguistic mediation applied to the healthcare sector. He is the author of the book *Comunicación y cultura. Propuestas para el análisis transcultural de las interacciones comunicativas cara a cara*, (2005) and the coauthor, together with the members of the CRIT Group, of the book *La práctica de la mediación interlingüística e intercultural en el ámbito sanitario* (2014).

Santino Severoni

Dr Santino Severoni is Coordinator for the Public Health and Migration and Area Programme Manager, Division of Policy and Governance for Health and Well-being at the WHO Regional Office for Europe. Since 2000, he has held senior positions at the World Health Organization European Office. He is a medical doctor, health economist, epidemiologist, and experienced system manager. He has over 24 years of experience as international senior technical advisor and executive, and has worked for governments, multilateral organizations, NGOs and foundations in Eastern Africa, Balkans, Central Asia, and Europe. During his professional career he has dedicated his work to global health with a particular focus on health sector reforms, health system strengthening, health diplomacy, aid coordination/effectiveness, and management of complex emergencies. In 2010 he moved to the WHO Regional Office for EURO in Copenhagen as the Regional Adviser on Strategic Relations with Countries. In 2011, due to the crises in Northern Africa and the massive migration phenomenon to South Europe, he was appointed as Regional Director's Special Representative for Health and Migration. Since 2013, he has coordinated the Public Health and Migration programme in the WHO Regional Office for Europe, Division of Policy and Governance for Health and Well-being.

Dr Severoni has written many scientific articles, book chapters, has given

interviews and participated to various TV and radio Broadcasts related to the Public Health aspect of migration both in Italian and international networks.

interviews and participated to various TV and Radio Broadcasts related to Public Health aspect of migration both in Italian and International networks.

Claudio Viscoli

Claudio Viscoli is an expert in the field of infectious diseases in children and adults with special expertise in infections in compromised hosts, fungal infections, infections in cancer and neutropenia, infections in liver transplant recipients, opportunistic infections in HIV, and HIV vertical transmission. Since 2005, he is Director of the Infectious Diseases Unit at the Policlinico San Martino in Genoa, Professor of Infectious Diseases at the University of Genova and Coordinator of the Post-Graduate School of Infectious Diseases of the University of Genova. His main activities are teaching, patient care and clinical research. Claudio Viscoli is President of SITA (*Società Italiana per la Terapia Antinfettiva*, Italian Society for Anti-infective Therapy) and ISGRI (Italian Study Group on Resistant Infections). In 2018, he received the “Excellence award” by the European Society of Clinical Microbiology and Infectious Diseases (ESCMID). The award recognizes and rewards an outstanding lifetime contribution in the areas of science, education or professional affairs in infectious diseases. Prof. Claudio Viscoli is author of more than 400 original articles or reviews on peer-reviewed journals and twenty-one chapters in international manuals on infectious diseases, including the last four editions of the *Mandell Textbook*.

Acknowledgments

I am indebted with the colleagues who participated in the design and organisation of the workshop from which this volume has stemmed. The contribution of the anonymous reviewers is gratefully acknowledged. My gratitude also to Dr. Nora Gattiglia for the invaluable contribution in the editing process and to Dr. Martina Maggi for technical assistance and priceless patience.

Cover: Bruce Clarke

Visual artist, Bruce Clarke was born in London in 1959 and is now based in Paris. He was initiated to the Art and Language movement at the Fine Arts School at Leeds University. Now, deeply anchored in a school of critical figuration, his artistic research integrates codes to use them to criticize and demystify structures of power and injustice. Exhibiting widely, he is also author of memorial works for the victims of the Tutsi genocide in Rwanda.

Health Pathways

Published volumes

1. *Health right across the Mediterranean – tackling inequalities and building capacities*, edited by Emilio Di Maria, 2019 (ISBN printed version: 978-88-94943-50-4; ISBN e-book: 978-88-94943-51-1).

Emilio Di Maria (MD, PhD) is a medical geneticist at the Department of Health Sciences, University of Genoa, Italy; visiting professor in Universities in North Africa and Middle East. His work in medical genetics has been regularly integrated with the implications of public health and technology transfer. Since the early 1990s he has been involved in a network of organisations committed to ensure health right and healthcare for migrant persons.

The Mediterranean has been – and is, to date – a battlefield for hope and despair, solidarity and segregation, knowledge and prejudice. The differences in ancestry, culture and heritage brought by the stream of refugees from Africa and Middle East, far from being sources of growth, are cause of conflict. While the principle of health right is repeatedly stated, the presence of striking inequalities in health status, healthcare and health promotion is dramatically apparent. This co-operative volume is based on a workshop which was focussed on one key question: what are the key actions to tackle health inequalities and improve health for people living on or moving across the Mediterranean?

The current situation regarding health and healthcare in the Mediterranean area was explored by applying the lenses of global health and public health. By the mean of a multidisciplinary discussion, the respective responsibilities for national and international agencies emerged, along with the role for lay organisations, decision makers and citizens.

Cover: Bruce Clarke ©

Sea Ghosts is an itinerant exhibition project paying tribute to migrants, victims of trans-Mediterranean human trafficking.

“I don’t judge the reasons that push so many to migrate; somebody who flees risking so much, everything, is doing so for valid reasons. Can we not refocus the debate in terms of humanity to defend the necessity of giving succour to a person in distress? We want to place the public visiting the exhibits in the positions of witnesses. To say: «yes, now I know that ghosts exist»”.

ISBN: 978-88-94943-51-1



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