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Health inequalities and prevention of cancers and sexually-transmitted diseases: a trans-Mediterranean research project*

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Abstract: The research investigates the strategies and procedures for including immigrant women in screening protocols for breast cancer and prevention of sexually-transmitted diseases. After analysing health inequalities from a theoretical perspective, the article provides a comparative overview of the state of health of the two populations in question (Milan and Beirut), interpreting various indicators of health. It goes on to examine the data on prevention of female cancer and sexually-transmitted diseases in either country. The attention then shifts to the results of field work, after consideration of some methodological points, proceeding by analysis of focus group interviews conducted in Milan and Beirut.

Keywords: prevention, cancer, women, Mediterranean.

Foreword

In this article we shall be presenting the first results from a still-ongoing action-research venture[3], as part of the EUROMED project funded by the Health Ministry[4]. The research investigates the strategies and procedures for including immigrant women in screening protocols for breast cancer and prevention of sexually-transmitted diseases.

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* The research pools some results in common. Formally speaking, section 1 is by Mara Tognetti, section 2 by Lia Lombardi; section 3, the opening and the conclusions are the work of both authors.

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3 Action-research sets out first to change a situation by extending the knowledge gained through the research. Methodologically, action-research acts as a pivot between the theoretical and the empirical-operative phase. It proceeds as an exploratory process that undergoes transformation and readjustment to the cognitive demands of the social scientist (Bertolazzi 2004).

4 "Promuovere la salute, ridurre le disuguaglianze di genere, migliorare la comunicazione interculturale. *Interventi di promozione della prevenzione oncologica in età riproduttiva e delle malattie sessualmente trasmissibili in due città del Mediterraneo: Beirut e Milano,* financed by the Health Ministry and conducted by the Dipartimento di Sociologia e Ricerca Sociale of Milano-Bicocca University, under scientific supervision by Mara Tognetti, in partnership with service-sector entities including the Association *BLIMUNDE - Sguardi di donne su salute e medicina* and *Cooperativa AMELINC* in Milan, as well as the Association *Les amis des marionnettes* in Beirut.

Theoretically, these health issues tie up with health inequalities and more specifically access inequalities. Such forms of inequity are particularly blatant when the women are immigrants (Tognetti Bordogna 2004). After analysing health inequalities from a theoretical perspective, the article provides a comparative overview of the state of health of the two populations in question (Milan and Beirut), interpreting various indexes of health. The same section will sift the data on prevention of women's tumours and sexually-transmitted diseases with reference to immigrant women. The third section begins with a look at some methodological points and then outlines the first results of the research, which will be discussed in the last section.

1. Health inequalities and the theoretical debate

The literature shows that inequalities may be objective, systematic disparities as to possession of resources and the ability to obtain privileges and remuneration. We can trace the distributional and relational pattern and the fact that they stem from the behaviour of individuals, groups and formal or informal selection mechanisms, and how these conform to the set-up of a given social system (Schizzerotto, 2002).

Distributional inequalities may be ascribed to a set of material and symbolic privileges, while relational inequity is due to power relations existing among individuals and social groups.

When inequity stems from people's social background, rather than any merits they have acquired, one talks of unequal opportunities.

It was publication of the 1980 *Black Report* in Great Britain that focused attention and study on the connection between social factors and health. Health inequalities stem from the range of variables just mentioned, but may also derive from health resources in their own right (ASR 2007).

Health disparities are caused by the health system, its organisation and mode of functioning; they may be a result of economic, social and health decisions, or the transformation of needs and of disease. As Strauss (1977) suggests, illnesses have differing trajectories: each is the outcome of a combined effort on the part of the patient and his family or care group.

Access to health care is, again, unevenly shared among individuals. The lowest

economic strata bear the brunt, being less adept at using the health system than the wealthier strata with their greater social defences.

Over and above the "normal" health disparities, inequality may be produced by social and health policies and decisions. In approaching this issue from the standpoint of immigrants one must go into the data on access to resources, the mortality and morbidity profile, and also the multiple factors behind inequality and the social mechanisms engendering it (Tognetti Bordogna, Olivadoti 2009).

Inequality must be analysed in terms of skills, recognition of resources, the multiplicity of health systems, the relational network, and social skills. This approach must be pluralistic, taking stock of a web of diverse factors and criteria. In the case of immigrants we cannot simply observe the socio-economic variables: we must weigh the general living conditions, the relational networks, the phase of the life cycle, the welfare systems and the human background (Tognetti Bordogna 2008; 2015).

Researchers into inequality have laid bare the wide range of factors and their cumulative effect. In what follows we will identify clusters of health inequalities from the main factors giving rise to disparity. Such clusters bear heavily on immigrants, of course; they interact to produce the individual's health capital.

We may list the inequality groupings:

- biological-genetic: encoded in our DNA;
- peri-natal and neonatal: caused by the mother's poor living conditions;
- linked to socio-economic condition and lifestyle;
- bound up with access to services, the process of using them, and the quality of them;
- dependent on *skill (S*en1992);
- due to the rationing implicit in welfare and the various healthcare systems;
- due to the different models of health and disease, the different pro-health systems;
- connected with "race", and the process of racialisation.

Over the years theoreticians have given various different explanations for the presence of health inequalities, claiming that they depend on:

- *differences of treatment*, somewhat unconvincing since individual survival

cannot in the least be correlated with the progress of medicine;

- *genetic factors*, a theory that has been heavily challenged (Wilkinson, 1996) by the "epidemiological transition";
- *lifestyles* an explanation based on the causal link between habits and diseases, such as lung cancer.

Equally controversial, this last explanation argues against recognition of *social origins behind health disparities*.

All these positions are decidedly arguable. There remains the question of identifying causal mechanisms reflecting the link between social class and health.

When it comes to sociological explanations for health inequalities, two broad patterns may be observed: the first connected with differences, the second with inequalities. We will not be going further into the general debate over inequalities, but will concentrate on the importance of studying them with reference to immigrants. When one studies immigrants in relation to health inequalities, a new factor emerges: no longer class or income, but race. The literature now contains various studies highlighting health disparities as a constant of our society, and within them a strong "racialising" and "ethnicising" tendency.

Racialisation has become a public reality, erecting internal frontiers based on physical differences. These need analysing not just by the traditional categories of social class, job and nationality, but according to real or presumed country of origin, as judged by skin colour or foreign-sounding name (Fassin 2000, p. 304).

Other studies highlight the impact of racial/ethnic differences among women, and how they bear on health behaviour. In the United Kingdom (Cooper, 2002) a study has explored how and how much economic privations affect gender and race inequality. In Italy there are still relatively few studies on the immigration population. A lot more attention has been paid to health inequalities in general (Tognetti Bordogna 2004; Dellabella et al. 2011).

The theoreticians have focused on social class as the central factor behind inequality, but it is now being strongly claimed that this is not the only variable leading to disparity: as much importance attaches to gender, ethnic origin and age (Gallino, 2000).

Study of social determinants of health shows that racial discrimination in various walks of life produces inequality of life expectancy (Wilkinson, 1996). The current view of some authors is that racial discrimination worsens, and outstrips, the inequality caused by socio-economic condition.

Other authors (Marceca et al., 2006) point out that race, ethnic identity and culture do not denote hard-and-fast categories. Without disguising the existence of inequality, they point to social processes that directly discriminate against certain classes of person, amongst whom we often find those with a history of migration.

It is these processes, rather than typical immigrant cultural or racial/ethnic features, that bias the incidence and severity of disease and the access to health services by these groups as compared to the population at large.

The ethnicising of inequality is a new phenomenon in Italy, and also in Europe, but – as Marmot (2006) reminds us – health inequality is a stable transnational phenomenon.

Some scholars (Fassin, 2000) have shown that immigrants in particular are vulnerable to health inequality. There are studies to show that groups with previous experience of migration have a lower average life expectancy than the general population, higher infant mortality and more frequent problems of health (Nazroo et al., 2006). People who have lived through migration tend to be poorer than the general population, more frequently unemployed and paid less (Brian et al 2002).

In the following sections we report the first results of research still in progress, to show health inequalities between women belonging to two Mediterranean countries (Italy and Lebanon), analysing indexes of health and bearing in mind the differing health systems and distribution of resources. The research topics are prevention of women's tumours and the sexual and reproductive health of adolescents, including sexually-transmitted diseases. Another focus is on access to prevention by immigrant women living in Milan and Lebanon, thus highlighting what is known as "cumulation of inequalities" (Lombardi, 2005, 2008, 2011; Tognetti Bordogna 2004) and/or multiple discrimination (Zanfrini, 2005) where social inequality is added to gender inequality (Tognetti Bordogna 2012) - to which we might add generational disparities and inequality related to migratory route.

2. Health, health care and prevention

The Italian and Lebanese health systems differ in organisation and distribution of resources; the Lebanese system is more prone to inequality than the Italian. Italy's system is based on a universalistic National Health Service guaranteeing all the resident population Essential Levels of Health Care (ELHC), on a region by region basis (Maino, 2001; Ferrera, 2006).

Lebanon's health system is of the "Bismarckian" model, based on private and job-linked insurance, and only a part being covered by public funds (Health Ministry, Ministry of Social Affairs). It is thus a highly fragmented health system with various supervising authorities making regulation and coordination complicated. The funding sources are a mixture of the Ministry of Treasury, employer contributions, worker contributions and family straight payments, on top of which there are various financial intermediaries in the form of public and private bodies. According to data from the *National Household Survey* 2004-05, less than half the population (46.7%) are covered by one or more public system or private insurance (Giarelli, 2010).

Beginning with the last reform (1993) and above all since the civil war ended, Lebanon has increased its health budget in relation to GDP (7.2% of GDP in 2012; 9.1% the Italian budget), and brought her per capita expenditure up to $1,092 in 2013 (Italy's equivalent was $3,126): http://www.who.int/countries/lbn/en/.

The most important points in that reform were reorganisation of the public sector primary care network, quality improvements in public hospitals, rational use of medical technology and drugs, and a surveillance system on public and private provision of services. At a primary and tertiary level, the effect of improving the public health system has been to let the poorer part of the population use services more (Kosremelli, 2012).

2.1 Health indicators: Italy, Lebanon

Let us now take a look at some health indicators in the two countries, based on WHO findings.

Table 1 - Health indicators: Italy and Lebanon

	Italy		Lebanon	
Life expectancy at birth	83 (F 84.6; M 79.8)		80 (F 82; M 78)	
Maternal mortality	4 (per 100,000 live births)		25 (per 100,000 live births)	
Under-five mortality rate	4 (per 1000 live births)		10 (per 1000 live births)	
Adolescent birth rate	7 (per 1000 women aged 15-19 years)		18 (per 1000 women aged 15-19 years)	
Adult risks factors				
Raised blood glucose (aged 25 +)	F 5.4%; M 8.8%		**F 11.0%; M 13.0%**	
Raised blood pressure (aged 25 +)	F 20.6%; M 28.6%		**F 26.1%; M 33.9%**	
Obesity	F 14.9%; M 19.3%		**F 29.7%; M 26.4%**	
Top 10 causes of death	Percentage	Rank	Percentage	Rank
Ischaemic heart disease	13.2%	1	31.1%	1
Stroke	10.2%	2	9.4%	2
Road injury	not in top 10		**4.0%**	**3**
Trachea, bronchus, lung cancers	**5.9%**	**3**	3.6%	5
Hypertensive heart disease	**5.2%**	**4**	2.6%	8
Alzheimer and other dementias	**5.2%**	**5**	not in the top 10	
Diabetes mellitus	3.6%	6	**3.7%**	**4**
Chronic obstructive pulmonary disease	**3.6%**	**7**	2.4%	10
Colon and rectum cancer	**3.6%**	**8**	not in top 10	
Breast cancer	2.3%	9	**2.6%**	**6**
Lower respiratory infections	not in the top 10		**2.6%**	**7**
Falls	not in the top 10		**2.6%**	**9**
Pancreas cancer	**1.9%**	**10**	not in the top 10	

Source: WHO, *Statistical profile*, http://www.who.int/gho/countries/

The data (tab.1) illustrate major differences between the two countries, though the average standard of health of the Lebanese population is high, and certainly the highest in its own region (Middle East and North Africa Region). Compared with the Italian

population, Lebanese men and women are more at health risk in terms of glycaemia rate, blood pressure and obesity. In both countries the first two causes of death are ischaemic cardiopathy and stroke, though the former regards 13% of Italians and 31% of Lebanese, while the figures for stroke are comparable (10.2% of Italians and 9.4% of Lebanese). Significant differences are found in deaths by road accident, the fourth cause of death in Lebanon, whereas it is not in the top ten Italian indices. The fourth cause for Italians is cardiac hypertension diseases, which are double the Lebanese incidence (5.2% versus 2.6%). Fifth in the Italian ranking comes Alzheimer Disease which is not present in the Lebanese top ten. Death from colon-rectum cancer, which does not figure in Lebanon's top ten, occupies eighth place in Italy. Death from breast cancer is similar in both countries (2.3% of Italian women vs 2.6% Lebanese), being the ninth cause of death in Italy and the sixth in Lebanon. Tenth place among Italians is occupied by cancer of the pancreas, which is not among the top ten Lebanese causes. The figures show that in Italy three forms of cancer figure in the top ten causes of mortality, as compared to one in Lebanon, breast cancer, which regards women.

2.2. Prevention and health: women's tumours

According to CNESPS/ISS estimates, in 2013 the commonest tumour throughout the Italian population was colon-rectum cancer, 58,700 new diagnoses of which were made: 33,680 men and 25,050 women. The most widespread tumour for men is prostate cancer, with over 43,000 new cases, while for women it is breast cancer (54,000 new diagnoses) (Health Ministry, 2014). The current trend is for fewer cases of stomach and lung cancer among men and cervical cancer in women. There is a steady rise in colon-rectum tumours for men and breast tumours for women.

According to ISTAT data, there were over 175,000 deaths from cancer in 2011 (98,700 men and 76,663 women), equal to 30% of all deaths. Cancer is thus the second cause of death in Italy (the first for men, the second for women). There is a growing 5-year survival rate (60% in women, 52% in men) among an increasingly wide spectrum of cancer pathology. Breast and prostate cancer here show the best results: respectively 85%

and 88% survival at five years from diagnosis. According to the national PASSI report[5], over 10 million people were invited in 2012 to undergo one of the three recommended screening tests, over 5 million of which were performed. From 2008 to 2011 on average 7 out of 10 women between 50 and 69 years of age underwent a preventive mammograph test on schedule. Fifty percent of these tests formed part of RHS[6]-organised programmes, while 20% applied for screening on their own initiative.

The women who went for breast screening were largely in the 50-59 age group, married or cohabiting, highly educated and enjoying medium-high economic status. By contrast, significantly fewer immigrant women do such screening (58% vs 70%). In the same period 75% of women in the 25-64 age brackets did a screening test for cervical cancer, as part of an organised programme or on their own initiative. There again proves to be a gap between Italian women and immigrants (76% vs 68%).

The PASSI report finds that effective promotion of screening derives from women receiving input from more than one quarter. An invitation letter from the RHS (Regional Health Service), combined with their doctor's recommendation, appears to achieve the best results (http://www.epicentro.iss.it/passi/dati/ScreeningMammografico.asp).

Lebanon has some 800 Primary Care Centres but only about 100 of them can provide a full range of primary services. The health centres are mainly run by NGOs, complying with Health Ministry and Social Affairs Ministry requirements, and are fundamental props to prevention and community services. Beirut has 35 social and healthcare centres with 865 beneficiaries each year per centre the highest user-rate in the country (MOPH, Statistical Bulletin, 2012).

Women are hospitalised more than men for nearly all the main pathologies, and are twice as numerous for: problems of blood circulation, the digestive tract, genital-urinary infections, bacterial and parasite infections, muscular-skeletal and eyesight problems, endocrine and nervous system disturbances.

Breast cancers account for 41% of all women's tumours, and cancers of the genital-reproductive system represent 6.8%. Breast cancer, as an absolute number, outstrip all

[5] The project PASSI (Progressi delle Aziende Sanitarie per la Salute in Italia) was launched in 2006 with the aim of achieving 360° monitoring of the adult population's state of health, in Italy.

[6] Regional Health Service

other neoplasias, both male and female. Unlike the average world pattern, almost 50% of Lebanese breast cancers are diagnosed in women under the age of 50; the incidence is on the increase, there being 76 new cases every year per 100,000 women of all ages.

Back in 2007 the Lebanese Health Ministry launched a sensitisation campaign to promote mammary screening, in liaison with a pharmaceutical company which was offering women a one-month chance of screening at a public health centre for the price of 30,000 LL (15 euros) and 40,000 LL (21 euros), i.e. a 70% discount on the going rate. The same campaign was proposed again in 2014. In 2012 the Ministry got up a prevention campaign for cancer of the womb (MOPH, Statistical Bulletin, 2012). The outcome of this campaign still seems to be poor and fragmentary. The absence of a national plan to fight cancer, and unequal distribution of resources, have ensured that cancer deaths have not diminished; tumours are increasing, above all breast cancer. The qualitative study being conducted in Beirut will take these factors into account.

2.3 Prevention and health: sexually-transmitted diseases

The Italian data on HIV and STD show that in 2012 there were 3,853 new cases of HIV infection reported, 79% of them among men. In the same year 6.5 new HIV-positive cases were reported per 100,000 residents, placing Italy in the medium-high bracket for Western Europe (Health Ministry, 2014). Most new diagnoses of HIV infection are due to sexual intercourses without precautions, which mean 80.7% of all cases reported. The median age of HIV-positive persons that year was 38 for men and 36 for women. Twenty-six percent of all those diagnosed HIV-positive are migrant men and women.

Between Italians and foreigners there is a different distribution of HIV infection. The incidence is 4.8 new cases among Italian residents and 24.4 new cases among foreign residents. There seems to be no clear perception in Italy of the risk of HIV and STD. Less than a quarter of the persons with a new diagnosis of HIV infection had done the test previously, despite risk behaviour or unprotected sex. Just over a quarter of the people diagnosed with AIDS carried out anti-retroviral therapy before their AIDS diagnosis. The main factor likely to make one do anti-retroviral therapy before being AIDS diagnosed is the awareness of being HIV-positive. It follows that between 2006 and 2012 there was an increase in the percentage of people reaching the stage of patent disease while still unaware

they were HIV-positive, a total of 67.9% of those with AIDS (Health Ministry 2014).

From 1991 to 2012 the STD (sexually-transmitted disease) surveillance system collected over 96,752 new cases of STD. The commonest pathologies were ano-genital condyloma (38.7%), non-gonococcic non chlamydial infection (NG-NC) (16.5%) and latent syphilis (9.1%). Of the two main viral STDs, genital condyloma was reported on a constant pattern up to 2004, and went on to a peak in 2012. In its 45 months' operating span the same surveillance system based on clinical microbiology laboratories registered 75,767 samples: the most commonly diagnosed infection is Chlamydia trachomatis (3.2%), followed by Trichomonas vaginalis (0.7%) and Neisseria gonorrhoeae (0.5%). The prevalence of Chlamydia trachomatis is highest among men who admitted to two or more sexual partners over the last six months (12.6%) and in young people between 15 and 19 years old (8.5%). The prevalence of Trichomonas vaginalis proved highest among immigrant women. Neisseria gonorrhoeae was highest in men, especially if multi-partnered (Health Ministry 2014).

Sexual health and sexually-transmitted diseases are a hard subject to discuss in Lebanon. Sexuality is still taboo, while strong prejudice and stigma is levelled at "free" women, gays and lesbians, and anyone not conforming to the strict dictates of religious morality. To give an idea, Lebanon forbids and prosecutes cases of cohabitation, civil marriage and pre-marital sex (Lombardi, 2010).

Some evidence from Pap smears suggests an overall 2.1% increase in sexually-transmitted diseases (from a minimum of 4.8% in 2002 to a maximum of 6.9% in 2006); there was an increase in papillomavirus from 1.4% in 2002 to 3% in 2006, and a consequent increase in diagnoses of atypical cells from 0.3% in 2002 to 2% in 2006 (a 6.7-fold increase in five years). These increases were seen among women of younger generations (from a mean of 42.4 years in 2002 to a mean of 31.6 years in 2006). The change is probably due to a lowering in the age of sexual relations and less stability among young couples (WHO, 2010).

The data on HIV were collected and analysed within the framework of a national campaign against AIDS. The number of cases collected up to November 2011 was 1,455, including 109 new cases: 93% of these regard the male population and age brackets of under-30 (28%) and 31-50 (30%). The health of the young population (adolescents and

young adults) has received little attention by the health services, although the young account for 20% of the Lebanese population. Most health services are designed to treat children or the elderly. The young persons needs are ignored, above all in terms of consultancy, reduction of health risks and health education (Kosremelli, 2012).

The data available on young people's health point to behavioural problems: violence, unprotected sex, dietary habits, lack of exercise and smoking. Young people are using alcohol more and more: 19.5% of school pupils had consumed at least one alcoholic beverage in the month before the interview. Consumption of narcotics was 3.5%. About 27% of Lebanese schoolchildren between 13 and 15 were tobacco-smokers (Kosremelli, 2012).

The data show that the young people become sexually active earlier than in the past. About 15% of schoolchildren say they are sexually active; 52% of boys declare they became sexually experienced before they were 20. Combined with a later marrying age for either sex (27 and 31 for women and men respectively), inadequate contraception and little awareness of the risks of sexual activity, everything suggests that the risk to sexual and reproductive health is becoming considerable in this age group (Kosremelli, 2012).

2.4 Migrant health status in Italy and the grey areas

The immigrant population in Italy (Health Ministry 2014) and the Region of Lombardy (Lombardi *et al*. 2015) displays a broadly good state of health and greater perceptiveness than the native population (77% vs 68%). Mortality is fairly limited and the hospitalisation of people from the Countries with a Strongest Migratory Pressure (CSMP) is lower than among Italians and foreigners from Advanced Developing Countries (ADC).

The grey areas of immigrant health are infectious disease (TB, HIV, STD) and cancer, which proves to be the main cause of death for women (32%), especially breast, lung and cervical cancer. This may partly be set down to insufficient use of screening programmes. Violence is the second cause of death among women from the Countries with a Strongest Migratory Pressure: this is three times as likely as it is for women from ADC. For immigrant men acts of violence are the first cause of death (34%), (Agenas, 2013).

At the risk of over-simplification, some recent studies based on cancer incidences show that foreigners from CSMP are less prone than either Italians and foreigners from ADC to

all types of cancer except those of viral origin. By way of example, the risk of liver cancer for men is 20%; that of cervical cancer for women is 86% (Health Ministry 2014).

The rationale for our research project stemmed from the statistical assumptions that we have reviewed. We aimed to explore the dimensions of the phenomenon as well as the perception of women's cancer and sexually-transmitted diseases, with a view to implementing sensitisation measures encouraging prevention, which is especially limited among immigrants from Countries with a Strong Migratory Pressure.

3. The research and its methodological basis: health centres and prevention measures

The project we are describing is of the action-research kind, based on qualitative research tools and methods: focus groups and in-depth interviews recorded and fully transcribed.

In all we conducted 31 interviews with socio-health stakeholders and workers (15 in Milan and 16 in Beirut); 20 institutions were involved, namely service sector associations and health centres (11 in Beirut, 9 in Milan). We also created two focus groups with health workers and 3 with immigrant women in Milan (Chinese, Coptic, Maghrebian).

In Lebanon two focus groups were formed: *one of Palestinian refugee women* (six in number) belonging to the UNRWA[7] medical centre of Saida, and *one of Lebanese women* (7-strong) based on a medical centre in the northern outskirts of Beirut. This was funded and run by various national and international bodies and by a religious foundation.

One special feature of the project is that it entails liaison among academics, NGOs and service sector personnel.

Our research divides into two lines of macro-action. The first is quali-quantitative and descriptive, consisting of a desk analysis of the data and information collected, followed by two case studies in the cities of Milan and Beirut, designed to detect the state of need and of awareness of women's cancer prevention. The second line of macro-action entails sensitising both women's groups to cancer prevention and the adolescent population to sexual and reproductive health. Sensitisation was conducted in public and private health centres, and in two high schools.

Apart from its own partners, the project involved various other entities[8,9] in an attempt to

[7] United Nations Relief and Works Agency for Palestine Refugees in the Near East

[8] Lebanese Health Ministry and Education Ministry, the Université Saint Joseph and the American University of Beirut; STD/CRH Public Centre in Milan

build up a network of synergic services and activities optimising resources and improving the potential for intervention and sensitisation.

The areas highlighted by the interviews were prevention of women's cancers and sexually-transmitted diseases (STD), organization of facilities, reception, communication, sensitisation and information, as well as the peculiarities of the facility users, their perception of, and approach to, prevention of health risks.

3.1 Field work: Milan

The Milan research field was built around interviews with representatives of two accredited family planning centers (FPC), one self-managed health centre, a public centre for sexually-transmitted diseases, one non-profit foundation, a national association for cancer prevention and two outpatient centres for immigrant women, an ONLUS health centre largely accessed by immigrants with socio-economic difficulties and irregular juridical/administrative positions.

At the first accredited family planning center[10] we held three interviews (with the service coordinator, a sexologist and a trainee psychologist). This FPC has an integrated approach to prevention/treatment of sexual and reproductive health issues (STD, Pap-Test, pregnancy check-ups, pre-childbirth courses, abortion certification, psychological consultancy and support, etc.). Thus one interview outlines the mission of the facility:

> *For an FPC and for us especially, I'd say it was an appeal to the individual to look after herself. That's what springs to mind first. What with rushing about, schooling, the social environment, the economic crisis and what have you, there's not much chance to stop and think about what is "good for us", what gives meaning to life [I. 1a].*

The center is used by about 500 persons, mainly Italian women between 30 and 40. There is quite a good flow of younger women too in their 20s, and older women for gynaecological check-ups and problems to do with the menopause. It has about 20 different workers

[9] NAGA Association, LILT provincial section, AIED and Aquiloni accredited Family Planning Bureaus, Bracco Foundation in Milan; One Wig Stand Foundation, Albert Nassar Foundation, UNRWA, Amel Association in Beirut

[10] Accredited facilities meet the general and specific structural, technological and organisational requirements set by the Lombardy Region, and can enter contracts with the Local Health Service in charge of providing health services borne by the Regional Health System.

(gynaecologists, midwives, psychotherapists, psychologists, a social worker, a nurse, an administrator, student-trainees and residents)

> *We do tons of projects. We begin with adolescents and go round the school. We start by working on sexuality and handling emotions, more the emotions, then education about relationships which is one of our pet things. I may be speaking for myself here, but it's a real wish that they should wise up to relating. Then here in the centre we work on themes, you know, the ones that led us to focus on women: self-esteem, fertility, conflict management, pleasure, sexuality, parent-child relations, with adolescents and otherwise, conflict in the couple, relating as a couple [...] Basically we try to set up settings and encounters so people can exchange experience and emotions, cos storytelling it not that much use, what counts is for people to bring up the underlying emotion and experience* [I. 1a].

On the issue of preventing women's cancer, the FPC lays on the pap-test and if necessary can help people take the diagnosis further.

> *If we get a positive pap-test, you don't come straight out with: "Help, we've got a ca cancer here". We inform and counsel the person all about HPV*[11] *which is the main concern at the moment for women who get a positive pap-test [I. 1c].*

The pap-test is done on each woman every three years, though if the diagnosis is HPV an annual check is recommended. Even among adults the health workers find there is considerable misinformation about sex practice and STD:

> *at least once a week we get ladies coming in to terminate a pregnancy, and the question that puzzles us is: what is missing here? (...) Quite often, you see, these women wanting to terminate a pregnancy will be in their 30s; they may be women who have had two pregnancies and two children and just can't afford a third one. What we ask ourselves is:*

[11] Papilloma virus. HPV is the world's commonest sexually-transmitted disease. Tissue microtraumas caused in sexual relations allow the virus to vault the defence barriers and infect the cells at points of epithelial fragility (cervix of the womb, small labia, vaginal vestibule and anus). This virus can cause a neoplastic alteration to infected cells in the uterus neck region. It has been demonstrated that a persistent HPV infection increases the relative risk of incurring a high-grade lesion (http://www.aiedmilano.com/attivita-socio-sanitaria/ginecologia/hpv/).

how can we help these women when there's just no personal sex education or knowledge about the contraceptive methods that exist [I. 1c)

Another way of getting through to women is the theme-based evening. When it comes to sensitising and informing high-school children, there is also a need for medical instruction: explaining about sexually-transmitted diseases, the anatomy of sex, prevention of STD, what to do and where to go if one suspects one has an STD.

The kids are all ears on this one; they ask lots of questions. We also give them a chance to ask anonymous questions in writing so they feel freer to speak without embarrassment. So much for preventive work in schools. Then you get them coming in here and saying they've had various sexual partners and not taken precautions. At that point we get them to delve deeper: it's something that needs to be done. [I. 1c].

Coming to immigrant users, it is chiefly foreign women from the mid to upper social stratum that approach the service, and often they are second generation. They are already informed women with good command of Italian or some other European language. The health workers find no difference of approach to sexual health issues between native-born women and this kind of immigrant.

Men rarely use the service, on the other hand. They will only come in to accompany a partner who is pregnant or having a check-up or on the childbirth programme, or they'll be there for support over a parenting issue. The healthcare workers note that not having an andrologist on the staff is a considerable drawback to male attendance.

The second health facility we involved is an Accredited Family Planning Center where as many as 1,385 people accessed in 2014. Ninety percent of them were women, 44% foreigners and 35% of these last were Asian, 32% Latin American, 27% African and 25% East European. The most numerous age group was 19-29 (472 attendances) followed by the 30-39 age group (414 users) who are central to reproductive life. The main services provided were the pap-test (14%), gynaecological examinations (23%), obstetrical check-ups (20%), and psychological consultations (42%). In the same year contact was made with 1,091 high-school users. The clientele of this FPC varies widely, owing to its location between a central district and a suburb of the city where many immigrants live.

Yep, ours is really a mixed bag. We get the "posh" user, ..., who may also be free and willing to come in and help the nappy-purchasing group. Our plan is to provide the tools and try and get even the most desperate women on track for independence. We don't do aid, you see. What we're trying to provide is the tools for these women to get through by themselves [I. 2a).

Among the considerable swath (44%) of immigrant attenders, there are different kinds of demand: women from North Africa and Egypt come in almost entirely for gynaecological and obstetrical services, or for social welfare; the same goes for the Chinese; but the Latin American women tend to use the whole range of services, although not always on a regular basis.

To improve relations with immigrants, the bureau uses a language and cultural mediator and also some foreign professionals, such as a Latin American social worker and midwife:

on the team we also have a social worker who's Latin American and a midwife who comes in on Monday afternoons to help give the Latin American women more visibility, if you know what I mean. When they get here, though, they must have the know-how to become colleagues. Otherwise we always swap them for other work placements. We used to have a Dutch social worker too, that is, over time our team has always reckoned with multiculturalism. (...) Now the language and cultural mediator is definitely a bridge. All the same, we can't just leave it to that bridge to keep contact. Because if so, we're not talking of integration any more. True, Chinese is incomprehensible, and true, the mediator helps an enormous lot, the chance to understand, you know, "but at the same time we have to go the next step, i.e. facilitating"[I. 2a].

Concerning prevention of women's tumours, this facility not only runs routine pap-tests and breast inspections, but twice a year (March and October) there are meetings called "Pink Prevention" - a whole month of appointments when women can do a free pap-test and find out about self-prevention.

At the end of the day, health tends to get delegated to the doctor. No way: the first form of prevention is observing your own body, knowing there's a drill even with contacting

doctors. Simple example: self-palpation of the breast, which E. goes over, reminds people or teaches them (she also has a short film, it's pretty clear). These two meetings give women information and also a chance to share it among one another. This sets up relationships which extend everything the midwife says. It's like, we go in for interaction, the second meeting does just that, it sends them out into the field, like [I. 2a].

Although immigrant women are using pap-tests and breast inspections less than Italian women, the health workers interviewed are positive that nowadays they all do know about prevention programmes.

Another FPC activity is with Milanese schoolchildren and teachers in both middle and high school. There is also a focus on sexual relations and emotional attachment. The approach is multidisciplinary and teamwork, including a woman lawyer, since:

sexuality, as it happens, means respect for the other person, so lawyers help us tackle the issue of rights and protection in sexual relations, the first point being consent. What does consent mean inside the couple? Where consent stops, we are in a no-man's land which can easily tip over into criminal offence. ... we have to remember that consent is fundamental in the relationship we set up with our partner so as to maintain parity [I. 2a].

At meetings the subject of voluntary termination of pregnancy is dealt with, and Law 194/1978 governing it. There is often a need to clarify incorrect information going the rounds among younger people which will expose them to unwanted pregnancy or STD.

You wouldn't believe the confusion: they mix up miscarriage with voluntary abortion and therapeutic termination of pregnancy. With moralising overtones rather than ... I mean, they don't help anyone understand. The same way they mix up post-coital contraception with RU486. There are times we have to deal with knowledge issues that don't help youngsters express sexuality as it should be expressed [I. 2b).

Pupil reaction to these topics is highly positive, say our informants. The scheme is both scheduled and open-ended: each of the three middle school years is covered and each year is different according to the pupils' age and how much knowledge they pick up from year to year.

Sessions in class are always a two-person affair: the first meeting usually involves the psychologist, the professional educator or the midwife. For the second meeting they change round, and in the third there is the psychologist and the lawyer. To end off, a class visit to the FPC is always scheduled with the teachers accompanying them. At the bureau the children meet the gynaecologist who explains and show the methods of contraception, talks about sexually-transmitted diseases and fields the pupils' questions and doubts.

Another organisation looked at by the research was the Milan province section of LILT, where a number of interviews were conducted. We shall be focusing on those with the people in charge of primary and secondary prevention.

LILT is active nationwide. When they realised that the mentality of primary and secondary prevention, and hence early oncological diagnosis, had not caught on in society nor among foreign women despite being an issue raised by hospitals, the LILT staff decided to take a leaf out of 1960s sensitisation and information on early diagnosis for Italian women and extend it to immigrant women, using mother-tongue medical staff without involving a language and cultural mediator.

Within one year 650 examinations were conducted. The foreign populations that responded best were from Eastern Europe and South America. Most of the doctors come from Eastern Europe. The facility also has a Chinese gynaecologist, one doctor and two obstetricians from South America, and an Egyptian woman doctor. LILT runs many other schemes, including one on healthy diet.

so it was the foreign associations that helped us in a kind of two-way education designed to create "ambassadors" to the community who would talk to friends, sisters and colleagues, so these groups would form and come to meetings. As the WCRF (World Cancer Research Fund) maintains, feeding properly is most important and directly connected with some kinds of tumour which are actually on the increase among immigrants. So to get this scheme going on diet we contacted the biggest Milanese communities of Filipinos, Arabs, Peruvians and Chinese, and set up a whole network of 15 associations, coops and non-profit organisations, trying to put across the aims and activities behind the scheme and get people

involved [I. 7].

We also interviewed the Director of the HIV and Sexually-transmitted Disease Public Centre of Milan. The centre accepts users on a regional and a national basis (7,300 patients in 2014), and immigrants account for 30%. Many services are provided free of charge (health interviews, HIV and other STD tests, dermatological and gynaecological examinations, treatment for venereal disease, guidance among the psycho-social services). The service is free of charge and users may preserve anonymity. It is open six days a week and does not require an appointment or referral by a GP. The Centre has launched various campaigns, including one during the Milan EXPO.

We produced an App called Smart-sex which can be downloaded both from Apple-store and from Google Store. This describes all the Milan activities of the Local Health Service and more besides. It's an interactive App with possibilities of question and answer and a host of information. It's a development on the website [I. 3].

Another awareness campaign was launched on the occasion of the Expo, by the LHU of Milan in cooperation with the STD Centre corresponding to the slogan "Keep calm and safer sex":

It's all to catch the visitor's eye coming here during Expo. You know, on these occasions people let their hair down, meet people and in a big city like Milan they may have sex and take no precautions [I. 3].

As regards minors, there are cases of HIV and STD but fairly few, and the same goes for the over-55s. Pathology of this kind is concentrated between 25 and 50, and really between 25 and 45 “there is the peak of the disease, this being the active, or most active, phase of sexual life. That's why the staff at the Centre, liaising with LILA (the Italian League Against AIDS), have entered an agreement with Milan universities to put on open days of information, consultation and guidance. The results seem to be gratifying, to hear the director of the facility.

He gives us some epidemiological data on HIV and STD: the prevalence in Lombardy

amounts to 30% of all cases nationwide. Every year 4,000 new cases of infection are recorded in Italy. Since anti-retroviral therapy started (between 1988 and 2002), the director cautions, attention to both kinds of infection seems to have fallen off. AIDS and STD have become more devious: they no longer just regard so-called "risk behaviour" (drug-dependency, homosexuality, etc.) but concern everyone and both sexes: sexual relations are more open nowadays, more frequent and with different partners. A population is emerging in Milan which the WHO calls "men who have sex with men" (MSM): they are not just gay or homosexual persons, but they are men who "occasionally have sex with men".

> *For some time now, an alarming fact has been on the increase in Milan. We have had to turn on the warning light. (...) Half-and-half is a national statistic, but the report is that half-and-half, the MSM population, is slightly up in 2013; in Milan that slight increase tells us that 70% of the new HIV-positives - including other sexually-transmitted diseases, above all syphilis - are in the MSM category* (I.3).

The user population for the CRH-STD centre in Milan, and those in general who contract sexually-transmitted diseases, are 75% young men between 25 and 45. Thirty percent of them are foreigners and among these there are more women than among Italians (they come from Eastern Europe and Latin America).
First contact with the foreign populations is even harder than with Italians, given their living standards and legal status.

> *That's definitely so. I mean, even with Italians we have some 30-40% of blissfully ignorant who, I don't know, live with urethritis, do nothing about it, and then it goes off by itself. They'll go to the doctor and be asked: "Had any complaints?" They answer: "well, maybe yes, can't say that I noticed really". Of course, you don't die of such complaints, they're a pain and take a long time but may clear up of their own accord. Or they may be treated badly. Then of course if there's less cultural interaction, the amount of knowledge is less. Or they come from countries where there's even less information than here, no service, nothing left. You may get phenomena that have modified with time in Italy, like drugs, but who says it's not still*

going on among those people? [I. 3].

On the question of immigrant access to the service, our respondent claims the problem does not exist.

That's not a problem at the STD [centre]; it's a problem of communications and one for public health. That's just my opinion, mind. I believe the Milan LHS has tried to bear in mind - at least for the services that are heavily in demand, the FPCs, the vaccine services, the adoption centres - you know, that the population of this city has changed for many years now. It's multicultural and multilingual with all the problems that raises. Let's say that those who've wised up, those who read, those who somehow get to know, the information is circulated in their cultural centres too. One way or another, they're coming in, and more and more of them, too.

3.2 Field work: Beirut

As mentioned in the introduction, the data are still being analysed. Here we can give only some of the results from the focus groups set up in Beirut. But most of the interviews with stakeholders suggest that there is inequality of access to health care, and social as well as health disparities.

The Saida UNRWA focus group involved six Palestinian women, four of whom were aged between 20 and 35, and two between 45 and 54. The education level was high (high-school) among the younger ones and primary in the case of the older ones. They all styled themselves housewives looking after children and the home. Apart from the youngest of all (expecting a baby), the others have four or five children.

On breast cancer the women seem well informed, possibly because they often have cancer sufferers in their midst. Their information largely comes from the television or from the health centre where doctors and nurses recommend they do a mammography test. The younger ones also get information from the Internet. The focus group members are less well-informed about cervical and uterine cancer. There are very few campaigns on the subject, though the health centre suggests women do the pap-test and nearly all the FG members know about it.

Breast screening and the pap-test are free of charge, covered by the UNRWA, but treatment for those who need it is hard to obtain since there is only one UNRWA-funded hospital which is overcrowded and under-equipped. The focus group women get little sympathy from the staff, "not because they are Palestinian, but because they are non-paying patients".

On STD and sex practice there is considerable misinformation. Although they know what it is and something about HIV and its increasing incidence, they are confused about how contagion spreads. They have never encountered prevention and sensitisation programmes about STD. Doctors do not refer to it, unless a woman has contracted an infection. The women are all nonetheless curious to know more and think the medical centre ought to inform them about the diseases and the risks.

The S.A. Healthcare Centre focus group in a northern suburb of Beirut includes seven Lebanese women between 25 and 65 years of age, though most fall between 45 and 54. With one exception, these mature ladies described their education as medium-low and one had had no schooling. They are all housewives except for a young woman who is an educator and one woman who is retired. On the whole they have fewer children (2-3) than the Palestinians, but one has five and another one eight.

These women again know about breast cancer and the prevention programmes, but they know very little about cervical and uterine cancer or STD. Perhaps more than the Palestinian women[12], they complain of the difficulty and even impossibility of getting treatment, since for them cancer treatment is expensive (from 50,000 to 100,000 USD); hence many die untreated. From what they see and hear in daily life, their perception is that cancer is becoming more aggressive and targeting younger women.

Some think that "prevention doesn't exist": cancer will anyway kill one because:

Prevention is when a small thing appears in some place and the doctor removes it and they say to you that you are cured, but in 3 or 4 years another cancer will appear but the doctor doesn't tell you that. We know this because we see cases of cancer with our neighbours and we see what is happening.

[12] We should bear in mind that, despite difficulties and malfunction, medical treatment for Palestinians is covered by the UNRWA, whereas if the Lebanese do not have insurance cover, they have to bear the full amount of their health bills.

This is how they describe women's cancer (generally meaning breast cancer):

- *It causes grief*
- *A disease that has no cure*
- *Its end is death*
- *Fear*
- *Death*
- *Suffering*
- *Every time I undergo a mammography I ask for other people to fetch the result and to lie to me if the result is bad. I am so scared. But I do it every year because at least I can detect cancer early. That's why I feel relaxed, because the people in the centre say the result is good, it's like last year. They even call and remind me to do the exam when it is time.*

To sum up in a nutshell, the gist of the focus group findings is that these women have an urgent need for health and treatment: their living conditions are hard either because they are refugees or because they are economically and socially underprivileged. Information and sensitisation about prevention is often deficient or poorly produced. There is virtually no information on sex practices and STD, although infection and genital complaints are frequent among women using the centre.

Even among young Lebanese women, cancer is widespread and survival lower than in Europe. The fact is confirmed by members of the focus groups.

Conclusions and critical issues

The data we present show different profiles for the two countries, despite breast cancer percentages being similar. There are many facilities and preventive campaigns for immigrant women in Milan, but little information in Beirut; again, Lebanese facilities are too few and inappropriate to cope with tumours, partly because of great differences in health systems.

The prevention picture is more complex. In Lebanon it is rather limited, partly because many women seem to have a pessimistic attitude; in Italy it is better developed with a high degree of participation.

The same gap concerns STDs once again because of prejudices or fear of talking in public about pre-marital sex. In both countries the age at which young people have sexual intercourses has fallen.

In both settings there emerges a need to provide more information about the clinical manifestations of sexually-transmitted infections (STI) and their complications; to promote safe sexual behaviour; to boost prevention, early diagnosis and therapy; to increase awareness of the role played by STI in transmitting/incurring HIV; to get up nationwide programmes to prevent STI; and to activate schemes of behavioural surveillance. In both countries there is still a long way to go in prevention of cancer and sexually-transmitted diseases, and there are still inequalities of access, although the dimension of the problem is different between the two countries.

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