

# one planet, one health, one world !



Educating, learning, succeeding together

## COOPERATIVE APPROACHES #5

“The only way that offers any hope of a better future for all humanity is through cooperation and partnership”. Kofi Annan

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**EDITORIAL**

# The Four Truths

Dominique B nard

The coronavirus pandemic reminds us of four truths:

## **1. We only have one planet**

Most scientists have been saying this over and over for decades. We are depleting the planet's resources and yet we only have one. The adverse effects we produce somewhere have repercussions everywhere. Yet many governments continue to act as if we live on separate planets. The United Nations is failing to build a consensus of national governments to collectively manage the climate crisis. It is still being treated with homeopathic doses, even though its consequences are well documented by countless institutions.

## **2. Human health, animal health and the health of ecosystems are closely linked**

The One Health initiative was launched in the early 2000s, and

at the time no one thought it was predictive. The initiative aimed to promote an integrated, systemic and unified approach to public, animal and ecosystem health. It noted that 60% of infectious diseases that affect humans are of animal origin and that at least 70% of serious emerging diseases that have appeared over the past century are zoonotic diseases (from animals to humans) that are facilitated by ecological and/or climatic imbalances. One Health advocated, among other things, the development of joint educational efforts among schools of human medicine, veterinary medicine, public health and training in ecology and the environment; the organisation of surveillance and epidemiological control of pathogens with "inter-species" transmission; shared efforts for a better understanding of the phenomenon of interspecies transmission through comparative medicine; the development and evaluation of new methods and tools for

diagnosing and measuring the effectiveness of medicines and vaccines to prevent and control diseases that pass from one species to another; and joint efforts to inform, train and raise political leaders' awareness. It would appear that at least the latter objective has not been achieved.

### **3. Global governance is needed**

The challenges we face cannot be solved at the level of nations. Even very large countries do not have the means to solve the environmental, economic and security problems in which the world has been mired for years. National solutions cannot regulate the global market, tax evasion, overexploitation of natural resources, conflicts, or poverty. And yet obtuse governments claim to be returning to the solutions of the 19th century.

### **4. We know how to react, but we are incapable of anticipating...**

The coronavirus crisis has highlighted our collective inability to anticipate. Alerts have been raised for decades, both for the climate crisis and for zoonotic diseases, but most politicians are

short-sighted and content to react to events. We have waited, here and elsewhere, for the virus to cross borders before starting to respond to the situation.

Suddenly, thousands of billions of dollars are being spent to fight Covid-19 and its consequences; a few months ago, it was hard to find a few to solve the ecological crisis. No doubt we are waiting for the first major disasters of global warming to occur.

This is humanity's misfortune: it reacts only in the face of tangible and immediate danger. It knows how to be reactive, it does not yet know how to be proactive. The current crisis should make everyone understand that only through international cooperation can we face global challenges and find solutions for the future. We need to build global governance capable of implementing a long-term strategy to safeguard life on our planet.

### **A diversity of views**

In this issue, from a variety of perspectives, we have tried to analyze how cooperative and solidarity-based approaches can help us to develop new solutions:

- Dominique Solazzi, a doctor in Vienne, France, tells the story of his efforts to create a local

- community of health actors at the outset of the pandemic;
- David Bull tells us how the United Kingdom has reacted, as usual, with calm and determination;
  - The saluteglobal.it team, with Carlo Cerini, Benederra Armocida and Beatrice Formenti, present their initiative to promote the right to health for all; they bring us information on Covid-19 in Africa;
  - Faride Boureima Karimou, a blogger from Niger, reports on initiatives taken by young people to fight the pandemic;
  - Hector Carrer explains how Argentina is reacting and preparing to face the economic consequences of the crisis;
  - Biorn Maybury-Lewis provides an enlightening political analysis of the situation in the United States, without a doubt the example not to be followed if we want to limit health-related and economic damage from the pandemic;
  - I have analysed the conditions that would enable the cooperative movement to make a decisive contribution in the health field;
  - Michel Seyrat gives us a new episode in the "Solexos" series illustrating the role played by young people in making containment more humane;
  - Finally, Eduardo Missoni, a doctor and teacher in global medicine, gives us an account of his experience and his vision of the pandemic.



Photo Ivan Samkov, Pexels

## STORY

# Local health actors facing the Covid-19 challenge

Dominique Solazzi



Vienne

Vienne is a small town of 30'000 inhabitants located in the Isère region, very far from the prefecture it belongs to, Grenoble, but very close to the metropolis of Lyon, its big neighbour. It does most of its trade with it, but it does not depend on it. This geographical position gives it resources to develop original local experiences.

## Health professionals are looking to establish partnerships

In the field of healthcare, four establishments are based here: the public hospital, the *Centre Hospitalier Lucien Hussel*, at the top of the hill; a private clinic, the *Clinique Trénel*, on the other bank of the river, in the Rhône department;

Calydial, a private establishment dedicated to kidney health and particularly dialysis, which uses a hospital building. And the latest addition is ESMPI (*Établissement de Santé Mentale des Portes de l'Isère*), a private law establishment that has been managing all psychiatric services since 2017.

In 1981 the doctors of Vienne, both hospital doctors and private practitioners, came together to found an association for continuing medical training: RMC Vienne, the "Medico-Surgical Meetings of Vienna", with the aim of providing themselves with ongoing training locally. In the years that followed, this association organised multiple training experiences to meet a constant demand for participatory pedagogy and conviviality.

At the same time, another association of general practitioners, the AMGVE (the Medical Association of Vienna and the Surrounding Areas) set itself the goal of organising general practitioners' on-call duty.

There has also been a geriatric care network for the most vulnerable elderly since the early 2000s: the VISAGE network. It brings together independent healthcare professionals and the health institutions that care for them to streamline their care provision.

Over the last ten years or so, these traditional cooperative organisations have struggled to function optimally, due to the lack of "activists" able to provide support, generally on a voluntary basis. There are many reasons for this: a more individualistic society, more oriented towards personal comfort, zapping between multiple commitments... and also, undoubtedly, the growing desire of many doctors to no longer make their professional commitment the unique focus of their lives. The low participation at training evenings, attended by only the most senior members of the profession, bore witness to this.

Thus, they had to evolve and reinvent themselves.

In 2012, RMC Vienne will launch inter-professional meetings and two training evenings per year for hospital doctors and city doctors. In 2014, it opted to become multi-professional for good and changed its name and statutes: RMC Vienne became "Medical Meetings and Multi-Professional Concertation of Vienne". Since then it has experienced very fruitful exchanges between professionals from different cultures, going beyond the challenges involved in aligning diverse points of view. In 2018, it will open up even more by associating itself with providers from



Dominique Solazzi

the medico-social sector and health users by co-organizing the 1st Vienne Health Day with them.

The AMGVE is promoting the principle of having general practitioners on duty alongside the emergency service, which makes it possible to pool resources and encourage cooperation between the two systems.

Public authorities' scepticism of "care networks", which have gone out of fashion, is pushing Visage to reposition itself by developing expertise in caring for patients with multiple pathologies, whether elderly or not. To do this, it is relying on the new regional tools for the secure sharing of health data, currently under development.

## A new project: CPTS

At the beginning of 2019, RMC Vienne will reflect on a new way of organising care proposed by the public authorities: the CPTS. An acronym that stands for "*Communauté Professionnelle Territoriale de Santé*". An administrative "thing" very similar to a gas-works, but also supported by providers in the field, activists grouped into a federation at national level, the Federation of Healthcare Centres and Clusters. It brings together structures that have recently appeared on the healthcare scene, the "*Maisons de Santé Pluriprofessionnelles*", which bring together all the health professionals in a neighbourhood or small town to work together on common projects.

The various CPTS apply the same principle to a larger area.

This federation defines what a CPTS is as follows: "It is the community of all healthcare, social and medico-social providers, around a global approach to health, for and with the inhabitants of the territory".

This definition corresponded well to what we were putting in place, and we decided to embark on the adventure of creating a CPTS, by once more adapting our associative structure. But such an adventure requires time and energy, and it proved difficult to progress quickly. It is necessary to go and meet the different providers to convince them, to overcome the force of inertia and reticence in the face of the complexity of the process and the fear of losing one's entitlements.

## **Covid-19 hits!**

And then, on Thursday, March 12, 2020, the President of the Republic announced that we were at war. A few days later, his Chief General, the Prime Minister, decreed widespread containment to limit the epidemic caused by a new virus which had appeared in China a few months earlier, responsible for an emerging disease called Covid-19.

The following week brought, for me, the closure of the adolescent

services where I work for half the week, and the introduction of new reception arrangements at the doctor's office, with the help of a former replacement staff member who spontaneously came to support me and who had already been confronted with a considerable number of cases in the Lyon region.

## **A collective organization takes shape**

A strange call to arms was issued to cope with the arrival of the announced wave that was likely to sweep everything away in the following days, just like what was happening in the Grand Est region... On Tuesday, RMC Vienne was contacted by the clinic's specialists to inform general practitioners of their new organisation of care, with all non-urgent operations being postponed and operating theatres being transformed into intensive care units "just in case". The Health Insurance Agency made telephone calls to doctors to identify those who agreed to treat patients suffering from Covid in the absence of an attending physician; e-mail exchanges multiplied among the AMGVE doctors to discuss the clinical situations encountered, where previous discussions had only concerned duty changes. Animated discussions took place in physician groups on social networks.

The risk of the disease worsening after a few days of evolution became apparent very quickly. General practitioners rapidly tried out solutions to continue monitoring patients remotely, by telephone, using Excel files and by adjusting the severity criteria to be taken into account on a daily basis.

I got in touch with a surgeon who had launched a Facebook group in another part of the Isère region to bring all the involved providers together. He convinced me that we urgently needed to rethink our organization ... and that it was worth launching a similar group, which very quickly brought together 120 professionals.

## **RMC Vienne takes the initiative**

On Monday March 23, together with RMC Vienne, we called a meeting among all the local providers involved in fighting the epidemic: the emergency doctor coordinating the system, the hospital infectious disease specialist, a general practitioner volunteering to get involved, the president of the AMGVE and the heads of the (Face Network). It was this small group of people, born out of improvisation, who then coordinated the operations.

It set up a "Covid Centre" able to host, in a secure place – a large auditorium provided by the Town Hall – patients suspected of having the disease, and of triaging those to be hospitalised from the others. It was quite naturally the AMGVE that took care of this.

It also set up a remote monitoring system for patients with Covid-19, the Covid-Suivi-Vienne, with the help of an application developed by a start-up in the region, Covidom, to which the Hospital Centre had given its approval. The Visage network made available its resources, its telephone platform and its expertise in managing complex situations.

## **Has the crisis been overcome?**

...Nearly two months later, deconfinement is beginning and we have been fortunate here to have been somewhat spared by the wave. The Covid Centre has closed its doors and has gone on standby, the Covid-Suivi-Vienne continues to accompany a dozen patients remotely and remains open just in case.

On Monday, May 18, a new meeting of the coordination unit and the biologists is planned, to implement the new strategy determined at national level: identifying new patients and testing all contact cases.

We have been relatively spared here, but there is a great risk that, once fear has subsided and the common enemy departed, the old reflexes of each one for him-/herself will regain the upper hand. Already there are signs indicating this. No more news from the clinic or the hospital, despite what had been announced to us, means that we are only marginally involved in organizing "crisis exit" care: the coordination of healthcare pathways is still a long way off.

## Relaunch of the CPTS project

But the world after Covid is not yet a return the world as it was before, and this unprecedented experience may be an opportunity for faster change. At the end of April, RMC Vienne thus decided to speed up the creation of the CPTS, building on the new dynamics of exchange and cooperation born during the crisis. We are no longer "just a few activists", we have identified new people who want to get involved and make a real "Community" of healthcare providers: it is time to act.

## A unifying event

We have also decided to maintain, whatever the cost, the event invented two years ago - the Vienne Health Days.

The first edition took place in November 2018, with the aim of promoting the plethora of healthcare services on offer HERE, without necessarily calling upon the services offered in Lyon, our big neighbour. All healthcare institutions had played the game, as had specialist doctors, non-medical healthcare professionals, EHPADs, listening devices for teenagers... as well as associations such as Handi-Vienne, which offers disabled people the opportunity to participate in sports. The event had



been greatly appreciated, the healthcare professionals had really enjoyed exchanging with each other and meeting users in a way other than in a care relationship.

The second edition was under preparation when the epidemic broke out and we decided, on May 14, to proceed with it. With an adapted programme, necessarily centred on the epidemic, still present or still close. More precisely, on the solutions that it will have generated, on its positive impact for the local community of healthcare providers: the new responsibilities of citizens for their own health and that of others; the existing resources

to get through the crisis together as serenely as possible (what kind of well-being can we expect as we emerge from the crisis?); the growing multi-professionality, the emerging partnerships... The CPTS, a new cooperative health organization at the service of all its actors, is perhaps in the process of being born.





Photo Anna Shvets, Pexels

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**COVID-19 POSTCARDS**

# United Kingdom: Meeting the Challenge

David Bull



*David Bull sits on the boards of trustees for a number of charities in the United Kingdom and is an elected member of the council of governors of a National Health Service provider in north-west England. He is Vice Chair of Cheshire West Voluntary Action and has been a lifelong volunteer with the Scout Movement. He is also a member of the UK Labour Party.*

## Introduction

At the time of writing this article, it is barely a month since the UK government, in common with the rest of the world, announced measures to meet the urgent challenge presented by the coronavirus pandemic. In the UK, the initial response was based on the existing emergency plan for dealing with emergencies such as the current one. The underlying expectation in the plan was that, after a number of infections – and of course deaths – the overall level of immunity would rise in the general population without the need for heavy restrictions on the activities of citizens.

Accompanying the run-up to the crisis, there was the sorry sight of members of the public panic buying food and other items – including toilet paper, for some reason. As in other countries, that has largely stopped now, and supplies are readily available.

The government's initial approach was soon shown to be obviously wrong and on 16 March, they announced strict measures which applied to all except essential workers:

- Stay at home
- Only go outside for food, health reasons or work (but only if you cannot work from home)
- If you go out, stay two metres away from other people at all times. Wash your hands as soon as you get home
- Do not meet others, even friends or family.

The police have temporary powers to enforce the restrictions and to levy a fine of EUR 70 (it doubles each time for repeat convictions).

Anyone with Covid-19 symptoms or who is in a household where someone has symptoms should not go to work and should self-isolate. There are special arrangements for older people or those with significant medical or health needs.

As in other countries, restaurants and hotels, cinemas and theatres and other public buildings, including schools, have closed. Meetings of more than two people from the same household are banned. Many businesses and other operations are unable to trade and

the problems, both now and after the pandemic has passed, are obvious.

Although schools and other educational establishments are closed, key workers (health and social care etc.) still have access to schools for their children.

The restrictions on society have of course impacted just as hard, if not harder, on voluntary and community organisations as on businesses. Many of them have little in the way of financial reserves to help them through the shutdown in activities.

## **National support for the voluntary sector during the crisis**

Nationally, the government has provided a EUR 860 million support package for charities during the coronavirus outbreak. A problem is that it can be said that there is a power imbalance: some larger charities could use their privileged relationships to engage with government departments, whilst smaller ones, with fewer contacts in the right places, could be left behind. The problem could be made worse in the case of groups that are entirely volunteer led. Some representatives of the voluntary sector are calling for more transparency from both government



and the voluntary sector on how the funding is allocated.

For businesses (including charities) with paid staff, the government has set up the Coronavirus Job Retention Scheme, to cover 80 per cent of salaries of staff who have to be temporarily stood down because of the shut-down.

Voluntary sector organisations which provide mental-health services in communities across the country have access to a EUR 6 million fund to help meet some of the initial costs.

New announcements on support for business and voluntary work continue to be made, including for example on improving some of the

tax privileges for charities.

Announcements are often made without much public debate – calls for an effective public debate continue to be made.

A national call for volunteers to help the National Health Service has resulted in an unprecedented response – recruitment had to be pause whilst the first 750,000 were processed.

## Local support

Municipalities and organisations are working together to help meet the needs of their localities. This involves providing funding (typically EUR 150,000 per 100,000 of population) to help meet the needs of people especially at risk during

the crisis. More importantly, this support extends, for example, to maintaining records of new volunteers who have come forward and linking them with suitable places to volunteer. About two per cent of the population of towns and cities seem to have offered to volunteer during the crisis

Where the local community and voluntary sector have good links with the municipality, recruiting volunteers has been much more successful. This is usually achieved by the work of an effective organisation representing the common interests of voluntary and community organisations and providing regular support for them. An advocate that organisations can trust is essential.

Use of video conferencing by voluntary groups is of course increasing. Support for this from tech companies is often offered – although there are plenty who are only too glad to charge a high fee! Community groups working together can achieve a lot in this area, at little or no cost.

## Personal action

Captain Tom Moore, a veteran of the British Army celebrated his 100th birthday in April. He initially set out to raise GBP 1,000 for National Health Service charities by walking a



hundred 25-metre laps of his garden, completing 10 laps a day. Since his plans went viral, his project has raised more than EUR 29 million. An amazing response!

On a different level, every Thursday evening at 8.00 pm, largely as a result of organisation on social media, many members of the public across the country step outside their homes to take part in the clap for carers and applaud the vital work done by health and care workers and other essential services.

Social media generally has been a helpful way of sharing perceptions of the pandemic, despite the inevitable small group of mean-spirited people who use the system to abuse others and spread vicious rumours.

Local groups such as residents' and tenants' groups have been active in recruiting volunteers to help with basic shopping, delivering medication and so on. And it goes without saying that a key action in

response to the issues raised during the current crisis is to be a good neighbour and to show kindness to others. Supporting those most in need, whether it is helping a local community initiative or with friends and families, is vital now and will remain so over the coming weeks and months.

## Learning the lessons

When faced by the crisis, many people have acted in a tolerant and compassionate way with concern for others and empathy with those in need. This is despite the political currents in the UK and elsewhere



which reflect a more populist, neo-liberal, even hostile view of the world.

The government in the UK has developed action quickly - not always doing as much as some of us would wish but going in the right

direction. A concern when facing a crisis is that steps can be taken that threaten human rights. For example, during the pandemic, it is easier for someone to be taken into a mental hospital against their will than under the normal law. There must be strict scrutiny of all such issues, and we must return to normal as quickly as possible.

The contingency plan to deal with a pandemic was not suitable for dealing with the coronavirus threat and the plan needs to be reviewed for the future.

Looking to the recovery from the inevitable down-turn in the economy, appropriate economic and other measures need to be taken, bearing in mind that since the banking crisis of 2008, public resources have been cut to dangerously low levels.

But the response from the public at large has been heartening and we need to make sure that the simple kindness shown by so many people to others is not just a single response to extraordinary circumstances but remains as a constant thread though people's attitudes. This needs to be reflected in public policy and the overall approaches of government and society at large.



Photo Gustavo Fring, Pexels

## COVID-19 POSTCARDS

# The pandemic in Africa

Benedetta Armocida et Carlo Cerini<sup>1</sup>



In Africa, Covid-19 is currently affecting 53 countries and there are 56,973 cases, with 2,124 deaths recorded and 19,119 hospitalizations<sup>2</sup>.

As the Covid-19 pandemic progresses, uncertainties are

increasing for African countries and predicting possible developments is complex<sup>3</sup>. It should be noted that many factors in African countries could influence the progression of the pandemic, such as the approximately 9.4 million HIV-

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<sup>1</sup> Both authors are members of [saluteglobale.it](http://saluteglobale.it)

<sup>2</sup> "Coronavirus (COVID-19) - WHO African Region - World Health ...." <https://www.afro.who.int/health-topics/coronavirus-covid-19>. Accessed 13 May. 2020.

<sup>3</sup> "Covid-19 in Africa - SaluteInternazionale." 25 Mar. 2020, <https://www.saluteinternazionale.info/2020/03/covid-19-in-africa/>. Accessed 13 May. 2020.

positive Africans who are not receiving antiretroviral treatment<sup>4</sup>, the approximately 60 million chronically malnourished children and the many humanitarian contexts of conflict and social tensions. In addition, given that 43 per cent of Africa's population lives in urban areas and about half of the urban population lives in unhealthy and overcrowded suburbs with insufficient access to running water and latrines<sup>5</sup>, social distancing and good hygiene practices are impossible. To this can be added the fragility of healthcare facilities, the difficulty of access to care and the severe shortage of beds in intensive care<sup>6</sup>.

In spite of this, African countries have also developed and supported cooperative responses that have evolved in the most diverse contexts, united by a strong need for a sense of community. Mozambique is one of the many African countries that

are experiencing the Covid-19 pandemic oscillating between fear and misunderstanding, faced with a fragile healthcare system and ineffective political strategies. This is where the strength and solidarity of individuals and the community in facing the epidemic's challenges together are clearly demonstrated.

Forty years ago, the eradication of smallpox marked the success of decades of international cooperation in the fight against this epidemic disease. "Now, more than ever, we need the same solidarity, strong cooperation and unity to overcome Covid 19," said World Health Organization Director-General Tedros Adhanom Ghebreyesus.<sup>7</sup>

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<sup>4</sup> "Africa: 2018 Global Nutrition Report Reveals ... - allAfrica.com." 29 Nov. 2018, <https://allafrica.com/stories/201811300144.html>. Accessed 13 May. 2020.

<sup>5</sup> "World Urbanization Prospects 2018 ...." <https://population.un.org/wup/>. Accessed 13 May. 2020.

<sup>6</sup> "Assessment of the current capacity of intensive care units in ...." <https://www.sciencedirect.com/science/article/pii/S0883944119310597>. Accessed 13 May. 2020.

<sup>7</sup> "Oms, contro Covid-19 solidarietà globale - Ultima Ora - ANSA.it." [https://www.ansa.it/sito/notizie/topnews/2020/05/08/oms-contro-covid-19-solidarieta-globale\\_cd74f6d5-6d92-49bc-b01d-cca0355dfc01.html](https://www.ansa.it/sito/notizie/topnews/2020/05/08/oms-contro-covid-19-solidarieta-globale_cd74f6d5-6d92-49bc-b01d-cca0355dfc01.html). Accessed 13 May. 2020.

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**COVID-19 POSTCARDS**

# Mozambique: the lockdown challenge

Carlo Cerini

Faced with a few officially notified cases, we have seen measures that are weakly restrictive, but they are having a significant impact on a population for whom daily movement and contact with people are the only forms of subsistence.



Paradoxically, the healthcare system is the one that has most restricted preventive measures, limiting access to health services and inviting people to visit health centres and hospitals only "when strictly necessary" and "not in the event of suspected Covid-19".

Mobile clinics, which provide essential healthcare services to communities in particularly

inaccessible places or remote from population centres, were suspended in early April by the Ministry of Health as a way of preventing gatherings. The immediate consequence has been that hundreds of children have been made much less likely to receive immunization or treatment for malaria, and hundreds of women have been made less likely to receive an antenatal visit. Perhaps many of them will be able to go to health centres to receive these services, perhaps not.

Among the suspended services is the distribution of antiretroviral drugs for HIV-positive people. In Morrumbene district, the district health services have decided to challenge current ministerial restrictions and continue to address the needs of this large rural population by designing an alternative strategy.

Thanks also to the cooperation between the NGO Medicus Mundi



Italy and the district health authorities, a team of a few healthcare technicians, equipped with the necessary personal protective equipment and a dedicated car, continues to reach three densely populated rural communities every month to offer vaccinations and treatment against HIV and tuberculosis to avoid dangerous interruptions in treatment.

Thanks to collaboration with community activists, known as Multipurpose Elemental Agents (MEAs), it has been possible to raise awareness of the need to respect social distancing measures even during visits, while continuing to offer services with a reduced risk of infection.

Despite the initial challenges, nearly 200 patients continue to benefit

from this service today. This is an example of how locally implemented cooperation can best understand and act to meet the needs in its own context.

## COVID-19 POSTCARDS

# Three young creatives in Niger

Faride Boureima Karimou

<https://faridebio.blogpost.com/>



FROM LEFT TO RIGHT : IBOU LÉLÉ, HAOUA OUMAROU MOUSSA ET ALTHESS

The announcement of the first case of coronavirus in Niger was made by the Nigerien health authorities on March 19, 2020. This disease first appeared in the Chinese city of Wuhan in December 2019 and rapidly evolved into a global pandemic.

Faced with this situation, several measures have been taken at both national and international levels, ranging from containment to the total halt of regional and intercontinental movements of people.

The youth of Niger has not stood on the sidelines in this struggle against Covid-19. Several actions have been carried out and continue to be

carried out with a view to raising awareness among the general public. Artists (musicians, comedians, etc.), youth associations of all kinds and young entrepreneurs are taking action to combat Covid-19.

### **Ibou Lélé, the humorist**

Nigerien humorist Ibou Lélé draws a



parallel between HIV AIDS and the new coronavirus in one of his videos to draw people's attention to the seriousness of the situation. This comparison is not incidental, he confided to us: "Everyone knows how serious AIDS is, and no one wants it. It's a disease that people fear, but at least when you have AIDS you can live for years, whereas with coronavirus you can die in a few weeks".

He added, "Although AIDS is a dangerous disease, the coronavirus is more dangerous because of the way it is transmitted. We must respect preventive measures".

### **Haoua Omarou Moussa, the entrepreneur**

Haoua Omarou Moussa, a young Nigerien woman studying at the African Development University (ADU) belongs to this new generation of young people with an entrepreneurial bent. One of the measures against Covid-19 is regular hand washing to limit the spread of the disease.

A handwashing device uses the lower limbs (feet) to avoid contaminating the tap by touch, explains Haoua:

"When someone is contaminated, he comes, touches the tap, washes his hands and touches the tap again to turn it off; 1. He has cleaned his hands for nothing; 2. If I, who am not



contaminated, come after him and turn the tap on to wash my hands before entering the shop and turn it off again, I will be contaminated".

### **Althess Slameur, the storyteller**



It is in a verse-rich freestyle that Althess Slameur narrates the misdeeds of the coronavirus, its arrival, the consequences and the modes of transmission, while recalling the Muslim religion's instructions in the event of a pandemic such as that of Covid-19. His oral and written expression and the texts referred to in this performance explain which protective gestures should be adopted in the face of Covid-19.

Youth is the key lever of development in all the countries of the world and Niger's youth will be our homeland's pride.

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**COVID-19 POSTCARDS**

# Cooperation and solidarity in Italy

Beatrice Formenti, Benedetta Armocida, Debora Zucca, Andrea Casale,  
Marta Lettieri<sup>8</sup>



Italy was the first country in the Western world to face the heavy burden of the 2019 coronavirus pandemic (Covid-19).

Since February 21, 2020, when the first case of Covid-19 was reported

in Italy, Italy has been under increasing pressure, with a total of 222,104 cases and 31,106 deaths (as of May 13, 2020)<sup>9</sup>.

To deal with the continuing contagion, on March 11, 2020, the

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<sup>8</sup> The authors are members of [saluteglobale.it](http://saluteglobale.it)

<sup>9</sup> "Monitoraggio 12 maggio 2020.xlsx - Ministero della Salute." 12 May. 2020, [http://www.salute.gov.it/imgs/C\\_17\\_notizie\\_4736\\_0\\_file.pdf](http://www.salute.gov.it/imgs/C_17_notizie_4736_0_file.pdf). Accessed 13 May. 2020.

Italian government adopted strategic measures unprecedented in the history of the European Union, by approving the decree known as "#IoRestoCasa"<sup>10</sup>.

In order to further contain the transmission of the virus, extensive containment measures were taken throughout the country, banning travel – except for legitimate and/or urgent reasons – and closing schools, places of entertainment, commercial and retail activities, with the exception of food shops, basic necessities and pharmacies.

Suddenly, on top of the fear for individuals' and the community's health, one in three workers<sup>11</sup> was confined to their homes and more than 3.7 million children and adolescents<sup>12</sup> were put on a distance learning programme.

It is said that "necessity makes virtue", and families, work and community realities have had to reinvent themselves to try not to lose this so banal yet so beautiful daily life.

We will certainly remember the lockdown period for homemade pizzas and cakes, the hidden talents they found time to discover, but especially the great and sudden need for community.

Between those who never stopped working, those who stayed at home and those who had to change their routines, the simple and authentic realities of community networks and solidarity came into being.

## **Suspended expenditure and solidarity networks**

Brescia is one of the Italian provinces most affected by the current Covid-19 crisis. The impact of the pandemic on community life has been considerable and far-reaching, especially for disadvantaged sectors of the population.

Following the adoption of measures adopted by the government, the municipal system of social services continued to guarantee services, improving the implementation of directives to

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<sup>10</sup> "Dettaglio atto - Trova Norme & Concorsi Salute - Ministero ...." <http://www.trovanorme.salute.gov.it/norme/dettaglioAtto?id=73643&completo=true>. Accessed 13 May. 2020.

<sup>11</sup> Dettaglio atto - Trova Norme & Concorsi Salute - Ministero ...." <http://www.trovanorme.salute.gov.it/norme/dettaglioAtto?id=73643&completo=true>. Accessed 13 May. 2020.

<sup>12</sup> Unicef.it Italia  
<https://www.unicef.it/doc/9752/coronavirus-bambini-restano-casa-giochi-diritti-infanzia.htm>

maintain maximum social cohesion.

The contribution of private companies and organisations in the tertiary sector has been fundamental in making this happen. As in many other provinces, hard hit by the health emergency, in Brescia traders spontaneously ceased their activities before the government's directives, showing a sense of responsibility and helping to reduce people's movements and potential outbreaks of contagion.

In many of the province's municipalities, in addition to ensuring medicines were delivered to people who preferred not to leave their homes - thanks to voluntary associations and the action of civil protection groups or Scouts - many cooperative initiatives have been carried out, demonstrating a deep sense of community based on mutual aid.

For example, in the municipality of Ospitaletto, a company involved in the slaughter and preservation of poultry, unable to sell its products due to a decrease in demand, donated them to the Caritas association. Thanks to the cooperation between the private company, Caritas, the San Vincenzo association and the municipality's social services, the

poultry has been donated to people living precariously.

The assessment of beneficiaries in need is made by municipal social workers based on applications for food aid. Once the beneficiaries have been defined, the members of Caritas and the San Vincenzo association manage the food delivery. Every week, 20 families living in the municipality receive poultry to supplement their food expenses.

*"The generosity of this company, which spontaneously decided to donate its products to the community, has helped those in need. Food like white meat is rarely found in food parcels because it is a very marketable food. Yet the owners preferred to donate their products rather than look for other ways to use them and make a profit,"* explains F. Pressante, a social worker from the consortium that operates in the municipality of Ospitaletto.

Another initiative that has helped to respond to the current social emergency in the Brescia region is the "**Spesa Sospesa**" (Suspended Expenditure) initiated by the Lamarmora district council in collaboration with the municipality's social services and various entities in the region such as Catholic parishes, the Islamic



Cultural Centre and associations operating in the southern part of the city.

The aim of the project is to increase integration among the social partners based in the region, laying the foundations for collaboration among citizens, formal and informal networks and business activities, aimed at developing behaviour that benefits those in a situation of a precarious economic situation, especially in this period of crisis.

Thanks to cooperation between associations and businesses, "Suspended Expenditure" allows customers, after making their purchases, to donate a small amount of money or buy products to be distributed to needy households.

Many other initiatives have arisen in the province and each of them demonstrates a strong sense of solidarity and the rediscovery of community identity.

The urgency in which we have all found ourselves has made us aware of our fragility and helped us to reflect on the consequences that our behaviour has for others. The need to limit physical contact and establish social distancing has led people to identify other ways of expressing themselves and making others feel close and supportive.

## **The contribution of Taranto retailers**

For decades, the city of Taranto has been affected by the dualism between the right to work and the

right to health following the Ex Ilva case (now Arcelor Mittal), a highly polluting steel plant.

The demand for the plant to be closed because of its impact on the environment and on citizens' health has always come up against the need to continue to ensure the production on which the economy of the city and the province of Taranto depend to a large extent. The Covid-19 pandemic has only accentuated this dualism.

An impressive example of a community response to the pandemic and the social responsibility of entrepreneurs is provided by retailers in Taranto who decided to cooperate by closing down their activities even before the decrees by the Presidency of the Council of Ministers had the force of law.

*"At the end of February, we were already very concerned about the first cases of Covid-19 in Lombardy", explains Giuseppe Spadafino of ConfCommercio Taranto, "and that's why we decided to stop even before the authorities asked us to. We did it to set an example for our community, as well as to make people understand that there is nothing more important than our citizens' health. We decided to protect*

*ourselves, our clients and our loved ones."*

Cooperation among retailers in the common interest of community health prevailed over the usual competition imposed by trade rules.

*"Once the decision had been made, the challenge was how to communicate and share the choice made with all the retailers, but it was easier than expected - a great sense of responsibility emerged", continues Spadafino who concludes with a reflection: "for many years, our city has been forced to choose between work and health; we didn't hesitate, we chose health".*

## COVID-19 POSTCARDS

# Mobilization of civil society in Argentina

Hector Carrer



On March 3, the Ministry of Health reported the first positive case of coronavirus in Argentina. It was a 43-year-old man who had arrived from Italy. The first death in the country was recorded three days later, on March 5, a 65-year-old man who had arrived from France and was suffering from serious health problems before falling ill with the coronavirus.

On March 11, the World Health Organization changed the coronavirus status from epidemic to pandemic, and the national government introduced mandatory quarantine for Argentines and foreigners returning from countries at risk. The Ministry of Transport established a new protocol for flights to Argentina, with enhanced passenger controls. All cases



involved people who had travelled outside the country in recent weeks.

## Quarantine

On March 15, the President announced the suspension of school classes throughout the country until March 31. In addition, work permits were issued for people over 60, pregnant women and people under 60 who were at risk. She also ordered cinemas and theatres, as well as national parks, to be closed. The restrictions were gradually to be tightened until, on March 19, the national government decreed preventive and compulsory social isolation throughout the country in the face of "an unprecedented potential health and social crisis". The measure made an

exception for those working in essential sectors such as health and safety, and permitted supermarkets, pharmacies, assistance centres and petrol stations to remain open, allowing minimal and essential movements to stock up on cleaning products, medicines and food.

Thus, with very few infections recorded, the national government decided to have the country locked down in order to flatten the infection curve and give the health system time to deal with the pandemic.

## Health before economics: a humanitarian response

The government of Alberto Fernandez, faced with an unprecedented global situation, had



come to power three months earlier, inheriting a very complex economic and social situation, the result, among other things, of four years of mismanagement by the neo-liberal Mauricio Macri.

The political decision to give priority to the population's health over the economy was followed by all kinds of pressures. This is the case of the multinational company Techint, one of the largest companies in the country, which, a few hours after the government's announcement, declared preventive isolation and reacted by laying off 1,450 employees. The government issued a decree prohibiting the dismissals for two months, as part of a policy to protect workers.

But much of the country's economy is informal. It is represented by more than four million informal or unregistered workers, excluded from enjoying basic labour rights such as pensions, holidays, social security, Christmas bonuses and paid vacations. The State has promoted a series of specific policies for the most vulnerable: emergency family income for informal and self-employed workers, additional bonuses to strengthen social plans, allowances for children and pregnant women, the delivery of food to community kitchens has been strengthened, the payment of credits has been postponed for two months and evictions have been suspended. In order to ensure social isolation, it is essential that the State



guarantee a certain income to the most vulnerable families.

## **Covid-19 sharpens the divide between social classes**

The crisis caused by the virus does not erase differences, but rather exposes historical social inequalities. It is not the same thing to be quarantined in middle- and upper-class homes as it is to live in precarious housing in the humblest neighbourhoods.

While middle- and upper-class families can spend their isolation watching Netflix, worrying about the kilos they've put on, arguing about the use of computers at home, or the amount of homework the school sends to their children, other families live in small, overcrowded, precarious buildings where they

suffer from a lack of basic services such as electricity, drinking water, sewage or pavements.

Forced isolation has intensified violent situations. On the one hand, cases of gender-based violence suffered by women who have to remain locked up with their aggressors have increased; on the other hand, cases of institutional violence by some members of the security forces, particularly against young people from poor neighbourhoods, have increased.

In terms of education, the pandemic has made it clear to many that school is an institution that not only disseminates knowledge, but also performs important functions of socialization, bonding and routine; the teacher's role seems to be revalued in terms of the personal bond that he or she establishes with



his or her students as part of the educational process. In this regard, is it not time to declare that access to the Internet is a basic and universal service like drinking water?

It would seem that families in working-class districts are experiencing lockdown in a much more communal way, precisely because community organization has been and is a strategy for dealing with the problems they have historically faced. Social organizations and cooperatives not only organize and maintain community kitchens that provide food to hundreds of thousands of families every day, but they also handle cases of family and institutional violence.

Some cooperatives of people working in the informal economy, collecting cardboard, paper and bottles in the streets, have distributed hand sanitiser, soap and masks to their workers. And they have decided that people who, because of their age or physical condition, might be at risk should not go to work. Among all the members of the co-operative, they will pay their income.

Once again, when human lives are at stake, the appropriate responses seem to be taken on the side of solidarity and cooperation represented by organised civil society, and with the help of a state that is making efforts to be involved.

Slogans that valued competition, individualism and the weakness of the State as answers to our problems now seem very distant.

To find out more, I share two alternative sources:

- The powerful: <http://www.lapoderosa.org.ar/>
- Sudestada Magazine: <https://www.revistasudestada.com.ar/>

## **Perplexity rather than panic**

So far, Argentine society has mainly been supportive of the isolation measures put in place by the government, which seem to be working, although some fatigue is evident, but there is enormous uncertainty about the economic, social, political and cultural consequences of this pandemic, in a society that was experiencing a huge crisis before this crisis.

Although many voices agree that the world will not be the same, even with the current pandemic, the strongest feelings seem to be fear and perplexity. At this point, it might be worth quoting Israeli historian Yuval Noah Harari, who seems to answer us from a text published in September 2018.

"What should be done then? The first step is to lower the tone of disaster prophecies, and to move from panic mode to that of

perplexity. Panic is a form of arrogance. It comes from the irritating feeling that we know exactly where the world is heading: downhill. Perplexity is humbler and therefore more perceptive. If the reader feels like running down the street shouting, "The apocalypse is coming," try saying, "No, that's not it. The truth is, I don't understand what's going on in the world." » (Yuval Noah Harari, *21 Lessons for the 21st Century* (London: Jonathan Cape, 2018), ISBN 1787330672).

## COVID-19 POSTCARDS

# The United States: a Counterexample

Biorn Maybury-Lewis



Written in May 2020, this article cannot chronicle the rapidly changing United States experience with the devastating and exponentially growing worldwide Coronavirus pandemic for a simple reason: the situation remains extremely dynamic. Accordingly, whatever 'snapshot' of America that it might provide would be a month or more out-of-date by

the time of publication. Alternatively, what is proposed, here, is to offer an historical understanding of why the United States policy-making response has been nothing less than catastrophic, making a ghastly pandemic much worse in America than it might otherwise have been. The argument revolves around the



last 40 years of radically changing US statecraft.

This history of these changes goes back to the 1980s. It is consistent with three critical recent trends that largely explain why the coronavirus has proved so exceptionally deadly to America on crucial dimensions related to these 40 years of changes in the conduct of American government public policy. The virus need not have spread and killed at the rate that it has and will continue to. The reasons for this exacerbated ongoing viral pandemic in the USA are the following:

1. The US has created by far the most inefficient healthcare system in the 'developed' world when observing three fundamental and objective variables: expenditure per capita, distribution of healthcare, and healthcare outcomes.
2. The US political elite has supported a concerted effort to place the US healthcare system in this desultory state for conservative, neo-liberal ideological reasons - affecting all government institutions - dating back to the 'Reagan Revolution' in the 1980s.
3. The presidency of Donald Trump has compounded and deepened this changing pattern of American statecraft preceding him, taking it to its ultimate conclusion: a state unprepared for anything beyond the 'day-to-day chat about this matter or that,' which the president himself seems happy to provide. Such manifest lack of substance is consistent with Mr. Trump's professional background as a low-brow television entertainer.

This article argues that these three factors, combined, explain where we are, in May 2020, and where we are likely to head in the USA during the ongoing coronavirus pandemic.

## **The contemporary US healthcare system: expenditure vs. outcomes**

When analyzing the USA's medical preparedness for any sort of medical emergency, the country presents a paradox. It boasts superb medical schools to which elites from around the world send among their very brightest young people to train for careers in medical research and practice. Its hospital centers throughout the country are among the most advanced in regard to personnel training levels, high technology diagnostical systems, and advanced patient-care facilities.

### **High inequality**

Yet, as with everything else in the US political economy since the 1970s, the distribution of those who enjoy high-quality healthcare and those who do not is highly unequal. Citizens in America widely obtain private healthcare insurance as a 'benefit' of employment, and not as a 'citizen's right': a

philosophical policy choice made into law in the United States during the post-World War II period. It follows, therefore, that those who cannot afford adequate levels of private healthcare or who have jobs without a health insurance benefit will not receive the healthcare of those who can.

### **41 million uninsured people**

The objective result? The population of uninsured in the USA is approximately just over 41 million people: the equivalent of the total combined populations of Greece, the Czech Republic, Sweden and Portugal. Added to this are an additional 3.5 million whose insurance was taken from them, in the last two weeks of March 2020, because they lost their jobs in the economic crisis that the pandemic precipitated. With the pandemic-induced collapse of the labor market go the job-related medical-insurance benefits.

### **45% of Americans underinsured**

Compounding this loss, healthcare providers deem an immense portion of the US



population 'underinsured,' that is, with insurance gauged at so low a level of coverage that - in a wide range of circumstances - they have little to no effective coverage. The Commonwealth Fund, in a recent survey, provided the following, quoted survey highlights:

- Today, 45 percent of U.S. adults aged 19 to 64 are inadequately insured - nearly the same as in 2010 [i.e., before the passage of 'Obamacare,' the Affordable Care Act (ACA)] - though important shifts have taken place.
- Compared to 2010, many fewer adults are uninsured today, and the duration of coverage gaps people experience has shortened significantly.
- Despite actions by the Trump administration and Congress to weaken the ACA, the adult uninsured rate was 12.4 percent in 2018 in this survey, statistically unchanged from the last time we fielded the survey in 2016.
- More people who have coverage are underinsured now than in 2010, with the greatest increase occurring among those in employer plans.
- People who are underinsured or spend any time uninsured

report cost-related problems getting care and difficulty in paying medical bills at higher rates than those with continuous, adequate coverage.<sup>13</sup>

As a result of this crisis of underinsurance, despite rises in the rate of those who have insurance, Senator Elizabeth Warren, from Massachusetts, points out from her painstaking research on the matter, that inadequate insurance is one of the largest causes of bankruptcy in middle-class America as families deal with unexpected healthcare crises.



This large-scale bankruptcy trend from healthcare crises is under 'normal' circumstances.

## Health as a consumer product

Compounding this insurance reality is the fact that the entire medical establishment is considered an 'industry' designed to 'meet the demand' of those with the privilege of access to medical care. The for-profit orientation continues to

prevail in American healthcare with 'Customers' being charged as much as possible; the overarching goal remains to satisfy shareholders. This makes healthcare enormously expensive, out of reach for many, a cause of bankruptcy for millions, and with remarkably ineffective coverage for a significant portion of US citizens.

The last, crucial point, that flows from this logic is the 'last-minute supply-chain' orientation of the for-profit hospitals in America. Such institutions face immense economic disincentives to maintain stocks of provisions for unforeseen emergencies like, for example, a pandemic. There is no money to be made in setting up expensive intensive care units and diagnostic equipment to keep

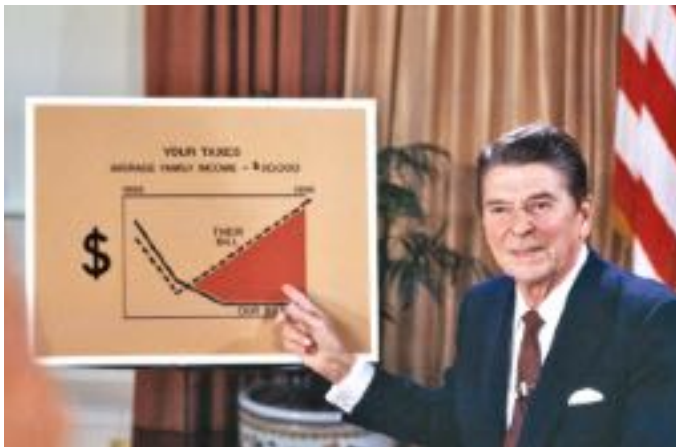
<sup>13</sup> This extended quote is from <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>, (retrieved on May 5, 2020).

in reserve, or storing large quantities of personal protective equipment (PPE), ventilators, and special supplies to prepare for an unforeseen and rare event. Such preparation, from a business perspective, is a 'money loser.' Hospitals, then, as we have seen painfully, are not prepared for a major crisis.

### **A very unfavourable cost-effectiveness ratio**

According to recent World Health Organization statistics, the overall, global result of these features of 'healthcare coverage,' in the richest country in the world, are the following:

1. The USA spends by far the most per capita on medical-related goods and services. Approximately, USD 10,600 per US citizen, about 16.9% of US GDP. A significant percentage of this money goes to the 'overhead' of providing salaries, bonuses and profits for for-profit healthcare companies, compensation for insurance company and private hospital executives, and profits for large-scale pharmaceutical corporations which charge more in the US
2. Yet the US healthcare system's medical 'outcomes' - operationalized as effective care on a wide-range of salient medical indicators across the entire US population - are ranked about 27th in the world: right after Costa Rica.
3. This relatively low ranking of US healthcare outcomes has to do with its skewed distribution of healthcare, its for-profit orientation, its consideration of healthcare as a privilege and not a right, its significant proportion of the population that remains either un- and under-insured population, and the 'for-profit' orientation of the majority of US healthcare services.
4. Most ominously, the logic of for-profit healthcare provision implies, unambiguously, virtually no pandemic-preparedness. For that, the nation would depend on a national leadership team - should one exist. In fact, there was a strategic plan and institutional framework for pandemic preparation that



was systematically dismantled in the transition between the Obama administration and the incoming Trump team.

## The US political elites' embrace of neo-liberal public policy since Reagan

The history of the dismantling of the incipient American welfare state - particularly on the healthcare side - goes back to the 1980s. President Ronald Reagan, while campaigning for office in the 1980 presidential election (and repeatedly while in office) proclaimed the following: 'Government isn't the solution. It's the problem.'

### The neo-liberal 'revolution'

The policy makers who came into office with Ronald Reagan in 1981 wanted, quite simply, to

dismantle the regulatory state and privatize state-owned enterprises, leaving the US political economy 'to the miracle of the marketplace,' once again. Such a devolution of erstwhile state regulatory and

production responsibilities to the private sector would offer large-scale capitalist enterprises new and lucrative business opportunities, at home and abroad: including notably within the healthcare 'sector.' The conservatives believed in the 'invisible hand' of free markets that Adam Smith wrote famously about in *The Wealth of Nations* (1776). They wanted to radically deregulate the economy and dismantle any state institutions designed to safeguard the public interest, and to sell them off to the highest bidders. Their goal was to take the country, again, to a period analogous to the pre-Depression-era's 'roaring '20s.' They dreamed of a new period of 'laissez-faire' capitalism and a much-reduced state role in public affairs. America, in this view, would rise

again out of the doldrums of the 1970s.

This new, neo-liberal, conservative 'Washington Consensus,' emerging in the 1980s, was a reaction against the 40 years of statism that FDR had launched during the Depression and WWII. The Reagan administration would deregulate and diminish the expanded state sector to increase capital and wealth formation opportunities for the upper classes to purchase former state-owned institutions, in the US and abroad, at bargain rates. For the lower classes, a 'trickle down' - they allowed - would occur, benefitting all eventually. 'Rising tides will lift all boats,' they argued.

### **Emptying the welfare state of all substance**

The term for the Reagan Revolution policy was 'supply-side economics:' give capital plenty of liquidity and freedom, and it will create ever more wealth for the entire society. The new leadership in Washington would systematically gut the growing welfare state in the USA and world of the 1970s, while also

attacking labor unions that resisted.

Presidents George H. W. Bush (1989-1992), Bill Clinton (1993-2000), and George W. Bush (2001-2008) would essentially follow the Reagan initiative, cutting back on state regulatory controls, diminishing 'welfare' to help the nations' neediest population, and reducing public-health programs.

### **Barack Obama's rebalancing efforts**



By contrast, President Barack Obama attempted to usher in a new era in 2009. The first African-American president,

Obama managed to stabilize the economy following the disastrous crash of the then largely unregulated US economy, in the last months of George W. Bush's presidency in 2008. He also was able, in the course of his first term (2009-2012), to take the country on its first steps toward some new regulations of economic activity as well as a national health insurance plan. Obama managed to pass through the US Congress his Affordable Care Act - or, Obamacare. This would prove an advance, though still a healthcare system based on private insurance companies that left tens of millions un- or underinsured.

Regrettably, Obama too, for all his honesty, managerial competence, integrity, and his hard work in creating Obamacare, would rule from the center-right in important ways. Obama left Wall Street executives who had caused the economic crash of 2008 unpunished; deported millions of Latin Americans; expanded the wars in the Middle East and around the world; and allowed the Republicans to take over the United States Judiciary, both on the Federal Bench and at the Supreme Court.

Despite the changes under Obama, the 36-year tendency of right-wing/center-right-wing rule continued to undermine the American government's ability to guard against economic depression, protect its own people from periodic crises, and to provide medical care, of the most basic kind, to significant numbers of Americans.

### **Donald Trump's presidency: consolidating the recent past**

Mr. Trump, since his 2016 election, has emphasized in his approach the public policy outlook that Reagan started: the dismantling and undermining of the government's ability to defend its own citizenry in the name of 'deregulation.' He has quite literally attempted to eliminate what Americans term 'the safety net:' the government institutions that can 'catch' and protect citizens in distress or crisis.

He has stated as his goal a desire to eliminate Obamacare and replace it with something bigger and better, though he never has released any blueprint for an alternative national health insurance. He



speculative corporate behavior – with quite clear implications for public health. Mr. Trump does not make appointments of professionals to key policy-making positions, leaving them open, or, if

attempted to simply overturn Obamacare. Yet Trump fortunately did not corral enough votes in the US Congress to succeed. The conservative-dominated American judiciary, however, has gone after key elements of 'Obamacare,' attempting to inflict 'death by a thousand cuts,' making it more difficult to enroll, and undermining its effectiveness and inclusiveness wherever possible.

### **Deregulation at all costs**

Mr. Trump's government has similarly attacked all vestiges of the regulatory state: on environmental protection, national parks, and preservation of public lands; on 'externalities' that industrial production inflicts on the American citizenry like pollution; on indigenous and minority rights; on immigrant rights; and on limits to

that is not possible, appointing 'political hacks' – people with no background in or (worse) hostility toward the agencies they are meant to head, their only 'virtue' being loyalty to the president. Trump brings to the American presidency an unprecedented new layer of contempt for science, professionalism, competence – even facts.

### **Massive tax cuts for big business and the rich**

The single legislative achievement of Trump's first term has been a massive tax cut to large corporations and wealthy individuals, again invoking the chimera of 'trickle down' economics. Widely documented 'corporate stock buy-backs' (to inflate publicly traded company stock prices) and massive executive bonuses have been the immediate result of Trump's tax cut. No

significant positive impact has resulted for ordinary Americans – only greater government indebtedness. This has, in turn, diminished further any government inclination to finance much needed public programs in infrastructure, education, public welfare, and – we have discovered painfully – pandemic preparation. The public, through their taxes, will pay for the elites' tax break.

### **Neglect in the face of Covid-19**

Trump's tax cuts, his gutting of government institutions, and firing of individuals associated with Obama has left the US government unprepared to deal with its normal, day-to-day responsibilities, much less a crisis. Particularly egregious was his firing of the entire pandemic preparation team, in May 2018, on the US National



Security Council. To Trump and his former National Security Advisor, John Bolton, pandemic preparation was an expensive Obama 'thing' that had to go. Such a team would have coordinated pandemic response and mitigation, testing and quarantining, and production of vital materiel such as personal protection equipment, N-95 face masks, and ventilators. It would help the president control the manufacturing and supply chain, channeling the equipment, systematically to where it would be most needed.

What the informed public has been nervously bracing for, since Trump's election, was a major crisis directed at the United States' executive branch. Would it be a war, or a nuclear confrontation? How

would a government devoid of professionals deal with such a crisis? Until the fall and winter of 2019, President Trump's inadequate, poorly staffed, disrespected, and foolishly cut and demoralized executive branch

had no major problem to deal with except for relatively minor ones of its own making.

Then, the Coronavirus crisis hit in December 2019, arriving in the US in January 2020. Trump ignored his own intelligence officials and the frantic government epidemiologists who warned him repeatedly of the pandemic's possible consequences if not dealt with immediately. Furthermore, the arrival of the Coronavirus (apparently, mainly from travelers from Europe, not China) would expose the consequences of a 40-year pattern of statecraft, as well as its ultimate logic: the person of Donald J. Trump.

## **Conclusions: America's strength and weakness**

### **Grasping at heroism at the grassroots**

For more than two months, from January to late March 2020, Trump ignored, played down, and lied about the pandemic. The New York Times and many other important American media outlets have offered a devastating exposé of Trump's early intelligence community warnings - as early as in December 2019 - about the

potential damage that the pandemic could do to the American public if not aggressively contained. Essentially, he dithered for 70 fateful days, mainly campaigning and playing golf, ignoring the growing catastrophe. Then, his government went 'into action' to mitigate, but only tentatively, and in a piecemeal fashion.

## **Massive failure of the Federal Government**

Huge gaps remain in the US pandemic response. At the time of writing in May 2020, there is no plan for national testing. Nor is there any mobilization for a national tracing program that would isolate the infected in safe quarantines and treat the sick. Nor is there a program to effectively shut down - and keep shut down - the entire society with a nationwide shelter-in-place order until testing, tracing, and quarantining may be completed and a vaccine or treatment widely distributed. Governments and communities are left to fend for themselves in finding tests, organizing public policy measures, and competing with each other for the equipment they need for their respective hospitals.



Incredibly, even when state or local governments go on the market and buy desperately needed medical equipment, the federal government has often swept in to steal it from them, taking it away to parts unknown.

In mid-May, as of this writing, before the pandemic has hit its peak, there are many states and regions already 'opening up' again, in order to focus on rebuilding the devastated economy and getting back to 'normal.' Epidemiologists all warn that such 'openings' are coming far too early. Given that scientists are (often as not) ignored or denigrated under President Trump, the epidemiologists have resigned themselves to the fact that premature 'opening' has and

will occur. They have accordingly increased in their models their predictions of the potential deaths owing to Covid-19 because of this massive failure of public policy. As of this writing, over 90,000 Americans have died. Scientists believe that this number will double long before the end of the US summer.

With aggressive public-health action, in early January 2020, the deaths could have been limited to a range of a few hundred to a few thousand - bad enough. Yet, in the month of April 2020, as a result of this catastrophic presidency and the history of statecraft that has undermined the US state since the 1980s - rendering a significant portion of its healthcare system a bloated

'commodity' to be bought and sold on the stock exchange - the USA has already lost almost twice as many to Covid-19 as it did during the entire Vietnam War (58,000 dead between 1960 to 1975).

Over 200 political scientists judged Trump the 'worst president in US history' before the 2020 pandemic. This consensus widens. Mr. Trump, in the opening months of 2020, remained focused on his campaign strategy for his coming reelection in November, which relied on good-to-excellent performance of the US stock market. The US Congress also was impeaching Mr. Trump, in mid-Winter 2019-2020, for his high crimes and misdemeanors, which of course distracted him. As Trump has, still, many criminal charges pending, his strategy has clearly been to 'pump up the economy' and win a second term in 2020. Then, he would stay in office for another four years, thereby allowing the statute of limitations to 'run out,' governing many of the financial crimes for which federal prosecutors will charge him after stepping down. Indeed, some of his very closest associates are already in prison for their crimes

committed, allegedly, at Trump's behest: campaign-finance and money-laundering felonies, as well as peculiarly close business relationships with Russian oligarchs and the shady Deutsche Bank, to name a few.

In conclusion, it is worth remembering that the USA was not prepared to enter WW I in 1916. Nor was it prepared to enter WW II after Pearl Harbor in December 1941. Yet rising to the occasion in both cases, Americans quickly planned and put into action major US initiatives on any number of fronts, at home and abroad. Now, there are untold numbers of citizens, local, regional, and state officials, public functionaries, and, of course, the frontline workers in hospitals, the workers manning the food supply chains and the transport systems who are all behaving with incredible professionalism and bravery. Coast to coast there are literally thousands of governors, mayors, doctors, nurses, technicians, janitors, supermarket cashiers, van drivers, policemen, firemen, first responders and many others who are living up to the 'can do' spirit of 1945.



The big difference is that we have no equivalent to President Roosevelt leading us today. Nor do we have a Keynesian consensus on the conduct of public policy. Instead, we have four decades of the pattern of statecraft which Herbert Hoover made infamous in October 1929. We are left with no choice but to shelter in place, in America, if we can. We must depend on our neighbors and local officials as well as on the quiet heroes who are right now trying to keep the country together, as we hope for the best. This is where we are obliged to look for the Cooperative Spirit which we all cherish.

Meanwhile, Mother Nature reminds us - lest we ever forget - who is really in charge.



# saluteglobale.it

PER LA PROMOZIONE DEL DIRITTO ALLA SALUTE A LIVELLO GLOBALE



**Benedetta Armocida**  
Présidente



**Beatrice Formenti**  
Vice-présidente



**Debora Zucca**  
Trésorière



**Lucrezia Gondini**  
Secrétaire



**Lorenzo De Min**  
Conseiller



**Eduardo Missoni**  
Conseiller



**Francesca Palestra**  
Conseillère

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**COOPERATIVE INITIATIVE**

# saluteglobale.it : a fair, egalitarian and cooperative start-up model

Benedetta Armocida et Beatrice Formenti

*"If you want to go fast, travel alone, if you want to go far, travel with others"* African proverb...

Saluteglobale.it is a social advancement association, committed to promoting the right to health for all and to disseminating global health issues through information, training, specialized education and scientific research.

Its history begins when a professor of the Advanced Course in Tropical Medicine and Global Health at the University of Brescia raised the idea of relaunching an information website on global health issues, which had been abandoned after the dissolution of the organization that had run it until a few years ago. Much has been said about globalization, but in fact - at least in Italy - there has been little room for information and in-depth analysis of its impact on health and on

national and international policies. The idea immediately captured our curiosity and passion and was then passed on by the same professor to the students on the planning and management of social services course at the University of Milan-Bicocca.

We decided to pool our strengths and professionalism and embark together on what is still today a great adventure. None of the members of the initial group were journalists or communication experts, some had some experience in managing simple websites, but our enthusiasm proved infectious. Moreover, few of us were able to meet each other, being scattered throughout Italy and abroad; we were also transnational, as were the topics we wanted to tackle.

After a few months of experimentation in search of news

and articles, and after learning how to communicate information, learn from each other and share responsibilities, we were ready to launch our site. What better date than April 7, World Health Day; on that day, [saluteglobale.it](http://saluteglobale.it) was born. Despite the difficulties in keeping up with current affairs, we were incredibly stimulated by managing this shared information space, trying to always be proactive in providing a useful information service that occupied a visible space on the Web.

But soon this space began to attract other channels for sharing and contributing. New skills, competencies and professional interests were quickly added to the group, to the point of fuelling the need for something that went beyond the mere transmission of information. We felt the need to grow, to unite, to become a laboratory for training, education and stimulation for the development of research and international cooperation. From an informal group of passionate friends and colleagues, we wanted to structure ourselves and transform ourselves into an organization embodying the spirit and ideals that animate us, but with greater possibilities for action. With this strong impetus, we have taken on one of the most exciting and



rewarding challenges in our short history.

At the end of 2019, [Salutegloable.it](http://Salutegloable.it) became an association for social advancement based on voluntary, equal and fair participation, with particular attention being paid to the aspirations of each of its members. The consensus among young professionals interested in the same issues and with the same sensitivity in the field of global health continues to grow and the association is also enriched by new voices.

In the early days of an association, there were many challenges in creating a unified and proactive group, as well as difficulties in meeting people who were diverse in terms of background, geographical origin, perspectives and professional history. The shared vision of diversity as an asset has led us to develop a cooperative, innovative, dynamic and multidisciplinary approach, a working model that values diversity and unites us around common values and objectives creating a sense of belonging.

Although it is still at the beginning of its journey, [Saluteglobale.it](http://Saluteglobale.it) represents a cooperative model that unites diversity and pursues, through collaboration among the members of the community that forms it, the common goal of affirming the right to health, without leaving anyone behind.

It is a source of pride and honour for all of us to be able to write a short page that tells our story - we look forward to continuing it.



Photo Matilda Wormwood, Pexels

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**DECIPHERING**

# Health cooperatives, a solution for the future?

Dominique Bénard

As the Covid-21 pandemic shook health care systems and brought them to the brink of collapse, many people questioned the need to rethink how these systems are organized. One question worth asking is whether cooperative approaches in this area, too, could not make it possible to respond better to current emergencies, for example, by improving prevention. Of the EUR 240 billion that France spends each year on health, barely 5% is spent on prevention. Let us try to examine the complex challenges involved.

## Health must be seen as a universal good

Liberal economic logic conceives of health as an individual private good. The sick person is considered first and foremost as a consumer who should be able to freely choose the provider that provides the best health service

for him or her. It is in this logic that there is pressure to replace universal health insurance with private insurance and to entrust healthcare to private hospitals or health centres deemed more efficient and more profitable.

However, health should be considered first and foremost as a universal common good, for three fundamental reasons:

1. Many diseases come from the environment: certain cancers and degenerative diseases, allergies, obesity and its consequences, certain respiratory diseases, infectious diseases linked to the quality of water and hygiene services, or transmitted by insect vectors, industrial accidents and of course diseases of animal origin, zoonoses such as Covid-19. The prevention and treatment of these diseases are impossible without action on



the level of populations as a whole.

2. The patient cannot be considered an "enlightened" consumer, capable of choice. He is first and foremost an anxious person, seeking a sense of confidence from the doctor. Doctors take an oath not to abuse this trust. Hence the vital importance of the independence of professionals from the health industry, managers and financiers.
3. Healthcare financing methods express a society's core values. No developed society can openly allow those who cannot pay die at the hospital door. The principle of equality of people in the face of illness and death, regardless of their social conditions, origins or beliefs, is a fundamental value of democracy. It is also a criterion of efficiency: when people renounce medical treatment due to economic difficulties, in

cases of contagious diseases, they put other people at risk. Refusing to seek treatment also leads to later consultations, the aggravation of pathologies and, ultimately, higher costs.

## However, health policies are moving towards privatization

Over the past three decades, governments, faced with increasing healthcare spending driven by medical advances, population ageing and pressure from the many social, economic and environmental determinants of health, have struggled to contain budgets. Public hospitals have been forced to adopt profitability policies and a "business plan" logic that disconnects the activity and its financing from its justification in terms of public health. Indeed, the criterion for a hospital activity is no longer the benefit for the patient and for the community, i.e. "the

right care at the lowest cost", but profitability for the hospital.

Intense pressure has been put on healthcare professionals to increase their productivity; thousands of hospital beds have been eliminated. Long-term strategies have been forgotten in favour of a short-term vision; for example, stocks of medical masks or drugs deemed too expensive have been abandoned. There has been a growing trend towards privatising health services. As private services are obviously oriented towards the most profitable healthcare, this has resulted in a relative reduction in health coverage and an increase in inequalities in access to care among social groups.

The link between the public hospital and city medicine is also in crisis. Economic constraints have led to the imposition on patients of increasingly short hospital stays (known as "ambulatory medicine"), shifting new tasks to city medicine that is unable to deal with them, both upstream and downstream of the hospital. Many patients can no longer find a general practitioner, especially in rural areas. The majority of young doctors, particularly general practitioners, aspire to practise their profession without the constraints of individual entrepreneurship and its

administrative burdens, which are inherent in the liberal profession in all its variants. Many patients then go directly to the emergency departments of overcrowded hospitals.

## **The law of reverse assistance**

The consequences of this policy for underprivileged populations have been described by the English physician Julian Tudor Hart, in a famous article published in *The Lancet* in 1971 as the law of reverse assistance: the quality of care is inversely proportional to the needs of the population. Faced with the seriousness and complexity of clinical problems - closely interwoven with social problems - the supply of health and social services is often insufficient in both quantity and quality. The entire primary care chain, including mental health services, is weak and does not allow for proactive prevention and the effective management of the most serious cases.

## **Mobilizing the population locally on health issues**

However, it seems that a reverse trend is emerging in order to mobilize healthcare professionals and the population on health projects that meet local needs. In France, for example, in order to



improve the geographical distribution of doctors by organising the supply of care in a coherent territorial approach, health centres and houses are increasingly being created throughout the territory. Most health centres and clusters are linked to local public health policies. They organise access to prevention and screening and contribute to equity in access to care. These health centres and clusters often adopt a cooperative status.

The Italian doctor Gavino Maciocco gives the example of the Piagge health centre in the suburbs of Florence:

*"We immediately understood that we had to intervene, and quickly. And within a few months, the situation changed considerably, for the better. The number of family doctors in the Health Centre has been reduced from three to five, group medicine has been activated and the daily access time for*

*patients has been considerably extended (7 hours from February 1). Intense and fruitful multidisciplinary work has been developed, particularly in the field of mental health, where the service has been strengthened. The agendas for specialist and diagnostic activities with direct access for family doctors have been strengthened. Work is in progress and the Casa della salute delle Piagge is on the way to becoming a "good practice" in territorial health, starting with the decent reception of patients, with the presence of a new secretariat that provides users with the necessary information to access and use the services".*

## Health cooperatives exist in many countries

Health cooperatives exist in many countries and an international organisation of health cooperatives has even been created: IHCO (International Health Cooperative Organization). However, depending on the country, cooperatives take various forms.

## Cooperatives of health professionals

Some cooperatives only include healthcare personnel: doctors, dentists, nurses, pharmacists and



paramedics. Their objective is to improve the working conditions of these professionals. This type of cooperative is very widespread in Brazil and Argentina. In Belgium, Spain and Italy there are also cooperative pharmacies; in Canada, the ambulance sector often operates in the form of a cooperative.

### **Users' cooperatives**

The need to fill gaps in health services, including preventing and improving well-being, explains the spread of user cooperatives. Often these cooperatives ensure access to treatment for certain categories of patients or provide services tailored to certain at-risk groups. In Canada, for example, cooperative clinics have been formed to provide healthcare services tailored to the elderly, aboriginals, people without resources or patients with chronic diseases.

Others have formed to provide health coverage in marginal or sparsely populated areas where access to health services is a problem. In Japan, user cooperatives take the form of community cooperatives, for example in rural areas. The services offered are better adapted to the needs of users and support the development of innovative practices, including in the field of prevention.

### **Multi-stakeholder cooperatives**

Other cooperatives are characterized by the involvement of a diversity of stakeholders in their governing bodies. For example, healthcare professionals, as well as users and other individuals or organizations with a stake in the cooperative's success. This shared interest strengthens the links that cooperatives build with the local community and their capacity to respond for the common good. Singapore has



developed this type of cooperative. In France since 2015, a new model for the management of healthcare centres and clusters has emerged in the form of a non-profit Société Coopérative d'Intérêt Collectif (SCIC).

## Between commercial competition and social solidarity

The International Cooperative Alliance defines a cooperative as "an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise".

## Are the values affirmed by co-operatives sufficient?

The core values of co-operatives, as defined by the International Cooperative Alliance, are personal and mutual empowerment and

responsibility, democracy, equality, equity and solidarity. True to the spirit of the founders, cooperative members adhere to an ethos based on honesty, transparency, social responsibility and altruism.

Is this enough to ensure that health cooperatives will always be able to take care of health as a universal common good? In Canada, where health coops are well developed, some people are very enthusiastic about this new form of medical practice, but others have relevant objections. Health cooperatives can also get caught up in the logic of consumerism and competition. In order to attract doctors, some offer them the possibility of special treatment rates that go beyond those provided for by health insurance, while at the same time offering their members special advantages that the rest of the population does not enjoy, thus breaking with the principle of universality and equality of care.

## Under what conditions can cooperatives contribute to the common good?

Health cooperatives represent an attractive formula for achieving a balance between the needs of cooperative members, the rights of community citizens and the demands of doctors. However,

they can also allow themselves to be drawn into competitive strategies that are similar in every way to those implemented by private medical companies. What are the conditions that can enable them to protect themselves against this drift?

1. The use of cooperative statutes to associate various stakeholders: the local community, professionals and other employees, and the patients of the health centre, without any one party being able to hold more than 50% of the voting rights. By giving users a place in governance, the cooperative form allows a new balance in the care provider/patient relationship to be established.
2. The definition of a local health project for the benefit of patients and according to the needs and resources of a territory, better articulated with hospital medicine, follow-up care services, municipalities, human services, retirement homes, mutual insurance companies, etc., is a key element in developing a local health project.
3. The validation of this project by the health authorities within the

framework of public health policy.

4. Financing by the national health insurance system.

Let us hope that, in the future, many health cooperatives meeting these criteria will be created to decentralize health services and directly involve the population, at the most local level, in the care of health as a precious common good.



Photo Anna Shvets, Pexels

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**THE SOLEXOS**

# Fifty-five days within four walls

Michel Seyrat

*There are seven SOLEXOS: three boys and four girls aged 15. Thanks to the grandfather of one of them, a collector and restorer of the VéloSolex of his youth, they became passionate about this moped which they have made their signature when they render services or publicize an event.*

When the First Great Universal Lockdown began in the twentieth year of the 21st century, Kevin was the luckiest Solexo to live it at his grandparents' home: with greenery, running paths, and a Solex workshop accessible day and night! But for the other six, the famous "social distancing" scattered them all over the city.

Ludovic and Anna, the Bergot twins, live in a one-storey town house with a small garden. The Solexos usually rely on them to take initiatives or organize the gang. Ludovic needs everything to be organized, programmed and in

place; Anna is rather sporty and eco-friendly and regularly cooks vegetable soups. After three days locked up, Ludovic wondered with his sister what they could do apart from the work the school was sending them and helping their younger siblings with their homework.

- Anna, we have to get moving. It's an endless day of lockdown.

- All right, but without getting out and seeing anyone, it's going to heat up our phones and screens.

- That's what it's for, right? So, let's get co-mu-ni-ca-ting!





- At home, we've never talked so much to each other, even Daddy talks!
- And the brother and sister are chatty!
- So, who do we communicate with?
- I was thinking we could interview "our fragile elders" to get them talking about themselves.
- For you, the fragile ones we're talking about are Grandma and Grandpa?
- Exactly, but not only them.
- There are more serious cases of fragility and once Grandpa starts, I sometimes struggle to keep up.
- And when Grandma hangs on to the phone, the lines go mad. I'm also thinking of Grandma Jeanne who's well over 90, if I remember

correctly, and Grandma's aunt...

- ...whoa, Auntie Agatha, that's going to be tough.

- No doubt, but they're our old folks and now we can make time for them.

- So, what are you proposing exactly?

- That we suggest a topic to them and that we phone them regularly to listen to them and transcribe their words into a kind of album.

- And what would you like them to talk about?

- I was thinking of Trenet's song, "What's left of our love", and asking them "What do you think is left from your twenties?"

- And do you think that's going to amuse them?

- I think that if we ask them, they'll be happy to pass on the memories of their youth.

- I think we should look for another topic, too, if they're not interested in the distant past. But, okay, brother, I'm with you on this.

Once those twins get something into their heads, they can be relied

upon to act on it. As soon as this decision had been taken, it was urgent to discuss it with the other members of the team, and also to know how they spent their days during the lockdown.

With Kevin, it was simple. They knew the place, the Lebrun grandparents, and their way of life. But Kevin had some big news to announce:

- Grandpa agreed to help his old friends restore their old mopeds that were lying around in the barns and they're doing it. So, as I told their grandchildren about the Solexos, they decided to create the Mobylos, on mopeds exhumed and resurrected. We've got followers, what do you two think of that?

Ludovic wasn't very enthusiastic, but Anna thought the idea was a nice one and persuaded her brother to see it more positively.

- We can't let you go to the countryside with your ancestor," she said, "without you setting a new mechanical challenge. You two really are maniacs.

- And apart from the mechanics, what's the lockdown like?

- Well, not great and on top of that my physics teacher pushes me to work as if I were preparing for the Polytechnic. Even Grandfather is overwhelmed and yet he was good at science. Fortunately, the village mayor has given me a travel permit "for assistance to vulnerable people", so I go around the village twice a day.

- And how do you assist these "vulnerable people"?

- Ah, that's the mayor's idea. He bought an infrared forehead thermometer and he asked me to go around the "seniors" as he calls them and tell them their



temperature morning and evening. Since they 've all seen it on TV, everyone agrees and writes down their temperature. I don't have to say anything, but if it's too high, they call the doctor. So, I have a healthcare Solex! I'm going to paint a red cross on it!

- And you talk to the elders?

- Yeah, it depends. Some of them don't like opening their doors too much and some of them won't let me go. But with the masks over their faces, it's difficult: I don't understand them and they can't hear me!

- In spite of your communication problems, do you think you could get into our project and ask them what's left from their twenties?

- I'm not saying yes or no, I'm thinking about it, but at this rate I'm going to be exhausted taking old people's temperatures, looking after granddad's mopeds, doing the "learning nation's" homework, and tinkering for my grandma. I can't wait for us to have some time off.

- I'll call you soon, Anna and I'll be filming the news. Say hi to your grandparents for us.

On the Solexos' tour, Anna wanted to find out quickly all about Samia Cosso who lived in a small apartment in the old part of town

with her mother. As everything was slow, the administration where she worked only mobilized her for two half-days a week, so they both had time, and her mother even enjoyed attending her daughter's "home" classes. But she was an active woman who had said from the very first days of the "lockdown":

- We're not going to sit around on the sofa doing nothing. I've found some very good strips of material to make masks with. If we set to it, by turning on the sewing machine buried at the bottom of the cupboard, what do you think, there's a need for them everywhere and my head of department would like to buy some for his colleagues.

- You know, Mum, I'm not very good at sewing, but it's a good idea.

Hearing how Samia and her mother had jumped in, Anna thought that the Solexos were definitely a force to be reckoned with.

- What about high school classes?

- I'm a little confused right now. How are you doing?

- Not so well. If you want, we can talk about it when we're stuck at home.

- I'd like that. And masks, do you have any masks?



Ding-dong, and the connection is established. Anna attacks:

- So, girls, apart from watching screens, what have you been doing?

- Well, like you, Mrs Laurent's text analyses, Jojo the math teacher's problems, Mr. Lebras' documents. We won't

- A few that the town hall gave me, but they're already worn out.

- I'll make you a dozen washable ones. I'll make you a package and we'll see each other when we get out for a "short trip", one kilometre you, one kilometre me, that must be about the count, no?

- Yeah, that's a great idea, but shh!

- Good for the masks, says Ludovic, we'll be needing them for a long time. And Julie and Elodie, do you have any news?

- We've got an appointment on Messenger in 15 minutes. Until then, I'll take some rest, it's exhausting being on the phone all the time.

The two Solexos, Julie Garnier and Elodie Morel live in the same large complex built downtown on the site of a former textile factory.

get bored.

- And apart from classes at home, what else, asks Ludovic.

- Our large complex is built on the site of a textile factory that was razed to the ground in the sixties.

- So, we've decided to present it to the people in our buildings.

- We contacted the nice librarian - you know the one with the soft blond hair, and he scanned a lot of pictures of the factory for us.

- We displayed some of them in the entrance halls, with a mailbox to collect testimonies from former workers.

- Nice!

- We didn't really think it would work, but seven people came forward, and now we're interviewing them by phone and

we're going to make a presentation for everyone.

- What do you mean, with the health restrictions?
- Don't worry, Ludo, with Dad's projector on Julie's balcony, we'll just show it on the college's blind wall and there, from their balconies, everyone will be able to see it. Isn't that great?
- Fantastic! You guys are champions.
- Yes, well, well, our parents are scared to see us connected all the time, but we've convinced them that it's interesting to let the people in the buildings know about the life of this demolished factory, and that it's useful for our studies.

Anna agreed and then summarized the conversations with the others. But it was time to call Pablo Sanchez, who had set a specific time "so that I have time to water my plants and feed my animals. In any case, Pablo Sanchez, whether it rains, the wind blows, the sun shines or it's freezing, he confines himself in the greenhouse abutting the family house at a regular time each day, to watch his plantations, observe his vivarium, his terrarium, his aquarium, cuddle his white mice and feed his

parakeets, without forgetting to note the readings from his personal weather station. The lockdown is simply giving him a little more time for his passion as a naturalist.

- So, Pablo, your toads?
- Ludo, you know I don't have any more.
- So, what do you do.
- Tell jokes, man, jokes.

You'd think Pablo would have understood that he's momentarily harbouring a whale in his pool or young cubs in his doghouse, but that he makes jokes was unpredictable.

- And how do you make them?
- I don't make them, I tell them. And starting tomorrow you're going to enjoy them. I'm building up my network of contacts to whom I'll send jokes every morning. Humans are like all animals, stress disturbs them. So, I've decided to do something useful by making them laugh at least once a day - that's a good idea, isn't it?
- Ah yes, very good, but it's just that we didn't see you in this role of public entertainer.
- If you think it's funny to make people laugh, you're wrong. It's a

dog's job to find funny things, not too stupid, short to text... I've mobilised my whole family and that's the good side because we have a lot of fun looking for the joke of the day! And I already have two correspondents who have sent me jokes - it's going to snowball.

- Bravo Pablo, shouts Anna on her brother's phone, sign me up.
- OK, but sometimes, for the girls, my jokes...
- ...come on, I'm big now, you know.
- Alright, alright, see you later. I still have work to do in the greenhouse. It's getting hard to find everything I need for my crops and livestock, but I'm trying new things, to observe how living

things adapt to new conditions, right Mr Darwin?

- Apparently, you're adapting quite a bit.

After that phone call from the Solexos, Anna and Ludovic remained motionless and pensive. Quite a team, though. Friends like that, you'll never forget them for the rest of your life.





Photo Cottonbro, Pexels

## MEETING WITH

# Eduardo Missoni



**Hello Eduardo, as an expert in global health, what do you think are the causes of this pandemic? Is it really related to the ecological crisis we are experiencing?**

Covid-19 is of zoonotic origin, meaning that the virus was normally present in an animal, perhaps a bat, and that at one point there was a "spill-over", meaning that the virus was able to pass from animals to humans. This was clearly facilitated by human penetration of forests, the natural habitat of the animal reservoir of the virus and the massive consumption of wild animals, with significant human exposure in so-called "wet markets", where live animals are slaughtered

on the spot. It is not these local markets, but THE Global Market, with its mechanisms for plundering natural resources, which is the main driving force behind the alteration of the delicate balance of the ecosystem.

**In many countries, the pandemic has highlighted the crisis affecting healthcare systems. What do you think are the reasons for this crisis?**

Franco Basaglia, the psychiatrist to whom we owe the transformation of psychiatric care in Italy in the 1970s, said during his conferences in Brazil: "Preventing illness means working to maintain health. But we doctors, who are trained in universities to treat illness, we don't know what health is, we only know what illness is. If we really want to change things, we have to start learning at university what social means in medicine, because Man is not only made up of the body, he is fundamentally made up of the social, and as soon as the social enters medicine, the doctor doesn't understand anything anymore, because he is used to thinking that the sick person he is looking at is a sick body, a tumour, a sick liver, a

sick head. It never occurs to him that this person, this illness, this situation can be a consequence of life".

The majority of doctors, during this extremely difficult period, although they were confronted with an unprecedented burden of illness and work, gave enormous proof of their humanity and dedication, even in the face of dramatic and perilous situations. At the same time, however, many health systems have demonstrated precisely the weakness and unpreparedness of community medicine services.

In Italy, as in Spain and certainly in many other countries, this is also the consequence of the dismantling of the national health system according to an economic and even mercantile logic: a logic that has led to the medicalisation, depersonalisation, hospitalisation and institutionalisation of disease.

**What can we learn from this tragedy? What do we need or what needs to be changed in the provision of care and to respond more quickly to epidemics that are likely to reappear in the future?**

Thinking about the post-Covid-19 period in healthcare, many people see only the strengthening (although clearly necessary) of intensive care units and the development and production of new drugs and vaccines. Yet few

people question the need to rethink how the whole system, not just the healthcare system, is organized.

Rather, maintaining and promoting health means seeing and understanding people and challenges in their communities, places of life and work – the circumstances that cause conditions of discomfort and illness. In addition, the Covid-19 patient should be seen as a person with his or her own history, just as a cardiac or mental patient is; not a patient with a medical history, but with his or her own life history. Think of the social dramas that the epidemic has brought to light – stories that need to be understood at their origin.

The community, from this perspective, becomes a place where an alliance can be created among healthcare personnel, teachers, students, workers, associations, cooperatives and movements. The community is reconstituted as a place of active and revitalized citizenship. The community becomes the place of solidarity and cooperation among citizens who may not even have known each other before the pandemic. Emergency and isolation have triggered an absolutely extraordinary dynamic of collaboration. These are the lessons we want to learn from.

Such changes would come from the encounter between people with their urgent needs and the resources available, after the remoteness that the pandemic has imposed. We hope and embrace a progressive social rapprochement enriched by experience and a new awareness of the value of solidarity and the strength generated by working together for the common good.

**In this perspective, is it necessary to review how medical studies are organized or even to develop new medical specialties?**

Healthcare workers are perhaps the most important asset of healthcare systems. Skills shortages and inadequacies seriously jeopardize the sustainability of health systems and are closely interlinked.

With few exceptions, medical schools continue to follow a biomedical approach, leading to "hospitalocentrism" which is at the root of the failure to achieve the goal of health for all, and to the reproduction of the consumerist, commercialized and globalized social model. The practice of medical studies is mainly based on the observation of a hospitalized individual considered a "patient" in bed and in a context that is too often socially and/or culturally alien to the social reality in which people

in their country are born, live, work, age and die.

The standardization of skills and learning objectives (specialization, high complexity, technological sophistication, etc.) corresponds to models of healthcare that are barely viable, even in middle- and high-income countries, and which elsewhere are accessible only to high-income population groups.

In poorer countries, such an approach tends to produce "export" health workers. Indeed, health workers, and particularly physicians, who are unprepared and unmotivated to serve in their own communities, will seek elsewhere – first in the private sector and large urban centres, and then abroad – the kind of professional integration that requires the skills and meets the aspirations suggested in their medical studies and that fits the globalized stereotype of the mythical medical hero of most popular series.

To address the shortage of healthcare workers and its distribution, policies and investments need to be thoroughly reviewed to align the skills of health workers (knowledge, experience, motivation, values) with the context and needs of the population they are expected to serve.

Healthcare worker curricula need to be radically rethought, shifting the primary focus to the determinants of health and systematically linking education, methodology, technology and experience to local realities. Solidarity with those most in need and a commitment to public service should inspire and guide health workers throughout their studies and later in their profession.

**Do you think that the Covid-19 pandemic will have such an effect on public opinion and governments that there will be a "post-Covid" or that everything will go back to the way it was before?**

Many communities are still in the middle of the storm. Nevertheless, while we record some significant ongoing cooperative experiences, we are also trying to imagine what "post-Covid" will be. We wonder whether Covid-19 will really mark an era - pre- and post-Covid - or whether the experience will simply overwhelm us, preventing any thoughtful change. Will the urgency to get back to "normal" simply push us to start all over again, as if nothing had happened? Are we simply going to return to the past without having understood what has happened on a planetary level? Are we collectively going to "forget" how everything is structurally linked to the society that has functioned, for far too long, on the basis of

individualism, competition, exploitation and, above all, the destruction of the environment? All these questions are open and the answer must not be left "blowing in the wind" as in Bob Dylan's famous song. We must learn from them and rather build a practical and urgent global response: reduce our environmental impact, redirect consumption towards essential goods, recycle and reuse, totally reduce the "speed" of our society. This can be done.

However, it requires what I call a paradigm shift, putting human and global health at the heart of our priorities and thus of local, national and global policies. To this end, active citizenship is essential.

**Thank you, Eduardo!**