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State of Affairs, Concepts, Approaches, Organizations in the Health Movement

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Italy

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1. A Brief Introduction

Laura Corradi

Welcoming the reader, as a coordinator of the Country Report, I feel the need of warning around the obvious boundaries of this work. This report is not exhaustive: It is a first, serious step toward a better comprehension of the Italian Health System, its principles and way of functioning, from a women's point of view (see Giovanna Vicarelli's essay), also looking at the complex interaction between health institutions and social movements, where women historically played an important role (see Anna Latini's essay).

We know how feminism impacted the health system and health professions (see Paola Vinay's essay) in the long run, by placing the women's body in the centre of radical discoursive practices. What we do not know relates to the extent to which the target has been missed - and how to interact with institutions today, to get a system "made to fit women's needs".

Often women get organized to supply the public system deficiencies: it is the case of those centres working on active child-delivery (see the essay by Anna Maria Gioacchini and Romana Prosperi Porta illustrates) and many more experiences, as reported in the Appendix. The emphasis on prevention - a milestone in the critique of patriarchal medicine - is discussed both in my essay on women in cancer activism and Elvira Reale's one - having as object a mental illness prevention centre totally geared toward women.

Many more topics could be added to this first effort: from traditional ones - such as menopausa and abortion - to new issues for women - such as the increase of cardio-vascular problems and allergies disorders. I sincerely hope this first country report will be a stimulus for new entries and contributions from the several groups and individuals contacted during the research process.

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And I wish to thank all groups of women who decided to answer to my questions, send me materials about themselves, and share their experience with the whole European Women Health Network.

2. The Italian Health System: An Overview

Giovanna Vicarelli

2.1 The institutional setting

Looking at the Italian experience from a broad and long-term stand-point, we can notice features which are distinctive, with respect to other European countries. Such differences originated from a delay in the process of creating a mandatory health insurance system and in the slow implementation of the public health protection system. This process encouraged mutual-aid experiences during 20 years of fascism. Then, it induced the country to go further in the expansion and establishment of the system during the fifties and the sixties, to modify itself in universalistic terms during the seventies, and to reach a revision during the eighties - a delay of 15 years with respect to most other European countries.

The Law 833 in 1978 mandated the introduction of a National Health System in Italy, with a strong territorial articulation. The activity of management and provision of health services was to be assumed by the Local Health Units (USL), today called ASL - Local Health Agencies. The Minister of Health and the Regional Governments are expected to program and control NHS activities.

Laws by decrees approved during 1992-93 (DL 502 and DL 517) emphasized management aspects and the organizational autonomy of ASL, introducing forms of "managed competition" similar to those expected in the British NHS plans of reform. Such decrees have been recently revised (Law 229-1999) re-stating the public character of the Italian Health System, and underlying the processes of managed co-operation that would replace competitive regulatory forms and excessively market oriented forms.

2.2 Ways of financing

In 1995 the Italian Health System was financed through health contribution (37%), taxation (31%), prices (24%), tickets (3%)[1] and insurance prices (3%). The fiscal pressure for financing the health system is today around 5.4% of GDP - after a growth up to 6.2 in the early nineties. The private component appears to be high for a public health system. It remained modest up to the last decade, when we had a strong acceleration in such a process, due to an increase in expenditure sharing, and following a reduction in public services. Today Italy ranks 6th among OCSE countries in terms of private financing per person after Germany, Australia, Canada, Switzerland and the U.S.

In public financing, health contributions prevail - in so demonstrating the hybrid character of the system, since such a form of financing is typical of merit-oriented models, instead of universalistic ones - where forms of fiscal financing tend to prevail. While in private services resources flow directly to the distributor, in public health resources they are located in the state budget in first instance, then distributed to the Regions following criteria oriented toward the re-equilibrium of the areas, ending with the subdivision of the funds among the ASL at the regional level.

The ways of payment of services are quite different: a per person quota to primary care physicians who are not enrolled as stable personnel (those professionals who have contracts for their work); a DRG tariff to private health clinics; payments per-hour to internal specialists and payments on the basis of service to external specialists.

2.3 The organization and the provision of services

2.3.1 Territorial assistance

The development of primary care medicine was one of the main goals of the health reform in 1978. It was supposed to be based on paediatricians and general medicine physicians working within socio-sanitary districts - intended as the organizational levels of USL - which should have been able to guarantee an adequate response to sanitary needs at the first level. Nevertheless, since districts became mandatory just during the recent reform (Law 229-1999) physicians have had to guarantee primary care up to now. Such physicians are formally autonomous workers who now receive a per person quota (per year, per patient), and whose tasks are regulated by national conventions every three years.

All citizens have the right to receive primary care assistance by the doctor they choose, on the basis of a trust relationship. Every primary care physician may carry a caseload (or panel) of no more than 1500 adults (aged 14 and up), while paediatricians may carry only a maximum 800 children, (up to age 14). In 1997, primary care physicians carried an average of 1051 adults and 685 children in their caseloads. The analysis of the national distribution of choices highlighted homogeneity for the general medicine physician and a lack of homogeneity for paediatricians, because of a shortage of the latter in some areas: where this occurs, parents can utilize the primary care physician also for children under 14 years of age.

The main problem for primary care doctors is being (and feeling) marginalized within the National Health System both because they have few opportunities to participate in USL activities and because of limited opportunities of collaboration with specialists and hospital doctors. Primary care physicians start their practice with little clinical experience and no training time with older colleagues. The opportunities for updating their knowledge are not many and the main source of new information on prescription drugs comes from the pharmaceutical industry. The payment of a quota per person - which should have implemented preventive medicine - ended up by emphasizing the perception of primary care as bureaucratic and routine-oriented serving only to prescribe what the patient requests rather than performing diagnosis skills. In this direction, the USL tends to limit the sanitary expenditure induced by primary care doctors, both through tickets on medicines, specialist and diagnosis services, and through increasing processes of self-regulation and control.

Two types of physician-on-call services - one for Italian subscribers to the NHS and one for tourists- were respectively introduced in 1982 and 1984 as part of territorial medicine. The first provides a service during the night (from 8 pm to 8 am on working days) and during week-ends (from 2 pm on Saturdays to 8 am on Mondays); the second coordinates the activity of physicians in tourists areas. With new conventions, equal status has been conferred to these professionals, the same as general practitioners and paediatricians enjoy. In 1997 doctors on call numbered 15,375 with a higher presence in the south of the country and on the islands.

The convention signed in 2000 allows all primary care physicians to associate with other physicians in order to carry out team work and offer more services to their patients. In parliamentary discussion we have a project to re-define the activity of paediatricians to guarantee the continuity of assistance through ambulatory associations open 24 hours a day and to allow paediatricians to work in close contact with structures for mothers and children to be instituted within the hospitals.

2.3.2 Ambulatory specialist assistance

Specialist assistance is provided within the national health service, through several types of structures: public outpatient clinics (in the hospital and outside); specific clinics such as maternal child health services (MCHS) and services for drug addicts - called "Ser.T".

The National Health Plan 1998-2000 establishes guidelines for pregnancy and childbirth and for the integration between services for mothers and children with social assistance and education. Awaiting the implementation of such standards, part of the assistance load for mothers and families is presently carried out by 2,386 public MCHS clinics nation-wide. In 1991 there were 3,178 MCHS clinics demonstrating both a reduction in public intervention in this area, as well as the dominance of specialist private medicine (obstetricians, gynaecologists) and hospitals (both private and public).

The field of drug addiction treatment is going through a deep change both at epidemiological level and organizationally. In 1996, 515 Ser.T. units were active, with a territorial distribution quite diverse in terms of centres and clients. In Lombardy Region, for example, 44 units supported 20,666 patients in 1996 - while in Emilia-Romagna Region the same number of units supported 8,943 persons.

2.3.3 Hospitals

Hospital assistance guarantees hospitalisation in public structures and private structures accredited for diagnosis and care for illness that requires emergency interventions and for acute or long illness, which cannot be dealt with at home or on an outpatient basis.

In 1997, 942 public institutes and 537 accredited clinics were active in the country - the latter reaching 43% of the total. The regional distribution of beds in accredited private facilities in the Lazio Region (Rome) is quite high, reaching almost 51% of the total. Such a trend is less evident but growing in the south of the country, especially in Calabria, Campania and Sicily. At the national level, 20% of all hospital beds are located in accredited private structures. This proportion is higher in the north and lower in the south.

2.3.4 Personnel

At the end of 1997 there was a total of 673,298 National Health System employees. The trend is towards a reduction (there were 692,757 in 1994) and not towards full coverage of staff (92.1%). Shortages of personnel are seen most often among top managers in administration and among technical-professionals. Nevertheless 96% of the personnel is working with an indeterminate time contract (permanent positions) - a high standard, very similar to the ministerial sector. Part-time employment reached 2.1%, with 10,832 workers - 77% of whom are employed less than half-time. In 1998 the ratio of NHS personnel to population varied greatly by Region. In the north of Italy - with no exception - the ratio was greater with respect to the national average (1:67 vs. 1:90). Specifically, in Emilia Romagna the ratio was 1:76. The situation worsens from Rome southward. In Lazio, the region that contains Rome, the ratio of NHS personnel to population is 1:109 and is only slightly better in Campagnia (Naples) and in Sicily (1:107).

In Italy, at the end of 1997, women represented 57.13% of the NHS employees - only slightly more than the year before. Among the individual positions in the health sector, women represented 70% of auxiliary health jobs, 26% of full time physicians, 22% of

contract physicians , and an even smaller proportion among veterinarians (12%) and dentists (15%). Even though females hold more than 50% of all health sector jobs, their presence is scarce in higher-level roles and is concentrated in health provider and administrative roles. Additionally, part-time employment is almost totally a phenomenon of women (93.4%). The highest rate of women's presence in health sector jobs is in the centre-north-west - the maximum being in the Bozen province (69.1%) and the minimum in the Naples Region (38.2%) followed by Calabria (40.5%), Sicily (44.9%) and Puglia (46.7%). Sardinia represents an exception: with a percentage of 56.6%, it is close to national average.

2.4 The population's state of health[2]

2.4.1 Mortality

Mortality data from 1994 highlight that most frequent causes of death were related to cardio-vascular diseases, with a crude rate (age not taken into account) of 399.9 per 100,000 men and 447.0 per 100,000 women. However, age standardized rates (taking age distribution into account) were higher for men. Cancer ranked second as cause of death with crude mortality rates per 100,000 inhabitants respectively of 328.9 and 220.4 for males and females. Age-standardized rates for cancer were 5 times higher for men compared to women (respectively 93.6 and 16.9 per 100,000). Respiratory illnesses ranked third as a cause of death with crude rates of 73.7 for males and 45.2 for females. Mortality due to infectious diseases, parasites, cancer, circulatory system diseases, and external causes (traumas and poisoning) were higher in the centre and northern parts of Italy, compared to the south.

2.4.2 Morbidity and perception of health

In 1997 the perception of health status, ranked from 1 (poor) to 5 (excellent) averaged between 4 and 5 for 79.3% of men and 72.7% of women. Nevertheless, 36.3% of the Italian population reported having one or more chronic illnesses, basically unchanged from the previous year (36.9%). Persons in the south reported more chronic illness than those in the north. More women than men reported suffering from chronic illness, including osteoporosis, arthritis and hypertension.

32.7% of the population reported having used a prescription drug during the two days preceding the survey. This proportion was higher in the north and in the centre compared to the south.

In 1997, 25% of the Italian population aged 14 years or older reported that they smoked tobacco. The percentage of men smokers, at 33.1%, was less than previous years while the percentage of women smokers remained stable at 17.4%.

According to a report issued in March 2000 by the EC, for Italian youth aged 15, present life expectancy is slightly higher than the average in Europe: 60.6 years for boys (European average 60.3) and 66.9 years for girls (European average 66.4).

A 1999 study carried out by the "European Observatory on Drugs and Drug Addiction" indicated that in Italy the rate of drug consumption among people age 15-54 was 5.3 to 10.1 every 1000 inhabitants. The largest prevalence of drug users was found in Luxemburg (8.2-8.6) and Great Britain (2.7-10.5) especially for I.V. drugs and long term use of opiates, cocaine, and amphetamines.

According to a Guttmacher Institute survey, Italy ranks in the bottom for teen pregnancy (10 per 1000) and abortion (6.6 per 1000) while Russia, the U.S., and several Eastern European countries rank in the top. The rate of abortion among girls less than 18 years old decreased from 4.3 per 1000 in 1983 to 4.1 in 1998 (Istat) while for abortion the rate decreased from 13.2 per 1000 in 1987 to 9.3 in 1995, remaining constant in 1996.

According to data produced by the Minister of Health, between 1994 and 1997 the number of hysterectomies grew in Italy from 38,000 to 68,000 per year. Essentially, this means that one Italian woman out of five undergoes a hysterectomy (in the Venice Region the ratio is one in four). Such an average is much higher than other European countries - France has a ratio of one in twenty which is closer to the average in the U.S., the leading country in this trend, with one woman in three.

3. The Italian model of health protection and the role of women

Paola Vinay

This contribution has been developed around two main topics: the first point is a brief description of the Italian Health Protection System, in a general European frame of reference; the second point has to do with the role of women (the women's movement, politicians and health professionals) in its implementation.

3.1 Models of health systems in the EU Member States[3]

Every EU country operates facilities designed to protect public health and a number of statutory medical facilities as public hospitals and community health personnel. Nevertheless, there are significant differences among the health systems of the European Member States. Two main "models of coverage" can be identified: the "occupational" (or "corporatist") model and the "universal" (or "statutory") one. In the "universal" model the main subject of public coverage is the citizen: all citizens are covered in the same way without regard to their work or family position; the financial support comes from taxation on general revenues. Whereas this model is historically rooted, it has engendered national systems of mandatory health insurance or national health services, directly managed by the State. In the "occupational" model the subject of coverage is not the citizen, but the worker paying contributions out of his/her income as "sickness funds", according to his/her employment category, while the non-active population has eventually acquired the right to coverage either as retired workers or as dependent members of the breadwinner's family.

The "universal" model of coverage prevails in all North European countries: Sweden, Denmark, United Kingdom, Ireland, and Finland; the "occupational" model prevails in all Central European countries: Austria, Germany, France, Belgium, The Netherlands and Luxembourg. The Southern European countries - Greece, Italy, Portugal and Spain - have according to their laws a "universal" model of coverage, but their national health service "contracts out" to private centres (the Spanish conciertos, the Italian centri convenzionati) the provision of a vast array of services. Moreover, Greece, Portugal and Spain still rely largely on contributions to finance their systems. For these countries we may identify a "mixed" model of coverage, which is formally "universal" while drawing an important proportion of its financing from occupational groups contributions and sub-contracting many public health services to private providers.

Another significant institutional feature of the health system is the devolution of power to sub-national and regional authorities. In France, despite recent important efforts to decentralise, the health administration remains united and centralised: local political authorities have only minor responsibilities in health care matters. On the contrary, in Germany and in Italy the sub-national authorities have their own separate health administration. In Sweden, the government of health is highly decentralised both functionally and geographically: for instance, the county councils levy their own health taxes.

Fig. 1 Distribution of the health systems of the EU Member States according to the model of coverage and the range of devolution of power to sub-national authorities.

Model of coverage	**Range of devolution**	
	high	**low**
"Universal":	Denmark, Finland, Ireland, Sweden	United Kingdom
"Occupational":	Austria, Belgium, Germany	France, Luxembourg, Netherlands
"Mixed":	Italy, Portugal, Spain	Greece

3.2 The Italian Model of Coverage

Until 1978, Italy had an "occupational" system of health protection; the National Health Service (Servizio Sanitario Nazionale, SSN) was introduced with the Law 833 of December 1978; since then a unique general scheme covers all citizens. The NHS provides all benefits in-kind free of charge (or with a small fee called with an english term "ticket") to all citizens. The health benefits (prestazioni sanitarie) offered to all citizen free of charge are: paediatric, gynaecological and general assistance; hospital assistance; emergency care; life-saving pharmacological products and some forms of ambulatory specialist assistance and secondary prevention such as PAP tests. Other benefits are offered under payment of a fee (free of charge for older and economically disadvantaged people): some pharmaceutical products; specialised medical assistance; diagnostic tests; radiology; laboratory analysis; rehabilitation and technical devices.

The administrative structure of the NHS is decentralised. At the central level, it is co-ordinated by the Ministry of Health. The Ministry lays down the guidelines of the National Health Plan (Piano Sanitario Nazionale) which must be presented to Parliament every three years. Regional governments have extensive power for organising their own health services. They develop their own regional health plan. At local level health services are delivered through the "Aziende Ospedaliere" (main Hospitals) and the "Aziende Unità Sanitarie Locali" (Local Health Agencies) which provide all health benefits and run small hospitals[4]. Both are headed by a "general manager". An agreement between doctors' unions and the Ministry of Health is signed every three years and regulates medical fees as well as other aspects of the medical practice. Physicians are allowed great margins of freedom to deliver services also on a private basis, even within public hospitals. As in the other South European countries, the NHS contracts out to private health centres ("centri convenzionati") the provision of a vast array of services: from diagnostic tests to minor and medium surgery. Almost 40% of public health expenditure flows through private centres of provision. This peculiar blend of public/private mix has originated wastes of public money and private interest between providers/suppliers and health administrators/ politicians.

In conclusion, the Italian health system is characterised by:

1. A "universal" model of coverage;
2. The devolution to Regions of decisional power.
3. A peculiar blend of public/private mix for a variety of health services, due to the diffusion of "sub-contracting" to private clinics and health centres.

3.3 The role of women in the implementation of the Italian Health System

The institution of the Italian NHS was necessary since the previous "occupational" system was fragmented, unequal and in a deep economical crisis. The first Minister of Health after passage of the law establishing the NHS was a woman, Tina Anselmi. The NHS was the outcome of a twenty year long struggle engaged by the working class and the left for an egalitarian and universal system of health protection. It was strongly supported by women's organisations and by emerging professions with a large female presence such as psychologists, social workers, sociologists, and psychiatrists.. On the contrary, most physicians opposed it considering such a law as a limitation to their professional autonomy[5].

During the '80's and early '90's the neo-liberal moderate parties, their Governments and Minister of Health opposed the implementation of the NHS by cutting State expenditures and by increasing fees for patients' participation to benefits costs: indeed they aimed at an economic regulation of the public Health system and the promotion of a partial privatisation. These measures were promoted in 1992 by the Minister of Health (DL 502), but were never implemented because the following Minister of Health (a woman: Maria Pia Garavaglia) modified them in 1993 (DL 517)[6]. In any case, the most innovative goals of the NHS, such as participation, prevention, health education and integration between social and health services, were never completely achieved. In this situation the same non-medical health professions which had strongly supported the reform felt an increasing unease, because it was difficult to implement the goals of the NHS and the out-patient clinics they had supported without adequate resources and without co-operation from the medical staff. They therefore asked for a revision of the system to make it more efficient, autonomous from political parties and to find a new professional identity.

This is the framework in which another woman, Rosi Bindi, Minister of Health of the centre-left Government from May 1996 to April 2000, promoted a rationalisation of the system making it more efficient from a qualitative point of view while strengthening its public nature and setting the citizen-patient needs at the centre. In the guidelines for the new National Health Plan. This female Minister has underscored the importance of principles such as prevention, integration between social and health services, equality and decisional autonomy of patients. Another important point for this Minister was the attempt to overcome the peculiar Italian public/private mix asking physicians to choose between work in the public system or in the private sphere. The norms concerning this last point were strongly opposed by a large part of physicians and the current Minister of Health - a well known physician himself - has decided to slow down this process.

3.4 The role of the women's movement and of female professionals

In Italy, as elsewhere, the women's movement has had an important role in the implementation of more democratic and woman-friendly laws and services. The theme of health and well being has always been an important issue for the women's movement and a logical consequence of female emancipation; the female political movement took strength from awareness raising groups and demanded laws for a woman-friendly legislation concerning the family, abortion, divorce, social services, maternal-child health service ("consultori familiari") etc.

The main types of woman-friendly legislation conquered by women are the following:

- the new, more equal, family legislation (1970);
- the law on divorce of 1970, confirmed later on, with a Referendum;
- the laws for maternity leaves (1971) and public nursery schools (1971);
- the law that gave authority to the public maternal-child health service clinics to provide information on contraceptives (1975);
- the law for legalised abortion of 1978, confirmed later on with a Referendum;
- the law for Equal Opportunities and the promotion of Positive Actions of 1991;
- finally, in 1998, after a long struggle started in 1977, the law against rape and sexual violence was approved: it took 20 years to cancel a fascist law and to assert that sexual violence is not a crime against morals, but a crime against the person! It must be said that the law by itself does not solve all problems: what is needed indeed, is a deep cultural change in society and in particular in the judicial system as demonstrated by some recent sentences (for example, in establishing proof that a sexual assault has occurred the idea that jeans cannot be taken off without the woman's consent!).

Using techniques developed in awareness raising groups, Italian women, both as health professionals and volunteers, promote "self help" and "mutual aid" groups for women with such problems as mental health disorders, eating disorders, cancer etc.. In medical practice women are bringing new strategies for health promotion not based on traditional instruments and pharmacology. Several women's groups and professionals (in particular, female gynaecologists and midwives) promote de-medicalisation, natural birth and re-appropriation of female positive energy. Women are present in different fields and health professions where they are bringing innovative inputs and a new perspective in medical and scientific research, emphasizing gender prejudices and calling the attention of the scientific world to the importance of taking gender difference into account.

In summary, the implementation of innovative aspects of the Italian NHS (prevention, social-health integration, development of out-patient clinics), have been strongly supported from the beginning by women's movement, by women in health professions as well as by the three women who have reached the role of ministers of health.

4. Women Movements for Health in Italy

Anna Maria Latini

In Italy during the seventies there were many and diverse groups for health, which found themselves in the core of militant feminism. From city-by-city forms of aggregation, we started organizing national coalitions which addressed the relationship with institutional politics - especially on the subject of abortion.

Some of the theoretical knots still remain: body and psycho-physical identity, the critique of science and the defence of health are still, and more, on the top of our worries.

In the story of groups for health, we may identify the two faces of feminism: the one geared to individual transformation and the one oriented to transforming sectors of society. The second was prevalent, since health related issues go beyond the private relationship with the other gender, and place into discussion parts of a woman's self having to do with institutions.

Early aggregations on women's health before 1974 represented a product of the first wave feminism and were affected by consciousness-raising practices. From the collective standpoint of finding oneself, these aggregations represented a re-appropriation of means in order to gain autonomy in the defence of health, and tended to affirm a female authority in society.

New values found an answer to the need of identity - not power - needs of liberation involving sexuality and roles in each person; the relationship with authority; mental and material structures of capitalism and patriarchy altogether. Anti-psychiatry; the politics of medicine (which gave birth to "Medicina Democratica", movement of struggle for health, 1976); and the rebellion against repressive social norms, are the background of many of us who carried within feminism those needs of liberation related to health.

In the radical culture the reference point was the person's rights - while in the new left the struggle for health puts into discussion power relationships within the medical apparatus and in health structure in general.

There was a widespread need to know one's own body, from sexual life and biology to illness. Yet the body, as Alma Sabatini used to say, for most of us is "a mystery wrapped into the mystique of maternity and sexology".

The Roman Feminist Movement took its stand to recreate self-help experiences born in the U.S. movement. In Milan, a group elaborated a proposal "For a Women's Medicine Centre" in 1974 getting more attention in the network of health groups than in the feminist movement in general. Their ideas were clearly expressed: "Only starting from our consciousness raised in feminist groups and from the comprehension of our historical and daily condition we women could put on a different basis the need of taking strongly into our hands those processes that deeply affect us, the functioning of our body, the relationship with physicians and the medicine".

At the February 1975 conference "Sexuality, procreation, maternity and abortion" held in Milan (Circolo de Amicis), many voices raised around the desire to find common threads among these experiences, in order to confront the social power exerted through medicine. Someone talked about sexuality in terms of "frigidity experiences, pretence, seduction and

everything related to our relationship with the man". While body and sexuality represent a plus in politics, regarding the individual privately, in feminism they constitute a decisive question - not only to denounce violence and oppression, also to positively state one's own potentials and desires. During the conference, abortion was addressed as "a problem that cannot be isolated from the political body, i.e., the re-construction of what connects politics with sexuality and body".

Since 1974 projects for the constitution of self-help centres - after incubating for two years - reached maturity in two collectives: Milan (via Cherubini) and Rome (via Pompeo Magno). In Milan a "feminist group for a women's medicine" was given birth: it published "Contraceptives on Women's Side" in 1974, and it carried out a project of "Women's Medicine Centre", following experiences of consciousness raising on body and sexuality. Simultaneously in Rome, Simonetta Tosi created a "contraception and abortion group" within the Pompeo Magno Collective, promoting the opening of a self-help centre in the San Lorenzo working class neighbourhood. In the same year, a new feminist group for women's health was born, located in the Trastevere quarter.

The struggle for legalized abortion and for a law instituting maternal-child health services becomes a test bench for early aggregations, which witnessed the growth of the movement and the arrival of women after demonstrations, before being capable of elaborating self-help suggestions in a practical manner.

The abortion issue acted like a magnet in the movement and became the funding reason of many collectives between 1974 and 1975; it reached the core in Mld, "movement for women's liberation" agenda, in the radical Cisa (Italian Centre for Sterilization e Abortion) and national demonstrations, such as the trial against Gigliola Pietrobon in June 1973.

Early resistance forms took place: women got out from under the social stigma of abortion and organized trips to London and contacts with the French Mlac (Association for the Freedom of Abortion and Contraception) spreading the "Karman" abortive method. Collectives and coalitions took form, such as the Crac (Roman Committee for Abortion and Contraception, June 1975). In Padua, Ferrara, Turin, Milan, the self-management was organized with the determinant contribution of women coming from the radical left. The Mld separated from the Radical Party organizing self-help groups in the collective site of via Governo Vecchio, occupied in 1976.

Several conflicting positions emerged, also in women's health meetings: the first was held in Rome at the end of 1975. A double existence started for women, between "mixed" collective demonstrations on one hand, and the women's political theory and practice on the other, the latter informed in reciprocal learning and socialization in self-managed sites - besides the material help for gynaecological problems and clandestine abortions.

Conflicts grew with the institution of public maternal-child health (MCH) services (Law 405, July 1975). Some self-managed MCH clinics, - supported in Rome by Crac, in Turin by the movement in support of public MCH service clinics - proposed a model to be implemented by the new institutions. In Turin, Rome and Milan, coalitions worked on the project to transform self-managed clinics into public structures. Soon, they realized that these clinics were not going to be controlled by women, on the contrary, their constitution accelerated the crisis of the self-managed ones.

The impossibility of negotiating new practices and new knowledge in politics narrowed the women's contribution, which became the one of "improving proposals" made by politicians, males and females. The perspective of MCH clinics supported by the Communist Party and the leadership of Udi (Italian Women Association, founded in 1945 by political refugees in France) was humiliating for feminist practice and knowledge.

In such a phase, meaningful experiences ended, such as the "Feminist Group for a Women's Medicine" in Milan (1977) and the self-managed MCH clinics in Turin - which decided to dissolve in order to contribute in the construction of public MCH clinics: a suffered decision that will brought on second thoughts. "From self-managing to institutions" was the title of an article on the women's "Bollettino" in Turin in 1981, where the object was the passage from "organized subjectivity" - which transforms institutional contents and give strength to the individual - to a politics of claims for the bettering of services - which renounce to the transformation of the material conditions of life.

The richness coming form the experience of self-management gave birth in Turin to workers' courses on women's health "Simonetta Tosi". Other groups still existing, like the "Feminist Group for Women's Health" have kept a distance from working with institutions fearing to become a surrogate service of the public one. Self-management becomes an isolating choice: an example is the "San Lorenzo" MCH clinic in Rome, continuing alone among a thousand problems.

What did follow was a slow individual flow toward parties or - for the majority - the rejection of politics, which became a professional occupation for some women.

Initiatives for the final formulation and implementation of the abortion law in 1978, like the law on MCH clinics, were meant to make the structure functioning without raising problems of content, relationships with medicine and with its operators. Feminist occupations of hospitals in 1978 (S. Anna in Turin and Policlinico in Rome) showed with no doubt the impossibility of informing the institutions about the outcome of self-management practices. The same can be said for the trainings directed to physicians.

From the experience of the past phase, we can outline some considerations around the theoreticl problems we had to deal with:

The search of individual identity and its relation with collective identity

In health groups born from the first wave feminism, the re-definition of identity comes through the relationship among women, mirroring experiences and reflections. A change in context is a condition to allow identity to expand. During such a transformation, the professional role of women working in research and health institutions is involved at all levels.

The passage from an analysis of self to the re-appropriation of knowledge instruments happens in group situations where communication is horizontal, where apparently role differences are flattened. Yet, the role of women experts re-present itself in every impact with the external world, putting at stake their role and the role of the other women. There is a continuous tension between affection and the sharing of experiences, and the realization of disparity - also because women gynaecologists and physicians are few. Beginning expectations of reciprocity and exchange get dramatically re-dimensioned, even though they started something precious: the tension toward transforming roles in the

sense of "doing", and to recompose oneself as a whole person, modifying the content of what we do.

The re-definition of identity

Given the trend of re-composing public and private spheres, the movement pointed the finger toward professionality, upsetting its rules, both the collective relationship with medicine as institutional structure and science. For those who are not experts, the problem was not just the one of acquiring knowledge and instruments, but also the one of acting with other women in order to create spaces of female authority in society. For a woman physician or scientist, the problem is to question her acquired knowledge, besides being the trait d'union between this knowledge and the other women - and to re-mould it in the self-management. The delegation refusal to male operators is replaced with the trust toward the woman expert with whom a new type of relationship is established, which gives each other strength, without being risk free (still delegation, passivity, hardship in working really together to transform something).

The issue of our relationship with science is internal to the health subject

A feminist critique within the medical and scientific world still does not exist, and women who are aware of the necessary work to get there are few. The internal statute of the discipline has not yet undergone the questioning. Simonetta Tosi in 1975 signed (with others) a letter to women's physicians, published on "Effe" magazine from which emerged the belief that acting in the margin between institutions and women's places was instrumental to the awareness awakening among women's physicians caring for women - and it facilitated the re-appropriation of medicine from each woman's side. The mobilization around abortion was an occasion of awareness of one's own oppression also in the specific medical field, concerning the male role exerted by women physicians, who ended up being oppressive towards other women.

Reflections and awareness raising, in the beginning of the nineties, highlighted more the private than the public sphere as the setting where the profession of women experts was put into discussion with the social power of medical-scientific and sanitary structures. We were not able to challenge the split of identity between private condition (politicised by feminism) and professional dimensions (subtracted to a political questioning); when "goals" have been set, they did not touch the way of functioning in scientific and sanitary structures.

The group's experience did not contaminate politics which remained fundamentally impermeable.

Both within political parties and among women (to whom the mediation of feminist claims had been entrusted at the end of the seventies, in order to inform the laws/institutions about the women) a culture supporting the image of a science as superior enterprise and as "super-partes" one still remained. The political agenda only recorded goals and translated them into the women's social issue.

The health movement did not have enough organizational strength; political weakness and the abandonment of autonomy and self-management shade many questions on what "feminist politics" really is, in the era of difference and differences. During the eighties and the nineties several practices - more or less informal, not interfering with institutions claiming a space for their own, without accessing politics - continued. As an example, the active child delivery movement (see chapter 7) was born from private efforts in the direction of non-violent childbirth (suche as: Il Melograno in Verona, Rome and Ancona; The Childbirth Home in Milan; The Elementary School in Florence) getting strength without the risk of being distorted or manipulated by institutions.

A new season?

In Ancona, Region Marche, since 1997 the Women's Forum in town has started a project on "birth". Beginning with the question "why do women not have power?", they elaborated a strategy using female energy as a leverage. Such energy is manifested in the moment of birth (as women confirmed in the testimonies collected in the book "Women Talk about Childbirth"). Then, the memory seems to fade away from the mind: a proof that women have to make an effort to recall it in their everyday life. The Forum opened a discussion on all this, activating necessary actions to put some order in different terrains:

- sanitary practices;
- the organizational asset of services and their structures;
- legislative instruments;
- professional competences.

In such a operation of change, women are involved with operators of both genders, and institutions (County-Hall, Region, and Local Health Units).

A new regional law today includes both at-home delivery programs and a Maternity House project. Two Local Sanitary Units (Salesi Hospital and Asl n.7) started a re-training plan to update and train personnel in order to unitarily activate a "birth path". The Maternity House project is in an advanced stage.

Similar experiences are maturing in different Italian cities. Maybe we are entering the time of a new season.

5. Women and Cancer Activism in Italy

Laura Corradi, Ph.D.

Italy has a story of popular mobilizations against cancer starting with the occupational health movement in industrial cities during the late sixties and the seventies. This movement was composed mainly by male workers in hazardous workplaces, radical unionists, and early environmentalist doctors unified under the slogan "la salute non si vende" ("our health is not for sale"). At the same time, the women's movement in Italy was establishing itself with a strong emphasis on health-related issues: from the very beginning self-help centres focussed on sexuality, contraception, active childbirth, rape, mental health, informed abortion, and menopause. Yet, during the golden age of Italian feminism, cancer was not in the agenda.

Presently in Italy there are several groups of women working on the issue of cancer. Many of them have a strongly institutional approach and are represented in a wider coalition called "Europa donna", (see Appendix: List of Italian Women's Health Associations) which was founded in 1991 by Prof. Umberto Veronesi, who subsequently became Minister of Health in the spring of 2000 during the compilation of this report.

How did cancer become an health issue - and an element of association - among italian women? During the nineties we witnessed a progressive shift of attention from AIDS to cancer in the media and in popular discussion. Yet, AIDS activism is still the closest model we have when considering cancer activism. AIDS activism is the health movement immediately preceding cancer activism and, in contemporary western history represents the only phenomenon where a physical disease has become a political issue on a large scale[7]. Yet, I must say that the differences probably outweigh the similiarities: AIDS is a contagious disease, and it is new, while cancer has been around for very long time[8] which also means that cancer activists have had to face a more powerful and established scientific milieu - with respect to AIDS activists. Moreover, most of AIDS activists have been gay men while cancer activists are heterosexual women, professionals, entrepreneurs, housewives . Additionally, I should mention that strategizing about AIDS prevention is quite a different problem compared to strategizing about cancer prevention, both because of the multiple etiology of cancer and the obstacles represented by vested interests on the side of the tobacco industry and many other corporate polluters.

In Italy, the religious context (illness as punishment) and the social attitude (illness as a shame, or a symptom of bad luck) played a negative role role in the making of cancer as a public discourse. Moreover, the medical profession has traditionally had a quite paternalistic behavior toward women - in general, and with cancer in particular. Male doctors are seen by diagnosed women as diplaying a "blame the victim" attitude that does not try to understand individual causes of cancer by listening to the patient's history and assessment of causes - always placing the responsibility of the illness' origin in individual choices, lifestyle factors, and genetic predisposition.

With respect to cancer treatment, there are few options besides surgery, chemotherapy and radiation therapy. Unlike other European countries, in Italy no alternative therapy is available thorough the National Health System - homeopathic remedies traditional phyto-therapy, Chinese medicine, and the like are discouraged and often discredited by the Italian medical profession. Despite such a context, many women reject the allopathic/industrial path to explore alternative ones - in Italy or abroad - with no institutional support.

While the rise of cancer activism in the U.S. since the early nineties can be already analyzed as an interface between the women's and the environmental movement[9]- with a strong ethnic component - cancer groups in Italy, although they sprang up spontaneously, seem to have emerged from the interaction of educated women survivors and sensitive doctors. In Italy as in the U.S., the cultural roots of cancer support groups are to be found in the feminist experience of the past decades, as in the practice of consciousness raising groups and in the statement that "what is personal is political". In the last decade, the politics of silence and guilt has been challenged by the rise of breast cancer support groups. Most of the groups' activities are focused on:

- support and solidarity to diagnosed women and the terminally ill;
- information and education for prevention campaigns by targeting mass-media; schools, and workplaces;
- lobbying as a pressure group toward the government; local public administration and agencies.

In the U.S., the cancer movement during the nineties challenged the establishment in a quite unexpected and radical way: rallies; massive cancer walks; blockades of corporate polluters' buildings, and street picket lines; invasions of medical symposiums followed by shocking press conferences showing scars in place of breasts. This model was adapted from the AIDS activist strategies of "Act Up". In Italy, cancer activism, however, has not taken this path. Even though in this country there are many support groups, there have been no public demonstrations - besides the yearly "day against cancer" - in terms of social movement action, civil disobedience or collective performance against avoidable causes of cancer.

Where is cancer activism going? In Europe several segments of the environmental movement started to give importance to human health and to re-conceptualize the body as part of the environment.[10] In Italy an interesting venue is represented by the "Forum on illness and environment" which includes the network of association of women with allergies who are demanding more research on domestic exposure to nickel and other environmental carcinogens, on theirimpact on minority women domestic workers and on asthma. There are also women's groups working on genetically modified organisms (Gmo) in agriculture and the risks for public health.[11]

Another area of cancer activism relates to alternative medical approaches to cancer: homeopathic remedies, often combined with allopathic ones; Chinese medicine, ayurvedic medicine, herbal and mineral therapies - fields where women are well represented both as professionals and users.

There are also groups of women in Italy who are actively working both on health issues in general, on cancer prevention and alternative therapies. The "Wild Rose Association" in Trento - a mountain city in the North - focuses on nutrition and alternative therapies and is well connected with a movement of "donne silvestri" ("women of the forests"). Another group to be mentioned AED Femminismo in Bergamo (see Appendix: List of Italian Women's Health Associations) which now includes "cancer primary prevention" among its field of intervention - setting a good example for others to look at. Strategies, alliances, and goals in the daily activity of the many support groups in the field will decide the political evolution of cancer activism in Italy. The development and the empowerment of cancer support groups and cancer action groups in our country is strictly connected with the valorization of women survivors' practices and analyses, and with the socialization of knowledge around cancer aetiology and prevention.

Other factors will affect the composition of the cancer arena and the outputs in terms of social costs in the war agains cancer: in Italy large amounts of money are spent in research on genetics, secondary prevention (early detection) and pharmaceutical remedies for cancer - while environmental etiology, social epidemiology and primary prevention (elimination of the causes) meet serious obstacles: let's consider the reasons why a national cancer register does not exist yet.

More research on environmental causes of cancer and primary prevention strategies is urgently needed. Plus, in our country, primary prevention strategies and guidelines have to be re-defined in a gender sensitive way[12] also keeping into account differences of class, ethnicity, religion and sexual preferences.

6. Women in health professions and new perspectives in research

Paola Vinay

This brief essay is divided in two parts: in the first part I will analyse the role of women in Europe as health professionals and their innovative method of work; in the second part I will discuss, with reference to Italy, new perspectives in women's studies and medicine for a woman-friendly health system.

6.1 The role of women in health and their method of work

Here I will refer to the results of a research on women's access to high level decision-making positions in health institutions of 15 European Union member states[13], and to the documentation of "good practices" in health collected for the European Action Project: "Hannah Arendt School of Politics: women involvement in the public spheres".

Today women are two thirds of health employees in all European Member States and present in all health professions. Nevertheless their participation in health decision-making is by no mean adequate in most European countries. We found considerable differences among the three "major European regions". As a matter of fact, the participation of women at top decision-making levels is higher in the five North European countries (Sweden, Finland, Denmark, Ireland, Great Britain); it is lower in the six Central (Netherlands, Belgium, Luxembourg, France, Germany and Austria) and in the four South European countries (Italy, Spain, Portugal and Greece).

The presence of women seems to be particularly low in professional groups holding decisional power. In most European countries the percentage of women as head physicians and administrative top managers is low. For instance, in Germany, in 1993, women were 35% of all practising physicians, yet they represented only 5% of chief physicians. In Italy, within the 208 Local Health Units in the National Health Service, only 2.9% of general managers are women. Similar percentages are reported for the main hospitals (3.6%).

Women are concentrated in certain health professions: biologists, psychologists, physiotherapists, and over-represented among nurses and non-medical health professions[14]. Within the medical professions, there seems to be a prestige and power hierarchy among different specialisations; women doctors have less access to some medical specialities, surgery in particular.

In synthesis, women in health care professions are still under represented at decisional levels because the professions in which they are more present (general practitioners, paediatricians, psychologists, nurses, technicians, midwives) are given low prestige and decisional power, in spite of the fact that these professionals have a direct knowledge of the patient's reality, and a better ability to communicate with them[15]. On this matter it should be mentioned that the prestige granted to the different professions is defined by culture and power relations; thus today's professional hierarchy may be vitiated by the unequal representation of men and women and by a power relationship which up to now has been in favour of men[16].

The question now is why the participation of women in health decision-making is important and whether it contributes in a new and valuable way in this field. First of all, I would like to point out that women's participation in the decisional processes is important not just for a principle of equity, but for the different ways women have of confronting health problems.

Thanks to their specific professionalities, they have developed an approach to health problems which makes them particularly sensitive to prevention and better able to meet the needs of the population, and of women in particular. As a matter of fact, our research underlined that women have different priorities than men on their agenda of health policies. They seem to give more importance to prevention; health promotion; integration between social and health services; caring of the elderly, and chronic diseases. They pay more attention to problems related with the maternal-infant sector and to all areas concerning specific female problems: pregnancy, childbirth, caring of the new-born child, prevention of breast and womb cancer, menopause and osteoporosis[17]. In other words, while men seem to be more inclined to medicalisation and the use of advanced technologies (intervening in the case of heart attacks, brain surgery, etc. - which have more prestige in the medical hierarchy). Women seem to have a broader view, seeking long term results and giving relevance also to low prestige areas.

Moreover, according to our european researches[18] on the role of women in health, often women have different ways of dealing with health problems and a different method of work from men: that is, in health services they resort to a method of work based on confrontation, group or équipe work and the listening of patients and colleagues; they give great relevance to interpersonal relations both with patients and colleagues. The result is a more effective health care due to a more global knowledge of health-care problems and a better way of communicating.

Again, compared to men's, the style of leadership of a good number of women appears to be more co-operative and consensus oriented. They tend to recognise authority to all professions, to respect different roles, to entertain clear, direct and informal relations with colleagues and people working under their direction. When conflicts occur in the decisional process, they take the time to discuss, focus the main goal of the service and reach collegiality. When conflicts occur between the different institutions they are able to start a tenacious work of mediation, connection building, and networking, without forgetting the main aim of the public service, and the general benefit. Of course, some women in top management positions have an authoritarian style of leadership, but this occurs more frequently if they are isolated; when there are several women in top positions, more likely they assume a democratic approach to work and leadership.

A good example of the innovative practices women bring in public health is given by the method of work developed in the public Mental Health service of Naples by Elvira Reale and her group of health professionals. In their work practice they verified that traditional mental health services do not fit the needs of women, because they do not take into consideration their private lives and living conditions. Therefore they decided to set up a new service, unique in Italy, addressed to women to prevent their mental illness: the Woman's Mental Health Prevention Centre, "Centro per la Prevenzione della Salute Mentale della Donna"[19]. Another good example is given by several women's associations such as "Il Melograno" that are devoted to promoting natural birth and preparing women and their partners to the experience of birth, matherhood and fatherhood[20].

Summing up: our research clearly shows that women bring with them new ideas, different priorities, different methods of work and a different style of leadership. They look for collaboration in the decisional process: they believe that when decisions are shared, they are also effectively carried out. The final result is a more effective health care system.

6.2 The status of the Italian research and the project at the Ministry of Equal Opportunities

A work group was formally constituted in September 1999 within the Italian Ministry of Equal Opportunities, named "Objective 2001: for a health made to measure to women's needs" ("Obiettivo 2001: Una Salute a Misura di Donna")[21]. The group is made of 11 women from different medical, health and social professions who in their practice and research have contributed to detect specific gender aspects of health. The group consists of 2 psychologists, a psychiatrist, an oncologist, a cardiologist, a gastroenterologist, an epidemiologist, a pharmacologist, an expert of occupational medicine and 2 sociologists.

The first task of our work group was documenting the inadequacy of health information systems and health research in Italy. Indeed, its deficiencies are relevant:

- in our country health data are not systematically collected and disaggregated by sex;
- there are no data on violence as a cause of women's ill health; it is often hidden among "domestic accidents";
- in Italian health research there are no rules for including gender differences in population samples. This omission penalises women as well as research on causes and risk factors of pathologies prevalent among women;
- also in pharmaceutical research there are no rules requiring the collection and analysis of data by gender in spite of evidence of gender differences in efficacy and in side effects of pharmaceutical products;
- there are no adequate inputs to make research on new frontiers for prevention in order to grant better health and lifestyles for women.

The aims of the group are:

- to create a unified field of observation over the main pathologies prevalent among women and over different areas of medicine;
- to point out research biases against women, and the under- or over-evaluation of some factors influencing women's health in medical research;
- to produce guidelines of intervention for a woman-friendly health system.

We faced two main sets of problems:

1. Inadequate consideration of gender differences. All biological differences seem to be reduced to the reproductive sphere without an overall consideration of other biological differences between the sexes: this is due to an ideological over-evaluation of women's reproductive functions. Man and his biology has been constantly taken as the sole reference point for clinical studies; all this has favoured the exclusion of women from clinical trials in fields other than gynaecology. In fields such as cardiology, oncology, pharmacology, and occupational health, the female and male bodies are treated as if they were the same; and the efficacy of diagnostic tests and treatments is essentially measured on men.

   The exclusion of the female body in medical research leads to several problems, related to:

   - instruments for diagnosis and treatment;
   - pharmacological trials to determine dosages and side effects (particularly in cardiology and psychiatry);
   - the definition of guidelines for prevention and treatment;

- the analysis of social risk factors since the male productive work model is considered while the double work model of women (professional and family) is excluded.

Some examples: In cardiovascular diseases, diagnostic tests based on a male model have been used despite the fact that the test results are much less accurate for women; chest pain in women is differet and called "atypical" (the male one being considered "typical"). In the field of pharmacology, drug dosages specifically for women do not exist; the dosage usually refers to the model of a "typical" male; no test is made on pregnant women and children (not even on females animals and puppies); when tests are made on mixed samples (male and females) the results are not analysed by sex.

2. The second set of problems refers the disparity in analysing male and female pathologies; in the case of women, important risk factors are not taken into consideration - in primis the environmental socio-work factor. Research done in the fields of stress, cardiovascular diseases, cancer, depression and on occupational diseases demonstrates a strong bias in the original study: on one side, the study of male pathologies focuses always on environmental, social and work risk factors; on the other side studies of female pathologies focus mainly on risks related to the biological - reproductive - hormonal sphere. The absence of environmental and occupational perspectives create obstacles to the highlighting of primary prevention strategies for women. It is therefore necessary to widen medical research on risk factors for women's health, including the double work load - professional and family-caring - and the study of environmental stressors, among which sexual violence and harassment are very important.

Some examples: In the diagnosis of cancer, while occupation is always considered a risk factor for men, in the case of women this risk factor is often not considered : there is a clear under-evaluation of environmental, occupational and domestic risks for women, particularly for low-income women. It is should be stressed, instead, that the individual behavioural risks are linked to the woman's lifestyle; indeed, toward women there is a "blame the victim attitude"[22]. The under-evaluation of environmental and work risk factors for women has consequences also on research on stress (as a risk factor for cardiovascular diseases, psychiatric pathologies, depression and cancer). As far as exposure to special stressors it has been underlined that violence is a transversal risk factor apt to cause severe psychological and psychiatric problems; for instance, women who have suffered physical and/or sexual violence may develop acute gastro-intestinal symptoms, and the severeness of symptoms is directly related to the level of violence experienced.

The final aim of the "Objective 2001: for a health made to fit women's needs" group is highlight operative instruments to modify medical practice and define technical-scientific guidelines to be experimented in some health units and to propose for adoption by the National Health Service in order to reach a health system more women-friendly, "made to fit women's needs".

7. Active child delivery and personalized assistance

Anna Maria Gioacchini and Romana Prosperi Porta

Since the times of the ancient Greeks until the XIX century, only women were admitted to assist in childbirth. Only with improved medical and surgical technologies has the male figure been introduced. At the same time, changes were also made in the location of childbirth - from the home to the hospital. The birth then moves from being a family event situated in an everyday life and context full of emotions and especially of women's solidarity to become strictly a medical-surgical event in the hospital structure under the management of a doctor.

The methods of childbirth assistance have become standardized and specialized. A series of practices such as the administration of ossitocine, tricotomy, litotomic position and episiectomy have become routine: they are more functional to the organization of the structure than to the improvement of labour and delivery, as widely demonstrated by scientific research on the subject matter. In addition, the environment where labour and delivery take place becomes a crowded place with no privacy. In this setting, women must passively submit to medical indications, losing trust in their own body and, as a consequence, losing the protagonist role they have always had throughout the centuries. Tension, fear and uncertainty increase. In fact, feeling passive and deprived of the possibility of fully living the process of giving birth - so deep, intimate and subjective - exacerbates a sense of inadequacy among women giving birth in this type of setting.

Even the welcoming of the newborn and its beginning relationship with the mother become standardized and aseptical: a few quick gestures - often violent - do not take into account the needs of both mother and child. The most common practice becomes one of separating them. Emotionality, affection, sexuality, and intimacy are neglected and assistance becomes de-humanized without the positive qualities characterising the role of the midwife: patience, sharing, support, respect, warmth, enthusiasm. Child delivery becomes increasingly medicalized, and the rate of caesarean sections increases: today Italy ranks second, worldwide.

All of this is done in the name of presumed safety for mother and child although the medical literature demonstrates that medical interventionalism and routine caesarian sections do not decrease maternal and perinatal morbitity and mortality. Rather, it is the improvement of economic, nutritional and hygienic conditions and the use of new technologies better able to identify high risk pregnancies which have contributed to reducing maternal and perinatal morbidity and mortality.

During the 1970s, thanks to feminist movements, a consciousness opposing this type of childbirth assistance grew among women who did not feel like passively living such an important event. Women's associations and opinion movements promoted many changes and enabled the passing of several laws to protect maternity (Law 1204-1971); to establish family planning clinics (Law 405-1975); and to reform the family law (Law 151-1975). In 1978 the law to establish a National Health System and the Law 194 for the social protection of maternity was approved.

Women increasingly demand to be protagonists in their own deliveries and to receive personalized assistance in an environment that creates a sense of serenity, trust, warmth, and support. Moreover, women state that the newborn has rights to be born in an intimate and

respectful way, taking into account particular needs. The parents need to start their relationship with the child in a context of support and respect for their competence.

All this is accounted for in the practice of "active child-delivery", backed by scientific evidence, which is essentially based upon the respect of each woman's choices in her own delivery, and in the trust of her own ability to give birth. In this perspective, the woman actively decides how to deliver her child in the best way according to her own needs. The midwife offers personalized assistance and allows the mother to utilize different positions (standing, squatting, sitting, laying down, in water) in accordance with her wishes.

During the 1980s in several Italian regions, associations were born such as "Il Melograno" (the pomegranate) and "Il Marsupio" (the marsupial) that served to breed a new culture of childbirthing. The activities of these groups included seminars, meetings, and public debates, in order to get attention of women also involved in politics and institutions. Besides cultural activities, these associations offered clinical services that were not connected to public structures, and which operated in a way to address the needs and wishes of the women giving birth. Other activities of these groups included classes of childbirth preparation ; training for obstetricians and other medical operators; lectures; and measures to apply regional laws where available and to call for the approval of a national law.

"Il Melograno", centre for information on maternity and birth, is a national non-profit association in the field of active childbirth, with several locations in Italy (Verona, Rome, Ancona, Gallarate). In Rome, Il Melograno is composed of professional obstetricians, gynaecologists, and psychologists, who work in a team but each bringing her own perspective and focus (such as physiology and pathology, body and mind). These women established a methodology and a personalized approach to birth, with a professional attitude informed by the respect of the individual needs and culture of every woman, without proposing a unique model. In the same way, Il Melograno has a team to provide active childbirth assistance at home - without claiming that such a model is in every case the best approach- as one of the possible choices every woman may have.

The WHO in 1985, approved a document with 15 recommendations for a "Proper technology for childbirth" which place into discussion most of obstetrical and paediatric practices in common use, and proposed some changes.

In several regions - such as the Lazio Region (Law 84-1985) - laws have been approved in order to humanize childbirth practices. In Lombardy (1987); Piedmont (1990), and Marche (1998) home delivery is reimbursed by the USL[23] and many hospitals have organized department for active child-delivery assistance - thus becoming important reference points for the rest of the country. However, despite innovations in these few regions, the majority of public structures still offer a limited service, inadequate to answer women's needs.

A final remark on the midwife's role. Historically, the midwife is the female figure whose professional role in the hospital has been progressively marginalized. From originally being an autonomous and determinant figure in supporting women, she has became the executor of de-personalized and punishing procedures that the woman in childbirth is made to endure.

Information, training, and dialogue on both the national and the international level may help the midwife to re-evaluate her professional abilities and recuperate the ancient art based on listening and observing, on respect and relationship, and on the continuity of assistance.

8. Women and Mental Health. Experiences, Facts and Figures in Italy

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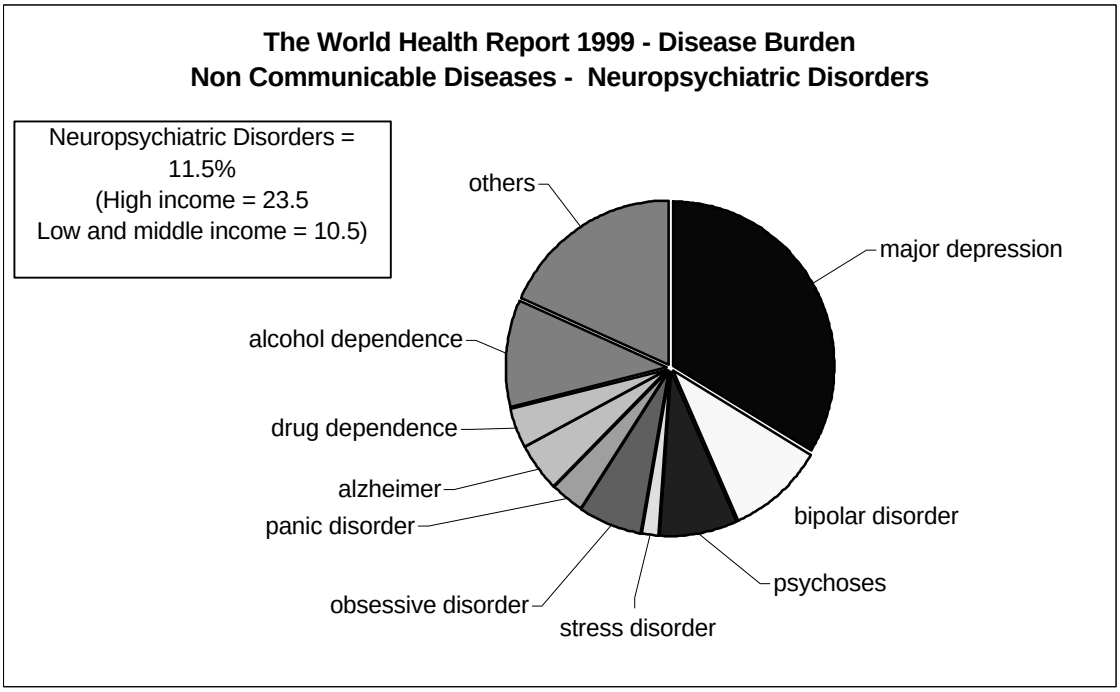
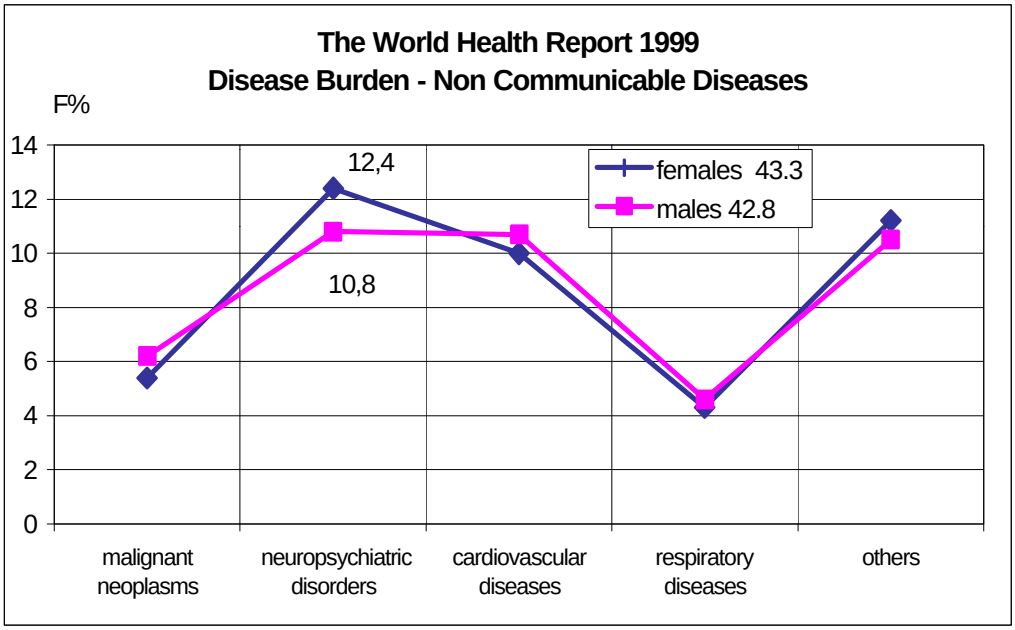
8.1 Introduction

A discussion of international data from the World Health Organization and the World Bank

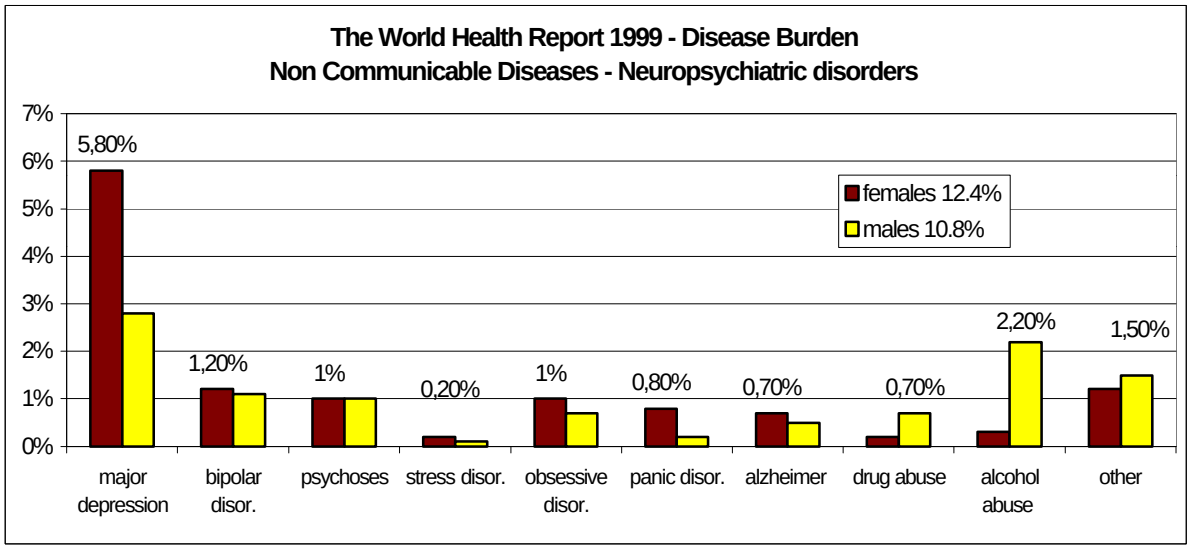
Women have a higher rate of morbidity in general and a higher rate of neuropsychiatric disease when compared to men. The higher rate of cardio-vascular disease recorded noted women, in terms of mortality, shows a reduction when measured with Dalys[24]. This means that women die more in absolute terms from cardiovascular disease, but lose fewer years of life expectancy. In other words women die later when compared to men.
Now we are going to evaluate the disease burden for causes related to neuropsychiatric disease:





The major disease burden concers depression, which is the most prevalent disorder among neuropsychartic diseases (42%). Looking at neuropsychiatric diseases by gender, all types of mental illness except alcoholism and substance abuse are more common among women.

In the disease burden related to depression, the difference among women and men is 3% - the same as for psychosis.



Among psychiatric illnesses, depression is the most common as established in the recent meeting of Tampere (Finland). It can be considered a world emergency for the next 20 years. During the meeting we discussed the inclusion of mental health among other problems in Agenda 2000: "Putting mental health on the European Agenda" (Dr. Eero Lahtinee, Minister of Health). In that occasion, the General Director of WHO summarized global perspectives on mental health, with emphasis on the "depression" emergency.
In 1998, the Daly index (rate of days of life lost and days spent in conditions of poor health) for mental disease was estimated at approximately 10%? of the total, with an estimated 23% in industrialized countries and 11% in developing countries. A growth of 15% by year 2020 was also estimated.

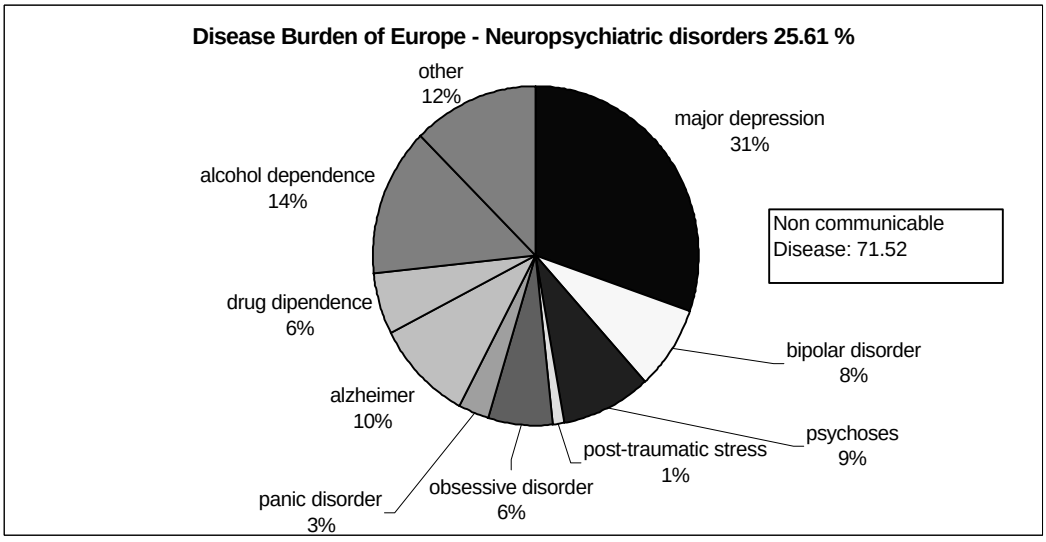
Major depression in 1998 occupied the 5th spot. The prevalence of depression has been increasing in recent years, and if this trend continues, it will become the 2nd disease in the Global Burden Disease by year 2020.

We find that major depression is at the 5th spot in the world as a cause of disability in general. Disaggregated by gender, depression is 8th among men and 3rd among women of all diseases.

DALYs in all Member States			
	Rank	% of total	(000)
Males Unipolar major depression	8	2.8	20 674
Females Unipolar major depression	3	5.8	37 572

8.2 European Data

In year 1998, non-communicable diseases contributed 71.52% of all European Disease Burden, while communicable diseases contributed 13.19% and injuries, 15.33%. Among non-communicable diseases, neuropsychiatric ones constitute 25.61% of disease burden. The following graph shows the proportion of all illnesses caused by neuropsychiatric diseases. Among all neuropsychiatric diseases, depression ranks 1st representing 31% of the burden.



In the analysis of leading causes of disease burden, depression ranks 3rd following ischaemic and cerebro-vascular diseases, which rank second.

8.3 Italian Data

Italian data confirm global and European ones that psychiatric disorders are more common among women, compared to men. Data from Istat (1998) show that, looking at population health in general, psychiatric disorders are more frequent among women.

Chronic Disease by Gender – year 1998
For both men and women, the most common diseases were arthritis and hypertension, which ranked respectively 1st and 2nd. Nervous diseases occupied the 5th spot among women and the 8th among men. Only in the age group 0-4 were nervous diseases more common among males. For all other age groups, the prevalence of these diseases for women is twice that for men, as demonstrated also in international studies.

In the following graph, we report the main diseases among women and men in Italy (data source, ISTAT). Women suffer more than men from arthritis, hypertension, nervous diseases, diabetes, and allergies. Only gastric ulcer and bronchitis are more common among men: 2 diseases out of 8.

The following graph shows data from an ISTAT survey of health perception among the Italian population.

The data show that the prevalence of all diseases except gastric ulcer and bronchitis is higher among women. Nervous diseases affect women almost twice as often as men.
Italian data confirm European and international data on the prevalence of psychiatric disorders among women, more specifically anxiety and depression.

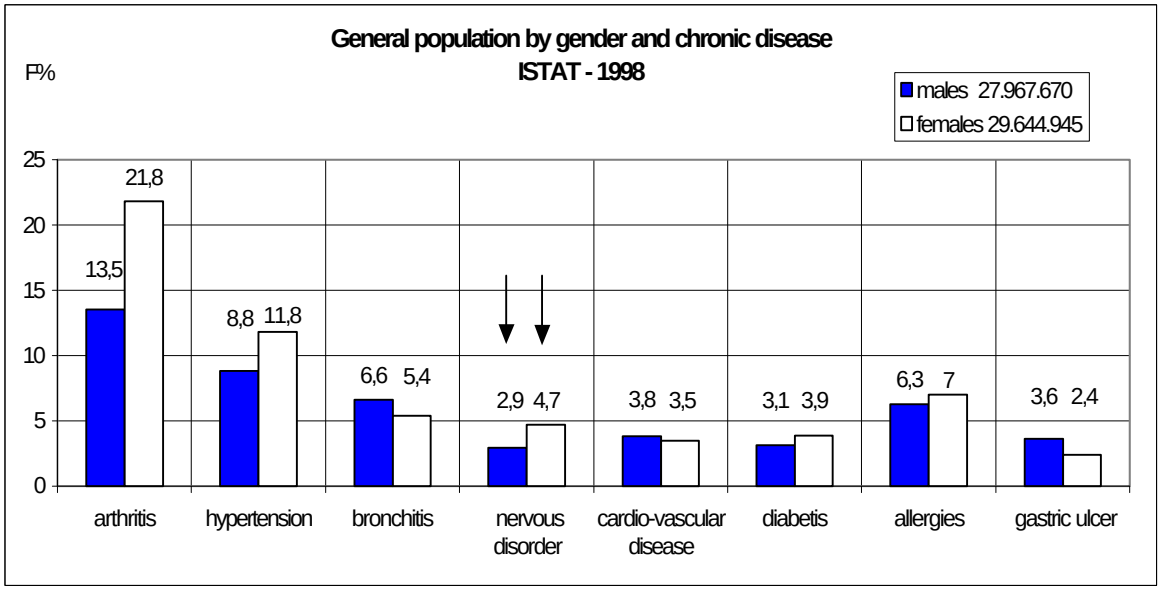
Data from a 1994 ISTAT study on the use of psycho-pharmaceuticals reveal that of 5.5 million consumers, 3.7 million were women and 1.7 million were men.

The Italian situation related to the population of health services users in local psychiatric services, hospital psychiatric units and primary care physicians has been analysed in a study by Censis and two studies by Labos Research centre.

- The Censis study was carried out in 1985 on 7837 users of psychiatric services. It represented all geographic areas and diverse types of services. In the part of the study characterising the socio-economic profile of the user, 48.22% of the population was female. The percentage of female population on the total psychiatric population showed to be inferior to the one recorded in the female population in general. This means that, among psychiatric users, an under-evaluation of women is evident because fewer women are referred to services compared to general population estimates of the proportion of women with some form of psychiatric disease. The distribution of the various psychiatric disorders showed that 39 women out of 100 suffered from depression, while among men, the rate was 21 out of 100. Among persons with depression, more women compared to men were married and fewer had steady employment.

- Labos carried out the second study in 1986 on 1000 users located in 4 selected areas. This study looked at the type of mental health service utilized, by gender. It found that women tended to be treated in out-patients services, rather than in-patients ones, while men had higher rates of hospitalization. Women, more than men, showed a tendency to seek help among private mental health professionals. Women requested services based upon listening, interview, and psychological support. Men to a larger degree tended to use services oriented toward socialization, job-finding and leisure time.

- The third study was also carried out by Labos in 1987 among primary health care physicians in (ASL - Local Health Agency, see Giovanna Vicarelli's and Paola Vinay's essays) in Rome. Results from this study showed that the subject showing highest risk of psychiatric disease is female, adult, and of average socio-cultural status. The evidence collected in this study around psychiatrically assisted population morbidity reveals the female component prevailed in 9 types of disorder in measure 5:2. Only in two types of disorders (psycho-organic syndromes and secondary illness with organic pathology) was there no difference seen between women and men. Such difference is represented (in the order) among those who suffer neurotic disorders (rate of prevalence 58.7%); psychosomatic disorders (49.8); affective problems (41.1%); depression (40%). Also women were more at risk for disorders related to the relationship with reality (hallucinations, delirium, confusion, extraneity): (26% women versus. 7.6% males). Males tended to have more disorders related to socio-economic factors (unemployment, economic instability), particularly in the case of drug addiction, where males prevailed at 66.5%.



In Italy, as well as in other European countries, despite the fact women are the major users of psychiatric services, both private and public, the percentage of women who actually follow treatment is relatively low. It is evident that mental health services do not take into account women's health-related needs. Recent studies on risk factors – both Italian and international[25] – show that psychiatric disorders among women are less affected by constitutional and biological factors while there is evidence of a major influence played by socio-cultural factors. Regardless of such knowledge, little is done in order to disseminate information among women around the risks related to life-style. Such issues as women's role in society, stress-related problems, and domestic and non-domestic overwork are often not taken into account. Women are not encouraged to modify the organisation of their

everyday life or their lifestyle, when - as often it happens – these are dysfunctional to psychological well-being. The organisation of mental health services in Italy has never taken much into account women's problems: There are no units specifically geared toward women – with the only exception of reproductive health services. There are no studies on the quality of health services in relation to women's health needs, there is no research on specific risk factors for diseases that affect predominately women; there are no epidemiological studies on the subject matter accounting for gender differences, and there is no systematic collection of statistics disaggregated by gender.

8.4 The Organization of Mental Health Centres in Italy

Mental Health Services have a complex structure which includes several services. On a national level, these services are located within the Asl (Local Health Agencies) (196 in number) and hospitals (85 in number). Each mental health service includes several structures:

- mental health centres (with a distinction among those that are open for greater or fewer than 12 hours a day);
- day centres where the patient engages in different kinds of activities;
- day hospitals with a certain number of beds only for clinical activities;
- residential structures with beds number allocated by the following typology:
- therapeutic/rehabilitative structures (24 hours a day)
- socio/therapeutic structures (12 hours a day)
- socio/therapeutic structures (for specific time-spans).

Mental health services are supposed to adhere to a standard of 1 professional operator every 1.500 inhabitants – while mental health centres and day centres operate on a standard of 1 centre every 150.000 inhabitants. Day hospitals, psychiatric services of diagnosis and care and residential structures have a standard of 1 bed every 10.000 inhabitants.

Organizational Components of Mental Health Services:

Mental health centres
They constitute the organizational sites coordinating psychiatric activity in each area. Each centre has a team of providers who carry out psychiatric activities both in the centre and on-call: visits, consultations, sheltering, therapeutical programming. They also offer a specific service of information and support for patients' families.
We have 695 mental health centres in the country, with an average of 1.81 every 150.000 inhabitants – almost twice the standard required. While 333 centres are open less than 12 hours a day, 362 are open 12 or more hours a day.

Day centres
In Italy there are 469 day centres, with a ratio of 1.26 greater than the standard. In fairness, we should also say that many mental health centres carry out a more informal activity compared with a semi-residential daily centres.

Day hospital
There are a total of 942 hospital beds – with a ratio of 0.16 below the standard.

Psychiatric Services for diagnosis and care (Spdc)
Hospital psychiatric departments located in general hospitals: hospital admission may be voluntary or involuntary (mandated by municipal authority, called Mandatory sanitary treatment – Tso). There are 317Spdcs are in Italy, with a total of 4.045 beds. The ration of beds is 0.71 inferior to the standard required.

Residential Structures

- semi-residential (or daily centre): with a predominant medical activity. Open less than 12 hours it is meant to take care of patients who need therapeutic re-socializing help during the day on the basis of short, medium or long term programs;
- residential: different types, depending upon population needs and the specific area where the structure is located. A residential structure may also host patients for medium-long term rehabilitation treatment, when psychiatric help is necessary for basic daily life activities.

Overall, there are 1043 residential structures, distributed as follow:

- 528 therapeutic/rehabilitative structures (24 hours a day)
- 213 socio/therapeutic structures (12 hours a day)
- 302 socio/therapeutic structures (for a specific time-span)

The total number of beds is 11.052, with a ratio of 1.96 – almost twice the required standard

The previously described organization of mental health services in Italy started with the "Psychiatric Reform" in 1978 (Law 180, called "Basaglia" – the name of the psychiatrist who promoted such a reform) which represented the end of traditional lunatic asylums. The new type of assistance was considered to be one of the most advanced in Europe; yet the organization of services for women was inexistent. A new experiences dealing with women's needs have been carried out by women professional operators (psychologists, psychiatrists, nurses) within the services, however, their work up to now has been acknowledged only at the local level, without impacting the health programming at the national level.

8.5 Services for Women in Italy

Here, as in other countries, women seek care more often in out-patient settings than in hospitals and residential services. The activity of rehabilitation centres for psychiatric illness are geared toward male needs and do not take into account women's realities. Men, more frequently than women, do not have family responsibilities, while women do. For this reason women do not prefer to spend time in residential or semi-residential structures.

While fewer women undergo drug therapy than men , they are treated for longer periods and experience more undesired side effects than men. Psychological and psycho-therapy treatments in public services are not very well-developed – especially short-term therapies based on methodologies of analysis of women's everyday life (analysis of domestic and extra-domestic work, and relationships geared to caring of others' needs).

Prevention programs are related to typically male risk factors such as unemployment, low education, violence, and homelessness without addressing women's health problems.

At the level of psychiatric patients (and patients' families) associations, there is no specific movement highlighting gender difference. Associations mostly consist of support groups for

specific illnesses (anorexia, panic disorder, etc.) and do not offer gender specific mental health programs.

Outside the health structure, there are groups of women – supported by public funding – who have organised residential structures as shelters for abused women in main cities (Roma, Bologna, Milan, Palermo, Naples etc). In these cities, self-help groups, psychological support, self-esteem classes etc. are offered; they constitute a de facto preventive program against depression and other psychiatric disorders.

April 4, 2000 a draft law was proposed that would strengthen the status of shelters for abused women through the creation of a specific public fund meant to implement activities support for women experiencing violence.

We should also point out the preventive activity of orientation centres for wome's work and job skills. Such centres are designed for women and tend to develop entrepreneurial talents by increasing cooperative work and associative skills among women with women's needs as a starting point, especially the need of combining domestic and extra-domestic work. These centres have a clear value in terms of prevention of psychiatric disorders since they are geared towards the value of women's competence, hidden talents, and their collocation in the labour market. Within such a context, also *retravailleurs* centres have been developing in Italy, in order to meet the needs of women who have been away from the labour market for long time: re-training and re-setting of their skills, and support during the first period back to work.

We also find in Italy, outside the health structure, some "social centres" and centres self-managed by women addressed to women and to the bettering of the quality of their lives – yet, within health institutions is quite difficult to find structures and experiences able to fit women's mental health needs.

- The health structure in Italy offers services for women exclusively related to reproductive health and mother-children needs

  The Italian Health System – as well as in other nations – is oriented toward women's reproductive health almost exclusively. There are maternal child health service centers ("consultorio familiare") for mothers and their children. At the level of mental health services there are no projects specifically designed for women: there is no awareness, despite the availability of international data showing the prevalence of mental illness among women and the need for research and actions for women – particularly around depression.

  For this reason, in Italy today, we can mention only three relevant experiences representing the different geographical areas: north, centre and south. The oldest one was funded in Naples, (South of Italy) in 1978, within a Mental Health Service, Asl (Local Health Agency). In Bologna, in 1983 a group of women professional health providers – psychologists and nurses – created a space for women with group activities meant to reintegrate them in society after psychiatric treatments. In Trieste (North) at the beginning of the nineties a Women's Centre was instituted within the Mental Health Centre: it is organized and directed by women psychiatrists. (see Appendix for addresses)

These important experiences had a bottom-to-top development: they were promoted and organized by the women working in such services of mental health. It was only much later that they got recognition by local health institutions.

Since it became necessary that these experiences should not be viewed as „exceptional events", and in order to encourage their expansion on a wider level, it would be reasonable and timing that The European Community and the WHO support initiative, and Recommendations to National Governments - orienting toward introducing in health programming specific indications for the organization of intervention and services in mental health also tailored for women. These initatives should be aimed to the following directions:

- a national and international institutional effort to acknowledge the growing relevance of mental health, with particular focus on women;
- research into causal factors that puts in evidence connections between personal psychological experiences and the environmental context;
- the development of new methodologies of intervention which take into account the the reasons behind mental disorders in women and that aim to improve the quality of life;
- training courses to those health care professionals who work with women suffering with mental disorders;
- differentiated planning in psychiatric assistance: one aimed at prevention and the other at treatments, along with developing different actions and services.

- The experience of a Mental Health Service with a focus on Women

As an example of an activity focused on women's mental health within the National Health System, we are going to discuss the experience of the Mental Health Centre in Naples.

The Centre "Women's Mental Health Prevention" (WMHPC) is involved in psychological aid with an office for women and adolescents, study, research and training on prevention and control of mental disorders.

WMHPC has been active since 1978. The Centre has been working for 22 years in the application of the national law n.° 180, issued on 1978, which mandated the closure of long-term psychiatric hospitals.

Since 1981, approximately 5000 women between the ages of 14 and 55 have been seen. These Women seek help mainly for the following reasons: anxiety disorders, stress disorders, major depression, panic disorders, obsessive-compulsive disorders, and attempted suicides.

On the average, the majority of clients are women between 30 and 55 years of age, with children. The percentage of women who have work outside the home, besides domestic work, corresponds to national percentages. Women who seek help in the Naples Centre undergo mostly a form of psycho-social treatment. Psychotherapeutic drugs prescribed by the consultant psychiatrist are used only where necessary, in situations of crisis or intolerance to psychiatric symptoms. Treatment consists of individual sessions followed by group therapy which addresses all aspects of everyday life – tracking back those factors that induced the manifestation of psychiatric symptoms in the woman.

Particularly, in a woman's life we focus upon the following factors:

- excess burden of work and responsibility;
- restriction or absence of external support groups;
- restriction or absence of personal interests or activities;
- reductions of personal expectations;
- subjective perception of inadequacy;
- disparaging judgement of the social context;
- the present of physical ailments and especially the presence of tiredness.

The goal of intervention is to modify:

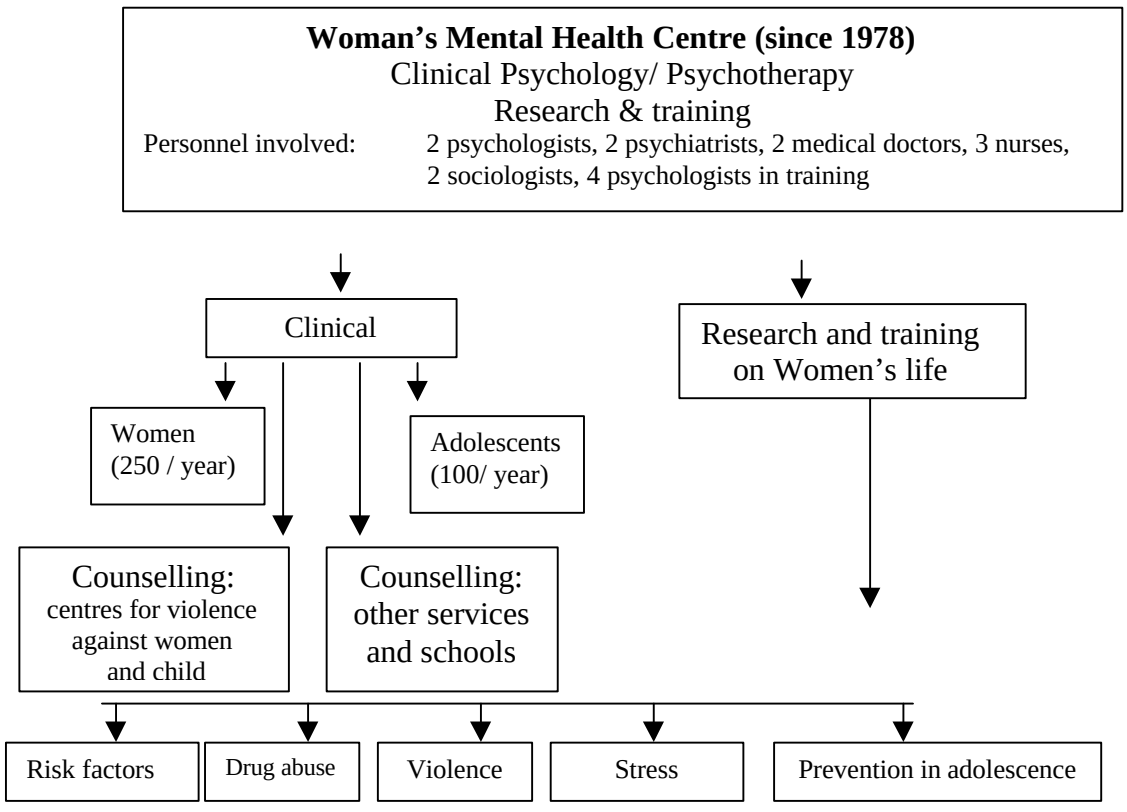
- the overall amount of work (domestic and extra-domestic);
- the style of behaviour learned through education and the maternal role model;

The maternal model – or more in general, the caring model – addresses women to answer to life-events coping with other's needs (especially within the family where there is more tolerance toward abuses and mistreatments), thus ignoring one's own needs.

It is this "simple" mechanism - denying satisfaction to personal needs to give priority in excess to other's needs) that increases the risk of psychiatric disorders – particularly depression – among women.

The Centre is not limited to intervention and clinical treatment: it also carries out research and training activities.

Activities SCHEMA



Clinical Activities

The Centre has increased our prevention activities especially in the following 3 areas:

- female adolescence, body image and risks of anorexia/bulimia
- female stress connected to an overload of family life caring
- women and their dependence in situations of violence

The Centre opened locally a "space of intervention" for adolescent student girls. The following activities are geared for those girls who have problems of anxiety, anorexia, bulimia:

- Individual psychotherapy;
- Group activity in order to help girls in the building of an autonomous life project;
- Orientation for parents and teachers;
- Body work.

Preventive activities for homewives, such as seminars about risks related to caring overwork. Goals are:

- The development of skills to reduce domestic work;
- The development of skills to optimize external work efforts;
- The develpment of the ability of recognizing personal desires and projects in the everyday life and integratine domestic work with professional work.

Intervention on psychological problems related to violence. The Centre is working on the risk of co-dependency. The Women Mental Health Project in Naples is connected with a battered women shelter (Centro anti-violenza) which takes care materially an psychologically of those women who cannot break the abusive relationship, even when they have the necessary legal and logistical support.

The Centre works on both the individual and group level:

- A short psychotherapy oriented toward overcoming co-dependency;
- Organizing women's groups for mutual support and for a collective sharing of the experience.

The Centre offers two kinds of health services to women:

1. The first one addresses women who are not mentally ill yet; it attempts to prevent specific distress situations; the goal of this counselling service is to reduce the damage caused by subordination and violence in every-day women's life. It brings their life problems into focus and promotes abilities, awareness and skills to find a solution. For this purpose, we have set up a " welcome and listening " Service, training courses, social and psychological support groups, self-help groups. These activities aim to address different problems typologies such as:
   - work interruptions for pregnancy and child care;
   - difficulties in social relationships;
   - difficulties in either housework or external work;
   - abuse and violence in and outside of the family;
   - drug abuse.

2. The second service addresses, instead, women who have already developed symptoms of mental illness and have already been treated for psychiatric diseases. This activity encourages women to see a connection between the kind of daily life they carry on and the illness they're suffering with. It aims to create

a concrete alternative to psychiatric hospitals /or cures by offering practical help and necessary support to:

- reduce or, at least, change, the meanings of some specific therapeutic terms such as hospitalisation, drugs and so on;
- consider the symptoms of mental illness as signs of unbearable life conditions;
- create new life styles according to women's aptitudes, interests and emotions.

Research activities

Besides the clinical activities, the Centre has been collaborating (from 1981 to 1998) at the C. N. R. (Italian National Research Council) activities as a "Research Operative Unit", carrying on a productive research activity.

The Centre has developed research in the following areas:

- methodologies of clinical intervention geared toward women's well-being;
- risk factors connected with women's everyday life;
- consequences of family violence on psycho-physical health
- depression as a consequence of stress in caring activities;
- specific pathologies in adolescent women (anorexia and bulimia)

Training activities

Projects and training opportunities are offered to teachers, physicians, nurses and other social service workers, with the goal of increasing the level of knowledge of women's problems:

- a project to increase school teacher's knowledge about psychological disorders in adolescents;
- a project to prevent and treat the psychological consequences in women with breast cancer;
- a project to prevent and treat eating disorders in women, directed to sanitarians, parents associations and school teachers;
- a project to help women psychologically affected by violent events and to give directions to people working with such women, in public services like Police, Court and social services.

9. Appendix: Women's Health Centres in Italy

Laura Corradi

Andos

National Association of Women who had undergone breast surgery.

In the North (Brescia)
phone.: 030 / 421 55

In the South (Naples)
phone: 081 / 566 66 14

In the Centre (Bologna):

Andos - Sempre Donna

This is an association of women with mastectomy. It delivers psychological assistance, information, yoga, massages, and cultural activities (seminars, research, public events) in the Bologna area.

Address:
Via Giorgio Ercolani, 8/10c
40123 Bologna
phone/fax: 051 / 55 15 90

Ala Group

Born in 1989, its main goal is the one of preventing Hiv infections and Stds. Activists are health operators who produce and distribute information free-condoms to sex workers in Brescia, also giving legal and medical assistance to those who are in need, such as Hiv-positive persons. The Ala Group is committed in monitoring prostitution and developing forms of intervention around migrating women and the issue of sex-slavery.

Contact person:
Miriam Gironi

Addresses:
Via Boifava 70/a
Milano
phone: 02 / 89 51 64 64

Via Villa Glori 10/b
Brescia
phone: 030 / 32 07 42
Centro.ala@tiscalinet.it

Associazione per la lotta ai tumori del seno (Naples)

phone: 081 / 551 10 45

Attive Come Prima

phone: 02 / 688 96 47

The first Italian association of women who have been diagnosed with cancer. Founded as a support group, now is part of a coalition of breast cancer groups "Europa Donna".

AED Femminismo

Self-help center, founded in the seventies, and financially self-sustained. It focusses (both politically and practically) on women's health. It provides gynaecological consultory, advisary bureau, legal assistance. It is a resource center which produces and distributes information.

Besides the established fields of activity - such as violence, contraception, abortion, early detection and sexuality - in recent years, the AED Femminismo started to intervene in the debate around the international traffick of organs and primary prevention of cancer

President:
Nerina Negrello

Address:
Passaggio Canonici Lateranensi, 22
Bergamo, Italy
phone: 035 / 24 43 37
fax: 035 / 23 56 60

Io donna

This is an association of volunteer women in the south of Italy, committed in promoting cultural and educational events for women's health and life. It offers an archive with documents, books, journals, bibliography and press review service. An anti-violence phone line and support for women in search of help.

A lab on dance, dreams and the food: "How to transform our relationship with food and detox our bodies". The lab is geared toward women who want to know more about food, its preparation and meanings, and toward women who experience problems related to the attempt of fitting the dominant sense of feminine beauty; and to women who live an out-of-balance relationship with food and with their own body.

President:
Rosa Cecilia Caprera

Address:
Via Cappuccini 8
72100 - Brindisi
phone: 0831 / 52 20 34
fax: 0831 / 56 30 51

Centro Documentazione Salute "Simonetta Tosi"

President:
Vicky Franzinetti

Address:
Via Madama Cristina 37
10125 – Torino

Centro Salute Donna

Located in Monza (Milano area) this group of women publishes a newsletter: "Salute News".

phone: 02 / 647 04 52

Comitato Sempre Donna

phone: 051 / 55 15 90
Bologna

Crisalide Adocm

Support group for women who undergo breast surgery in the Bologna Region, seaside. It was funded in 1992 to stimulate research and to give answer to psycho-physical problems women with cancer experience. Among its projects, is one for activating a service for welcoming within the Hospital that keeps emotions into account.

Contact person:
Marisa Monari

Address:
Via Bastioni Occidentali, 8/10
47900 - Rimini
phone: 05 41 / 38 23 63

Europa Donna

Born in 1991 as an opinion movement, thanks to the effort of Prof. Umberto Veronesi, today Minister of Health in Italy. Its goals are to call public attention in all Europe to face cancer with adequate means, by alerting governments, and health authorities, sensitizing women, doctors and focussing mainly on early detection (secondary prevention) and the improvement of assistance for women who undergo surgery. Europa Donna is represented in 20 European countries and counts 80 groups and associations of women in Italy. Its structure was inspired by the National Breast Cancer Coalition in the U.S.

President:
Francesca Merzagora

Address:
Via Beatrice d'Este, 37
20122 Milano
phone: 02 / 58 31 56 17
02 / 58 31 62 84
fax: 02 / 58 31 61 30

Imp-Sex

Born in 1995 in Brescia, this volunteer groups mostly composed by women. Brescia is the first Italian town where 22 sex importers have been charged and condemned at the end of a trial having 30 street girls testifying against them. The group focuses on imported sex workers/slaves and their health problems. Activists contact sex workers - here named "street girls" - directly and offers gynechological support, screening for Aids and Stds, medical and legal assistance. The group is composed by Catholics and non-Catholics. It does not offer condoms (differently from Ala Group, see) and does not encourages abortion. It gives assistance for pregnancy, financial support for the new-born up to the 6th month of life, and helps in job searches in favour of the mother.

Main goal is to find alternatives to sexual slavery, also sensitising the public and clients around North-South relationships and global injustice. Their methodology is informed by the necessity of giving back dignity to street girls - in any possible way, up to supporting those escaping from sexual slavery - eventually accepting forms of protection by the police. Imp-sex rejects public fundings. It offers to street girls a self-sustained Ambulances service.

Contact person:
any volunteer

Address:
Via Noce 103
20125 - Brescia
phone: 03 38 / 746 32 93

Ipazia

Women's Collective which focuses on science and medicine.

Contact person:
Marina Pasquali
phone: 02 / 242 40 49

"La Melagrana"

Association for women's health, it is composed mostly by women who have been undergoing breast surgery in the centre of Italy (Bologna Region).

Contact person:
Reggio Emilia
phone: 05 22 / 54 17 34

"Molise Donna"

Regional League Against Breast Cancer in the centre-south, this association is formed by volunteers, technicians and health operators. Its goal is the one of increasing sensibility around cancer through conferences, videos, public debates, demonstrations and by educating professionals. Two main targets: women with cancer and the public administration.

The center promotes information on prevention, early detection, and cure - with the help of physicians, oncologists, radiologists and surgeons. It also promotes social happenings, cultural meetings and exchange, recreational activities.

Contact-person:
Giovanna Di Rienzo

Address:
Via delle Frasche 38
Campobasso
phone: 0874 / 41 27 89

Eutopie (Onlus)

No-profit organization (Onlus) funded by a group of women who are active in medical fields, psychoanalysis, arts. Its goal is the one of informing and practicing those therapies geared to body-mind integration: holistic medicine, particularly non-Western ones, and those techniques recently developed in Art-therapy.
Activities:

- integration and correct use of allopathic medicine, natural medicine and techniques borrowed by traditional therapies;
- Body-lab, working on menopause and chronic diseases in economically and socially disadvantaged contexts;
- Self-help Theatre Lab "Acting Out" meant to rescue psycho-social capacities.
- Publication, every six months, of Eutopie. Convergence between Science, Imagination and Art.

Address:
Via Venini 46,
Milano
phone/fax: 02 / 282 29 95

Fados

Federation of women who did undergo breast surgery in the north-east (Venice Region)

phone: 049 / 875 21 15
Padova

Forti e Serene (Strong and Serene)

The specific goal of this group it to call attention and inform about prevention and care of breast cancer. Born in 1990 thanks to a group of women who underwent mastectomy and a surgeon, Dr. Federico Cozzaglio, it is a support group for hospitalized women, working on solidarity and counseling. It also promotes events to educate younger people in schools; adults through mass-media and by organizing courses for the maintenance of a good physical and psychical balance; hypnosis training; short trips in culturally or artistically relevant areas and other recreational activities

President:
Antonietta Tumolo Ranaldi

Address:
Via S. Carlo 32
Arona, Italy
phone: 0322/243518

"Il Melograno" (The Pomegranate)

Centre for information on maternity and birth, is a national no-profit association in the field of active parturition, having several locations in Italy (Verona, Rome, Ancona, Gallarate).

In Rome, Il Melograno is constituted by several professional obstetricians, gynechologists, psychologists, who work in a team with different mansions and focus (such as physiology and pathology, body and mind). These women established a methodology and a personalized approach to birth, with a professional attitude informed by the respect of each individuality and the diversity in each woman, her culture, her needs - without proposing a unique model. In the same way, Il Melograno constituted a team for active parturition assistance at home - without priviledging such a model as the absolute best - as one of the possible choices every woman may have.

Metis - Medicina e Memoria

This is a Women's Health International Centre Research and Therapy based in Milan supporting the idea of cure and scientific research which brings to the centre the relationship between the persons (health worker and patient) involved in the therapeutic action

Contact Persons:
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phone: 02/29515510

Mipa

International Movement for Active Child-delivering.

Contact Person:
Piera Maghella

Address:
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25080 – Brescia

Safe - Forum per la Salute al Femminile

No-profit, its main goal is to network among all Italian associations promoting actions for women's health, and the improvement of the social, professional and family context. It promotes information campaigns and sensitises education and formation actions. It encourages prevention in scientific research and the respect of women's rights.

The Forum is activating a Coalition of Associations - each maintaining their autonomous existence, and going on in each one's specific activity. Projects involve medias, health authorities, and communities as a whole. It articulates partnership with European and global organizations having common goals. It accepts sponsors among insurances, banks, and pharmaceutical industry.

Among proposals: a survey on one thousand Italian women 15+ about "Female tumors: cure and quality life in healthy women's perception.

Self-Help Women's Centre

Born in 1994 within a self-managed "Social Centre" in historical squatted block (since 1974) located in Milano, where an out-patient "Ambulatorio Medico-Popolare" (Medical Clinic for the People) was successfully working with low-income persons, marginal people, occupational health, immigrated, mentally ill, handicapped, and drug addicts.

The "Social Centre" feminist collective, founded in 1987, had an emphasis on women's right to health from its very beginning. The project of a self-help centre has two important features:

1. self-management: financial and political autonomy from public institutions, whose centres and clinics for women failed the goals in terms of information and prevention;
2. de-medicalization: the chemical-pharmaceutical approach is seen in a critical way, as well as the hospitalization of child-delivery and the vision of sexuality and pregnancy as pathologies.

The self-help clinic works on counseling and empowerment: women are given all information necessary to make their own decision about contraceptives, abortion and therapies (both institutional and alternatives). Main focuses are: the practice of gynaecological self-visit; active child-delivery with the assistance of the obstetrician; Hiv-Stds prevention (the centre distributes free condoms); and orientation toward "tested" public structures, when analysis, surgeries or specialized assistance are required.

The "Self-help Women's Centre" makes no discrimination between citizens and non-citizens, documented and un-documented workers and migrants. It organizes informational meetings for schools, unions, women's centres and women's collective. Any service is free of charge.

Contact Person:
any volunteer

Address:
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"Wild Rose" Association

No-profit, cultural association oriented toward ecological and holistic approaches. It organizes orientations on natural foods; counseling; preventive and therapeutical potentialities of nutrition; psycho-physical balance; stress coping strategies; lifestyle choices, and encourages intentional communities.

"Wild Rose" association produces projects and practices of everyday life, respectfully of environment and health in general. The name of this association comes from a Dr. Bach remedy: it represents - against apathy - the joy of life.

Coordinators:
Marina Bianchi and Itala Borioli

Address:
Via Torre Vanga14
38100 - Trento
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04 61 / 50 32 34
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Women's Mental Health - Prevention Project

Centre of Clinical Psychology and psychotherapy for women and adolescents, it works on three areas:

1. Clinical Psychology and psychotherapy for women, individual and groups. Counseling, self-help, self-esteem. Project-labs .
2. Clinical Psychology and psychotherapy for adolescents. Counselling and short therapies. Project-labs. Consultanthship for parents and teachers.
3. Research and Training. Mental health risk factors; stress and women's everyday life; sexual abuse and related pathologies; depression and medicalization of mental discomfort; drug abuse. Training targets teacher, primary care physicians, social workers and health operators.

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Similar centres:

CENTRO donna salute mentale,

Coordinator: Amalia Signorelli
Androna degli Orti n.4 - Trieste
phone: 040 / 36 88 40

Gruppo Donne Dolci

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11. Footnotes

[1] The term "ticket" refers to a mondatory form of financial participation in health services and drugs. See Paola Vinay's essay (chaper 3) in this Report.

[2] On this subject matter - and more statistics - see also Elvira Reale's essay in this Report.

[3] See on the subject. Massimo Paci: “Health Institutions in the European Member States” in Paola Vinay – Prospecta “Gender, Power and Change in Health Institutions of the European Union”, Employment & Social Affairs, Equal Opportunities and Family Policy, European commmission, 1997

[4] See on this matter Giovanna Vicarelli's essay in this Report.

[5] On this matter see: Giovanna Vicarelli, "Dal sapere delle donne alla scienza degli uomini. Percorsi maschili e femminili di professionalizzazione", in Proceedings of the European Conference "Sanità: Quando le donne fanno differenza", Prospecta, Ancona, 2001.

[6] Ibidem.

[7] In the past, similar health emergencies were produced by syphilis, tuberculoses, and other contagious diseases - without organized forms of .subjectivity on the side of the ill and the survivors.

[8] Yet, as Nancy Stoller pointed out, cancer as an epidemic is a new phenomenon. See Judy Brady, One in Three: Women with Cancer Confront the Epidemic, Cleis, San Francisco, 1994.

[9] See L. Corradi, The Debate Over genetics and environmental causes of cancer among scientists, women survivors and people of Color, Ph.D. Dissertation, Umi, 1995; Laura Corradi, "Il movimento delle donne Usa contro il cancro: reti di supporto, leadership e buone pratiche" in, Proceedings of the European Conference "Sanità: Quando le donne fanno differenza", Prospecta, Ancona, 2001

[10] Laura Corradi, "When Body Is Environment. Environmental Causes of Cancer and Primary Prevention. The Movement for Environmental Health in the United States", in Ivano Spano (a cura di) Systemic Complexity and Eco-Sustainable Development, Quaderni della Comunità Europea, forthcoming; italian edition "Quando il corpo é ambiente. Cause ambientali del cancro e prevenzione primaria: il movimento per la salute ambientale negli Stati Uniti", in Ivano Spano (a cura di) Complessità eco-sistemica e sviluppo eco-sostenibile, Edizioni Sapere, Padova, 2001.

[11] See the italian eco-feminist magazine "Marea".

[12] Terri Ballard, Laura Corradi, "Una prospettiva di genere su epidemiologia e prevenzione primaria dei tumori al polmone: i limiti di una prevenzione gender blind", in Atti del gruppo di lavoro "2001: una salute a misura di donna", Ministero Pari Opportunità, Roma, 2001.

[13] Paola Vinay - Prospecta, "Gender, Power and Change in Health Institutions of the European Union" ("Genre, Pouvoir et Changements dans le Secteur de la Santé dans l'Union Européenne" - Geschlecht, Macht und Veranderung in Institutionen des Gesundheitswesens der Europaischen Union"), in Employment & Social Affairs, Equal Opportunities and Family Policy, European Commission, 1997.

[14] In France, women are about 75% of psychologists, 85% of chief nurses and almost 100% of midwives, but 28% of general practitioners. In the United Kingdom, women constitute 89% of the non-medical staff; about 50% of paediatricians, but only 7% of surgeons (1994); the percentage of women surgeons in Ireland is only 3%.

[15] Other obstacles are a minor access to "informal networks" and to "influential people" and their supposed lesser "aptitudes for management". Other important obstacles depend on the difficulty of combining professional and family life. Where this is concerned a large number of women in top positions are "single" or "divorced" and have no children. On this matter there are significant differences among the European Member States: compared to the ones in the North, a much higher number of women in Centre and South of Europe who have reached top decisional roles are "single" or "divorced" and without children: among the women of the South 47% (but only 9% of men) doesn't live as a couple, double the number of those in the North; 39% have no children, while two thirds of the women in the North have at least two children.

[16] Beccalli B., "Comparable Works", in Pari e Dispari, giugno 1994.

[17] Several surveys show a correlation between a wide representation of women in the political-administrative level and the development of social services, particularly those for children. Moreover, they show wherever female problems are taken in consideration, there are women bringing them up in the political agenda. See: Eduards M., "Participation des femmes et changement politique: le cas de la Suède", in Ephesia, La place des femmes. Les enjeux de l'identité et de l'égalité au regard des sciences sociales, Paris, 1996 and cited bibliography.

[18] See: Paola Vinay - Prospecta, "Gender, Power and Change in Health Institutions of the European Union" "Genre, Pouvoir et Changements dans le Secteur de la Santé dans l'Union Européenne" - Geschlecht, Macht und Veränderung in Institutionen des Gesundheitswesens der Europäischen Union"), in Employment & Social Affairs, Equal Opportunities and Family Policy, European Commission, 1997, and the bibliography there

mentioned. See also: Scuola di Politica Hannah Arendt: Presenza femminile nella sfera pubblica, "Catalogo delle buone prassi", Pitagora Editrice, Bologna, 2001.

[19] See for a description of this service Elvira Reale's essay in this Report

[20] On this matter see Gioacchini and Prosperi Porta's essay in this Report.

[21] The group is coordinated by Elvira Reale; the information given in this paragraph is drawn from the documents produced by the group itself.

[22] See Laura Corradi's essay in this Report.

[23] See Vicarelli's essay in this Report.

[24] Disability adjusted life years: this index was jointly developed by WHO, Harvard University and World Bank. It measures the total amount of illness combined on one hand with YLLs (years of life lost) or untimely death from the illness. On the other hand it is combined with YLDs (years lived with disability) or the amount of unproductive time related to the pathology.

[25] E. Reale (a cura di) (1989), Acts of the First International Seminar on Woman's mental disease, Italian National Research Council (CNR), Roma; M. Piccinelli and f. Gomez Homen (1997), Gender differences in the Epidemiology of affective Disorders and Schizophrenia, Nation for Mental Health, WHO, Geneva; Michelle Gomel (1997), Focus on Women, WHO, Division of Mental Health; K. Abel e M. Buszewicz (1996), "Planning Community Mental Health Services for Women",Routledge, London; E. Reale et al. (1998) Stress and women daily life: an experimental study about pathology risks, Italian National Research Council (CNR), Roma.