Talking the illness

Swahili for medical aid and cooperation in Turin

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This article presents and discusses the results of a pilot course aiming at teaching Swahili grammar and lexicon as well as cultural awareness in the field of health to a group of medical staff doing voluntary work in medical cooperation in East Africa. The different conceptions of illness and cure in traditional African and allopathic (Western) medicine are analyzed and discussed (sections 2 and 3). Notwithstanding the government policies advocating a better integration between African traditional medicine and biomedicine, true mutual understanding and communication on the field keep being a real challenge, and special attention was therefore given to the communication between doctor and patient. The use of Swahili in patient reports (section 4) and a modicum of language knowledge on the part of the volunteers can make a difference if coupled with some awareness of local cultures. As an output to the course (section 5), four bilingual English-Swahili patient reports were produced (personal and family's physiological and patient's pathological report, as well as a specialized patient report for language and communication disorders). They have, albeit partially, been tested on the field (section 6).

1. Preliminaries: who, what, where, when, and why[1]

The articles reports on the results of a pilot course in Swahili language and culture aimed at medical staff belonging to Piedmontese NGO's and operating in East Africa. The pilot course was carried out in October - December 2016 in Turin. One of the authors (GA) was the teacher.

As the project was devoted to personnel active in medical cooperation, the actual course was preceded by a series of meetings and interviews with medics and paramedics who had long been

[1] Preliminary results were discussed at the XIV International Conference of Africanists: "Africa and Africans in national, regional and global dimensions", Moscow, October 17-20, 2017. We want to thank the conference organizers and all the attendees for their precious help, criticisms, and remarks. This study was further presented on 21 May, 2018 to the "Unito-Africa" Conference at the University of Turin, and on 8 June, 2018 in Turin, at the workshop entitled "Frontier Semiotics" within the project "Education for Citizenship and to Global Health", AID no. 011369) supported by the Italian Cooperation and Development Agency. Of course, all errors and omissions are our own only.

As per Italian academic regulations, the authors declare that Graziella Acquaviva is the author of sections 1, 2, 3, 4 and 5, and Mauro Tosco of section 6.

active in voluntary medical aid in rural areas of East Africa – and most specifically in Kenya and Tanzania.

The project *Talking the Illness* (It. "Parlare la malattia") was designed and developed in collaboration with the Piedmontese Centre for African Studies (It. "Centro Piemontese di Studi Africani")[2] and was first presented in April 2016. It was approved by the regional Cooperation Medical Board (It. "Tavolo Sanitario della Cooperazione"), a consortium made up by the Piedmontese NGOs operating in the field of health cooperation and spearheaded by CCM (Italian: "Comitato Collaborazione Medica"), a Piedmont-based ONG established in 1968 in Turin and which is active in different aspects of medical aid (participation of medical personnel on the field; rehabilitation and enhancement of infrastructures; delivery of medicinal products and surgical instruments; personnel training in collaboration with local governments).

The course took place between October and December 2016 at the Piedmontese Centre for African Studies and consisted of 12 lessons, each one 3-hours long. The medium was Italian.

Attendees were a limited number of medical doctors, speech therapists, paramedics and students in medical anthropology; apart from the latter, they work in different hospitals in the Turin area and doing voluntary work with NGO's based in Piedmont and operating in East Africa (mainly in Kenya). *Voluntary* is the keyword here: the attendees are regular employees of the Regional Health Service and take leave in order to volunteer in medical aid in non-governmental hospitals and dispensaries, often managed by different Christian denominations and with no help or assistance by the national health service. The volunteers engage usually in short periods of voluntary fieldwork; this circumstance limits the possibility of learning local languages and cultures. Still, all of them had a previous knowledge of basics of Swahili, learned either in the field or at the University of Turin (where Swahili is taught since 2010).[3]

At a preliminary meeting with all the participants, the attendees shared their own individual experience and expressed their expectations.

The meetings with the Cooperation Medical Board and the attendees helped to define the following course topics:

- the perception of illness, both from an allopathic (Western; imported) and traditional (local) perspective and the ensuing clash;

[2] http://www.csapiemonte.it

[3] The only other university in Italy where Swahili is taught being the University of Naples "L'Orientale" (formerly the "Oriental Institute").

- an introduction to Swahili from a language-in-use perspective: greetings; overview of grammar (noun classes, word and sentence structure); specialized vocabulary in order to elicit the patients' medical history cards, especially in the perspective of
- fostering new communicative skills, based on mutual knowledge and trust, between Western doctors/paramedics and the patients.

2. The perception of illness: Western and African approaches

The Swahili word for medicine is *dawa*, a loan from Arabic and a term boasting a wide range of meanings. When used in relation to healing it can refer to all kinds of actions, words or curses that can be obtained from medical specialists. The effect of *dawa* is not exclusively positive, as it can also be used as an agent to cause harm (*dawa mbaya* "bad medicine"; Larson 2008: 23). Healers use herbal medicine (*mitishamba* "wild herbs or plants") for the treatment of chronic disease (Nsimba and Kayombo 2008: 319). Sometimes treatment with plants can be complemented by a ritual evocation (*kubariki* "to bless") through the healers "powerful hands" (*nguvu ya mikono*) (Langwick 2011: 79; Feierman 1981: 357). On the Swahili coast and islands, where the majority of people are Muslims, healers write charms on clothes to be worn by the patient, recite religious texts and/or read special verses related to healing to the patient. The base for these is always the Qur'an and the Qur'an verses are essential for the *dawa ya suna* ("medicine of good tradition"; Larson 2008: 12).

This shows how much the Western and the traditional African approaches to illness (and cure) differ, and why they have long been seen as irremediably conflicting. Basically, two radically views of illness and remedy are at stake:

- allopathic medicine, or biomedicine, tends to understand diseases as a form of biological malfunctioning, with ill-health manifesting in chemical, anatomical or physiological changes (Ross 2008: 16);
- on the contrary, African traditional medicine refers to health practices, knowledge, and beliefs incorporating plant/animal/mineral-based medicines, spiritual therapies and manual techniques applied to diagnose and prevent illnesses (Feierman 1985: 110).

Although some scholars view the coordination between traditional African medicine and Western biomedicine as still in its infancy in most African countries (Gessler et al. 1995), it is apparent that the use of traditional medicine has received renewed attention due to epidemics such as HIV/AIDS, malaria and tuberculosis (Nsimba and Kayombo 2008: 319).

In the last decades, traditional medicine policies have been adopted in many member states of WHO (the World Health Organization), Tanzania included (Akerele 1991; Langwick 2011: 58) and a more nuanced approach has seen the light, and some kind of dialogue and coordination are being put in place. WHO reconsidered traditional medical practices as early as 1978 (WHO1978: 8, 29, 38; WHO 2000a, 2000b), and the collaboration between traditional and biomedical health practitioners was legally accommodated in Tanzania in the same year (Akerele 1991; Langwick 2011: 58; Ahlberg 2017: 1-4): traditional medicine received legal status in the Medical Practitioners and Dentist Ordinance Act (caption 409, section 37) and the Pharmaceutical and Poisons Act 1978, which stipulates substances and their use (Akerele 1991: 6).

Again at the end of the 1970s, the Traditional Medicines and Drugs Research Centre of the Kenya Medical Research Institute had been able to establish some form of dialogue with the traditional healers on an interactive basis (Aluoch et al. 1991: 9).

In 2002, the Muhimbili University College of Health Sciences (MUCHS) of Dar es Salaam established an Institute of Traditional Medicine whose focus was researching and developing standardised quality herbal medicines (http://www.muchs.ac.tz/ITM1/aboutus.htm).

On the other hand, efforts to recognize and foster the use of traditional medicine have long been and still are jeopardized by mutual distrust as well as by the difficulties in many African countries in regulating such practices (Mwambo et al. 2007). Again in 2002, highlighting again the complexity of the situation, herbalists (Sw. *mganga, mganga wa kiasili,* etc.)[4] were allowed to practice and distribute their remedies in standard (allopathic) facilities (Traditional Medicine Act) in Kenya, but the law has since been stricken due to the opposition of the allopathic medical personnel (Amutabi 2008).

Although many people use biomedical treatments, expecially in urban areas, the majority of people use traditional medicine (Makunnah and Mshiu 1991: 85). The usage of and/or the compliance with therapeutic health care is influenced by several factors:

- the availability of health service:
- the relative and absolute costs;
- the patient's classification of diseases and her/his perception of quality cares: hospitals, modern medical practice and the doctor-patient relationship.

[4] Cf. also Acquaviva's article "Healing and Spirituality in Tanzania: the *mganga* figure between literature, myths and beliefs" in this issue.

In comparison to the allopathic medical doctor, the local healer and medicine-man is part of the culture and operates within a known cultural environment, with its own definite known cultural norms, values and beliefs (Waane 1991: 212).

3. The semantics of body and illness and disease

If considered at different levels, the disease is a symbolic network conditioned by the structural construct in which it is manifested or is perceived.

To consider medicine as a hermeneutic process and illness as a symbolic and an organic construct involves the need to go beyond the linguistic level, where the two codes are different in lexicon and semantics and cannot be superimposed: it becomes necessary to reach a metalinguistic level where specific terms correspond and depend on the speaker and his or her own culture. This level of cultural communication highlights how behind every concept and expression there is a specific semantic system (Mazzetti 2005; Fantauzzi 2010).

A semantic analysis of Swahili idioms shows that body parts and bodily fluids (e.g., *kichwa* "head", *mkono* "hand/arm, *moyo* "heart", *jicho* "eye") are metaphorically used as a source domain for more abstract and /or cultural concepts and meanings, such as character traits, feelings, emotional status and so on.

Random examples of nontransparent idioms with body parts include:

- *kichwamaji* (*kichwa* "head" + *maji* "water") 'silly person' (lit. "water(ly) head"; Kraska-Szlenk 2014: 63);
- *usimkanie vyanda vitano* (a Swahili proverb; lit. "Do not think he does not have five fingers") 'Do not think he is not able to take what does not belong to him' (Knappert 1997: 11);

In particular, *mkono* "hand/arm" (like many other languages in the area, Swahili uses here the same word for both referents) conceptualizes a man's participation in social life. According to Talento (2014), a physical participation is suggested by means of expressions like: *mkono kwa mkono* → ' hand in hand'; *mkono mmoja haulei mwana* → 'A single hand cannot nurse a child'; *kuunga mkono* (lit. 'to join one's hand') "Many hands operate for the society and the community" (Talento 2014: 270). *Mkono* is found in many other idioms, such as:

- *mkono wa birika* (*mkono* "hand/arm" – like many other languages in the area, Swahili uses here a single word + *birika* "kettle") → 'miser';
- *mkono mtupu haulambwi* (a Swahili proverb; lit. "An empty hand is not licked") 'A poor man is not served' (Knappert 1997: 98).

According to Kraska-Szlenk (2014: 55-57), *moyo* 'heart' is conceived as a container in which all kinds of emotions may be kept and which may be full or empty, closed or open:

- *majonzi aliyokuwa nayo moyoni* "grief that he/she had in his/her heart"
- *alianza kumfunulia moyo wake* "he/she started to open his/her heart to him/her"
- *moyo wake ulijaa hisani* "his/her heart was filled with kindness"
- *utazame moyo ulivyoungua* "look how the heart is burning"
- w*anatuzidi silaha lakini hawatuzidi moyo* "they beat us as to weapons, but they do not beat us to the heart/courage"
- *moyo wangu huwa haupendi kuona watu wanasumbuka* "my heart does not like to see worried people"

Sometimes *moyo* gets associated with *jicho* 'eye' as a locus of love, as in the verses *jicho ndilo la awali, mashaka kukuletea, moyo ukawa wa pili matatani kukutia* "the eye was the first to give you trouble and the heart was the second to entangle you" (Knappert 1972: 157), while in its turn *jicho* is also used for "a dear person": *huyu ni jicho langu* lit. 'he/she is my eye' (Kraska-Szlenk 2014: 57).

If the physical body is conceived as a 'locus', a sacred place through which one expresses oneself both from a linguistic and an emotional point of view, it is equally true that the illness/disease - that threatens and often destroys it - becomes unspeakable or manifested through the use of linguistic expressions designed to generalize rather than individualize the illness/disease.

As a consequence, the popular and everyday use of words and concepts referring to health is greatly at variance with scientific terminology. Let's take two examples. When talking of "fever", the word *homa* is in general use. *Homa*, a loan from Arabic, is mentioned as a symptom of almost every illness but it is also an illness itself:

- *homa kali, homa ya kuchemka* ('hot fever', 'boiling fever'): "high fever";
- *homa ya kawaida* "ordinary fever";
- *homa ya vidonda* "fever from ulcers" (*kidonda*, Pl. *vidonda*). Some scholars translate *vidonda* as "boils";
- *homa za matatizo* "fever of problems" (*matatizo;* from hard work, inhability to sleep because of mosquitoes, hunger or sorcery);
- *homa za vipindi* "fever of periods" (*vipindi:* different periods of time; joints of body): intermittent fevers every 48 hours, or seasonal fevers, or associated with joint pain;
- severe fevers are referred to as "out-of-the-ordinary fevers" (*homa zisizo za kawaida*) or "fevers which do not respond to hospital treatment" (*homa zisizokubali tiba za hospitali*; Winch et al. 1996: 1061).

In Swahili there is no indigenous specific term for "malaria" and the word *homa* is used in rural regions or by people with a low level of formal education. Otherwise the loanword *malaria* or *maleria* is used:

- *homa ya malaria* "malaria fever";
- *malaria ya kawaida* is the equivalent of "clinical malaria" in Western medicine;

- *malaria ya kichwa* (*kichwa*, Pl. *vichwa* "head") "cerebral malaria". Locally, this form of malaria is separated into *Malaria ya kuanguka* (the verb *kuanguka* means "to fall") which causes convulsions, and *malaria ya kichaa* (*kichaa*, Pl. *vichaa* "madness") which only causes confusion;
- *malaria ya tumbo* (*tumbo*, Pl. *matumbo* "stomach, abdomen") is an "Abdominal malaria" (Gessler et al. 1995: 124 – 125);
- *ndegedege* or *degege* "convulsions". The word *ndegedege* literally means "bird-bird", and it is used as a translation for febrile convulsions in children and is recognized by the sudden onset of severe fever, trembling and/or stiffness of the limbs, frothing at the mouth, babbling incomprehensibly. This illness is so feared that people use a euphemism for it: *ugonjwa wa kitoto* ("childhood illness"). In Kenya, convulsions in children are very often attributed by mothers to supernatural forces and therefore require a traditional treatment. The belief in the supernatural causation of the illness contributes to a notion of defence mechanism referred to as *kinga* ("protection"). The individual can protect him/herself by wearing *hirizi* ("amulets") prepared by traditional healers (Gessler et al. 1995: 122; Winch et al. 1996: 1061-1062).

When taboo gets associated with illness, metaphors as always abund. Swahili has *UKIMWI* (*Ukosefu wa Kinga Mwilini*) for "AIDS" and *VVU* (*Virusi vya Ukimwi, Virusi vinavyoleta Ukimwi*) for "HIV". In everyday usage, where the sexual organs are called *sehemu za siri* ("secret/confidential parts"), anything related to sex is likewise perceived as "secret", and sexually transmitted diseases are *magonjwa wa siri* "secret diseases" (Mutembei 2015: 196). Metaphors likely to be used in colloquial Swahili include:

- *kale ka Mdudu* (a kind of bug?; non-standard/local) "HIV";
- *ugonjwa wa kisasa* ("modern disease") "AIDS" (Kirkeby 2000: 29);
- *Juliana* (name of a brand of cloth commonly smuggled between Uganda and Tanzania at the time the HIV epidemic began) "HIV";
- *silimu/slim* (from Eng. *slim*) "AIDS";
- *Dubwana* ("a huge nameless effigy that kills indiscriminately;" Mutembei 2015: 197) "AIDS".

4. The situation in the field/1: what medical personnel find and need

As anticipated in section 1, in order to understand what the medical personnel needed, we interviewed around twenty medical doctors and/or paramedics. During a preliminary meeting, the attendees recalled their experience as voluntary workers in Africa: everybody had deeply enjoyed and appreciated the new impetus given to their profession, too often stifled in Italy by the usual red tape. At the same time, they stressed the problems of operating in areas about which only very superficial previous knowledge of the local language and culture had been made available to them. Their experience highlighted the eminent role of communication in health services: language

barriers negatively affect not just the access and use of services, but also the quality of health care and its results, the patient's satisfaction, and jeopardize the prevention campaigns in rural and peripheral areas.

Our attendees, as anticipated in section 1, rotate their voluntary work in non-government health facilities: in these small hospitals are usually manned by a resident doctor (either a local or a foreigner) and a local Clinical Officer (CO). Paramedical staff vary in number and are usually trained locally by the missions or international NGOs. They may perform different duties according to the necessities, from acting as an operating room nurse or as an obstetrician. It is not unusual that both the resident and the voluntary doctors, who can be a surgeon or as an ENT specialist in Europe, may also happen to work as a gynaecologist, an infectious disease doctor or an ultrasound technician.

What follows is a selection of experiences collected at the Cooperation Medical Board and may help elucidate the issues at hand:[5]

> "An elder (maybe 70 y.o.; no identity card) is admitted with high fever and strong abdominal pain. On the basis of the available data, the Clinical Officer prescribes hospitalization and an abdominal ultrasound exam. The latter reveals a hernia as well as many adhesions. During the medical examination the local doctor and me had already noticed that the patient had several keloidal scars on his abdomen, and we even thought that he had already undergone surgery. Abdominal palpation clearly revealed local inflammation and therefore hard to the touch.
>
> I decided it was better to ask for more to the person accompanying the patient. After some resistance, the patient finally admitted having undergone traditional healing practices in the form of repeated burning of the groin area.
>
> At the beginning we had selected our course of action on the basis of objective data; later, the clinical history made us choose a different treatment (anti-inflammatory drugs, pain-killers, and antibiotics, followed by surgery). Emergency surgery in the absence of such an information and on the basis of the Patient Report only could have resulted in the patient's death on the operating table".
>
> (B. S.; August 2014, Sololo, Kenya).[6]

> "The patient arrives at the OPD [: Out-Patient-Dept.]. She has strong pain, fever and general debilitation. She has done a 12-hours walk from her village. After admission, the CO prescribes malaria and HIV tests. The woman is found positive at the malaria test and gets hospitalized for the required therapy. Two days later I was doing rounds together

[5] For privacy reasons, the first letters of the names only are provided.

[6] This and the following reports were originally collected in Italian and have been translated by the article's authors.

> with the CO, who speaks Swahili. Thanks to pointed questions, I find out that the patient is two months pregnant. I immediately have her transferred to the maternity ward and prescribe re-dosing her therapy and fetal monitoring … Well, we really risked a lot because the pregnancy was not mentioned anywhere".
>
> (L. C.; Summer 2015, Mwika Health Center, Kenya)

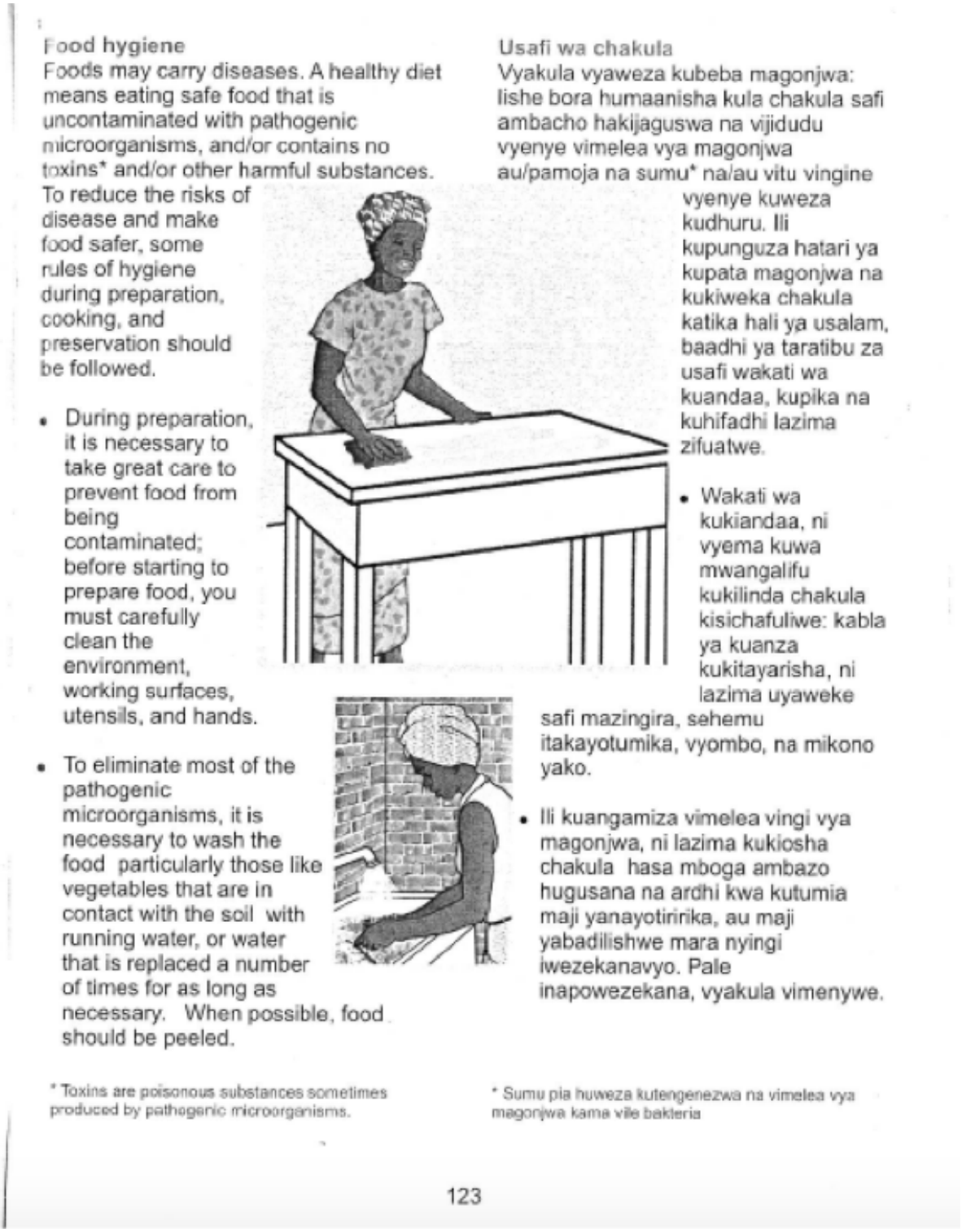
> "The patient arrives at the OPD claiming to suffer from acute abdominal pain and diarrhea – these are the only objective data. The Clinical Officer prescribes text for parasitosis and hospitalization. Since the afternoon of the hospitalization day the patient starts vomiting blood and pain continues. She repeatedly gets blood transfusion for three days. Her clinical situation later subsided, but we could never diagnose her due to the lack of adequate tools and the absence of the patient's clinical history".
>
> (M. C.; April 2014, Itololo Hospital, Tanzania)

> "The elderly woman comes to the OPD together with her daughter, who says that her mother has trouble swallowing and lost much weight lately. The CO prescribes hospitalization. She is tested for HIV, malaria and parasites with negative results. The next day during rounds I ask the CO to help me talk to the daughter, who could not speak English – the tests had been negative, and I had no patient's history to start from. I therefore managed to realize that she was by now in a chronic condition. This was later confirmed by X-ray: this showed a tumor that was deviating the trachea. The woman was redirected to the Mbeya Referral Hospital, even though the situation was by now quite serious. Had we not been able to reconstruct, even partially, her clinical history, the woman would have probably died in our ward without even knowing the cause of her death".
>
> (A. F.; March 2013, Chimala Mission Hospital, Tanzania)

It is against the backdrop of histories like these that many course attendees stressed the need to get a better knowledge of Swahili grammar and lexicon in order to interact with patients.

5. The situation in the field/2: the (possible) role of Swahili in medical aid

Swahili is certainly the most "developed" African language. With "developed", "Ausbauized" is meant here (Tosco 2008), in the sense of made fit to be used in a standardized variety (the *Swahili sanifu*) in a wide range of contexts and most specifically in administration, education and in principle any other modern fields. Still, the Swahili tehnical lexicon of health care is greatly lacking in both precision and uniformity. One example will be enough: Figure 1 shows one page of a bilingual Swahili-English booklet used for teaching hygienic basic procedures.



Food hygiene

Foods may carry diseases. A healthy diet means eating safe food that is uncontaminated with pathogenic microorganisms, and/or contains no toxins* and/or other harmful substances. To reduce the risks of disease and make food safer, some rules of hygiene during preparation, cooking, and preservation should be followed.

- During preparation, it is necessary to take great care to prevent food from being contaminated; before starting to prepare food, you must carefully clean the environment, working surfaces, utensils, and hands.
- To eliminate most of the pathogenic microorganisms, it is necessary to wash the food particularly those like vegetables that are in contact with the soil with running water, or water that is replaced a number of times for as long as necessary. When possible, food should be peeled.

* Toxins are poisonous substances sometimes produced by pathogenic microorganisms.

Usafi wa chakula

Vyakula vyaweza kubeba magonjwa: lishe bora humaanisha kula chakula safi ambacho hakijaguswa na vijidudu vyenye vimelea vya magonjwa au/pamoja na sumu* na/au vitu vingine vyenye kuweza kudhuru. Ili kupunguza hatari ya kupata magonjwa na kukiweka chakula katika hali ya usalam, baadhi ya taratibu za usafi wakati wa kuandaa, kupika na kuhifadhi lazima zifuatwe.

- Wakati wa kukiandaa, ni vyema kuwa mwangalifu kukilinda chakula kisichafuliwe: kabla ya kuanza kukitayarisha, ni lazima uyaweke safi mazingira, sehemu itakayotumika, vyombo, na mikono yako.
- Ili kuangamiza vimelea vingi vya magonjwa, ni lazima kukiosha chakula hasa mboga ambazo hugusana na ardhi kwa kutumia maji yanayotiririka, au maji yabadilishwe mara nyingi iwezekanavyo. Pale inapowezekana, vyakula vimenywe.

* Sumu pia huweza kutengenezwa na vimelea vya magonjwa kama vile bakteria

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Figure 1. Food Hygiene (Marazzi 2007: 123)

The "pathogenic microorganisms" which appear twice on p. 123 (and once again on p. 125) come to have three different Swahili renderings:

- *vijidudu vyenye vimelea vya magonjwa* (Marazzi 2007: 123), lit. 'small insects which carry the parasites of disease';
- *vimelea vingi vya magonjwa* (Marazzi 2007: 123), lit. "many parasites of sickness";
- *vijidudu vingi* (Marazzi 2007: 123), lit. "many small insects (i.e., germs)"

When a patient first enters a dispensary, he or she will find in the Out-Patient Department (OPD) a specialized health worker, the Clinical Officer (CO), whose task is to collect the patient's data and his or her symptoms on a "Patient Report". It is on the basis of the patient's answers that the CO will decide whether the patient needs hospitalization and which medical tests he or she will undertake.

In East Africa, especially in the rural areas which are our concern here, most often the patient's data, clinical history and symptoms are written down by the CO on a blank piece of paper and only in a few lucky occasions on a form, such as the one found in Warner (1992). The latter is an updated edition of *Where there is no doctor. A village health care handbook for Africa*, a handbook written for paramedics operating in rural and peripheral dispensaries but which could be useful for village people themselves. The first edition (1977) was translated into Swahili as *Mahali pasipo na daktari. Kitabu cha mafunzo ya afya vijijini* (first edition 1978, second edition 1984) and published in Tanzania with funding from Rotary International. Sadly, the Swahili text did not include any type of Patient Report. Nel 2007, the Italian "Comunità di Sant'Egidio" published in Tanzania *How's Your Health? How To Help Yourself and Others Feel Well / Je! Waijua Afya yako? Jinsi ya Kuitunza Afya Yako na ya Wengine Ili Kujisikia Vizuri*, a bilingual English/Swahili handbook of hygiene written in layman's terms and useful for disease prevention (cf. Fig. 1 above).

Patient Report (Warner 1992: 45)

PATIENT REPORT

To Use When Sending for Medical Help

Name of the sick person:_____Age:_____

Male_____Female_____Where is he (she)?_____

What is the main sickness or problem right now?_____

_____

_____

_____

When did it begin?_____

How did it begin?_____

Has the person had the same problem before?_____When?_____

Is there fever?_____How high?_____° When and for how long?_____

Pain?_____Where?_____What kind?_____

What is wrong or different from normal in any of the following?

Skin: _____**Ears**_____

Eyes: _____**Mouth and throat**:_____

Genitals: _____

Urine: Much or little?_____Color?_____Troubles urinating?_____

Describe:_____Times in 24 hours:_____Times at night:_____

Stools: Color?_____Blood or mucus?_____Diarrhea?_____

Number of times a day:_____Cramps?_____Dehydration?_____Mild or severe?_____

Worms?_____What kind?_____

Table 1. Werner's (1992) Patient Report

5. The output

During the course the attendees were urged and helped by the teacher to devise and implement four bilingual English-Swahili report forms for collecting the patient's data at the OPDs on the basis of those currently used in Turin hospitals; the first three are presented below and deal, respectively, with:

- the patient's physiological history (Table 2),
- his or her family's physiological history (Table 3), and
- the patient's pathological history (Tables 4a, b, c).

Patient's Physiological History/ **Historia ya fiziolojia**
Did you have a natural birth? ***Umezaliwa kwa uzazi wa kawaida?***
Were you breastfed? ***Umenyonyeshwa?***
Did you get a tetanus shot? ***Umechanjwa dhidi ya pepopunda?***
How do you judge your health in general? Good, average, bad?
Unafikiriaje hali yako ya afya? Safi, nzuri lakini sio sana, mbaya?
Do you smoke? ***Unavuta sigara?***
If you smoke, how many cigarettes per day do you smoke?
Ukivuta sigara, sigara ngapi huvuta kila siku?
When did you start smoking? ***Ulianza lini kuvuta sigara?***
Do you drink alcohol? ***Unakunywa vinywaji vikali?***
Do you drink tea, coffee, soft drinks? ***Unakunywa chai, kahawa, soda?***
At what age did you get your first period?
Ulipokuwa na hedhi mara ya kwanza, ulikuwa na miaka mingapi?
When did you get your last period? ***Mara ya mwisho ulipopata hedhi ilitokea lini?***
What is the date of your last period? ***Tarehe ya hedhi yako ya mwisho, tarehe gani?***

Table 2. The Patient's Physiological History

Family History/ **Historia ya familia**

A. Patient's Generalities/ **Dati a zake Mgonjwa**

Name/ **Jina**_____

Family Name/ **Jina la familia au la ukoo**_____

Date of Birth / **Tarehe ya kuzaliwa**_____

Landphone No./ **Namba ya simu ya nyumbani**_____

Cellphone No./ **Namba ya simu ya mkononi**_____

Residence/ **Makazi**_____

B. Clinical History of the Patient's Family/ **Historia ya familia ya mgonjwa**

1. Does/did anybody in you family suffer from heart diseases? YES/NO

Yuko mtu mwingine wa familia ambaye anaumwa au aliumwa na magonjwa ya moyo? NDIO/SIO

2. Did anybody die suddenly? YES/NO

Je, mtu mwingine wa familia alikufa kwa kifo cha ghafla? NDIO/SIO

3. Did anybody in your family have a myocardial infarction? YES /NO

Yuko mtu wa familia aliyeumwa mshtuko wa moyo? NDIO/SIO

4. Does/did anybody in you family suffer from hypertension? YES /NO

Yuko mtu wa familia ambaye anaumwa au aliumwa na shinikizo la damu lililopanda sana? NDIO/SIO

5. Does/did anybody in you family suffer from high cholesterol? YES /NO

Yuko mtu mwingine wa familia anayepata au aliyepata tatizo la kolesteroli? NDIO/SIO

6. Does/did anybody in you family suffer from diabetes? YES /NO

Yuko mtu mwingine wa familia anayeumwa au aliyeumwa na ugonjwa wa kisukari? NDIO/SIO

7. Does/did anybody in you family suffer from thyroid diseases? YES /NO

Yuko mtu mwingine wa familia anayepata au aliyepata magonjwa wa kikoromeo? NDIO/SIO

8. Does/did anybody in you family suffer from lung diseases? YES /NO

Yuko mtu mwingine wa familia anayeumwa au aliyeumwa na magonjwa wa mapafu? NDIO/SIO

9. Does/did anybody in you family suffer from neurological diseases? YES /NO

Yuko mtu mwingine wa familia ambaye amepata au alipata magonjwa wa nyurolojia? NDIO/SIO

10. Does/did anybody in you family suffer from cancer? YES /NO

Yuko mtu mwingine wa familia anayeumwa au aliyeumwa na kansa? NDIO/SIO

11. Does/did anybody in you family suffer from asthma? YES /NO

Yuko mtu mwingine ambaye amepata au alipata pumu? NDIO/SIO

12. Does/did anybody in you family suffer from allergies? YES /NO

Yuko mtu mwingine wa familia anaye mzio wa kitu chochote?

Table 3. The Patient's Physiological Family History

Patient's Pathological History/ **Historia ya Patholojia**

Do/did you have any allergy? Does/did the patient have any allergy?	☐ YES ☐ NO	**Una/Ana mzio wa kitu chochote?** **Ulikuwa na/Alikuwa na mzio wa kitu chochote?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from asthma? Does/did the patient suffer from asthma?	☐ YES ☐ NO	**Umepata/Ulipata pumu?** **Amepata/Alipata pumu?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from other lung diseases? Does/did the patient suffer from other lung diseases?	☐ YES ☐ NO	**Umepata/Ulipata magonjwa mengine ya pumzi?** **Amepata/Alipata magonjwa mengine ya pumzi?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from otitis? Does/did the patient suffer from otitis?	☐ YES ☐ NO	**Umepata/Ulipata uvimbe wa sikio?** **Amepata/Alipata uvimbe wa sikio?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from anemia? Does/did the patient suffer from anemia?	☐ YES ☐ NO	**Umepata/Ulipata upungufu wa damu?** **Amepata/Alipata upungufu wa damu?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from epilepsy? Does/did the patient suffer from epilepsy?	☐ YES ☐ NO	**Umepatwa/Ulipatwa kifafa?** **Amepatwa/Alipatwa kifafa?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from a heart disease? Does/did the patient suffer from a heart disease?	☐ YES ☐ NO	**Una/Ana magonjwa ya moyo?** **Ulikuwa na/ Alikuwa magonjwa ya moyo?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from palpitations? Does/did the patient suffer from palpitations?	☐ YES ☐ NO	**Umepatwa/Ulipatwa mapigo ya moyo?** **Amepatwa/Alipatwa mapigo ya moyo?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from faintings? Does/did the patient suffer from faintings?	☐ YES ☐ NO	**Umepata/Ulipata tatizo la kuzimia?** **Amepata/Alipata tatizo la kuzimia?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from chest pain? Does/did the patient suffer from chest pain?	☐ YES ☐ NO	**Umepata/Ulipata maumivu kifuani?** **Amepata/Alipata maumivu kifuani?**	☐ **NDIO** ☐ **SIO**

Table 4a. The Patient's Pathological History (part 1)

Do/did you suffer from breathlessness? Does/did the patient suffer from breathlessness?	☐ YES ☐ NO	**Umepatwa/Ulipatwa mtweto?** **Amepatwa/Alipatwa mtweto?**	☐ **NDIO** ☐ **SIO**
If "yes," when?		**Kama "ndio", imetokea lini?**	
Did you have a heart attack? Did the patient have a heart attack?	☐ YES ☐ NO	**Umeumwa/Uliumwa mshtuko wa moyo?** **Ameumwa mshtuko wa moyo?**	☐ **NDIO** ☐ **SIO**
When?		**Lini?**	
Do/did you suffer from hypertension? Does/did the patient suffer from hypertension?	☐ YES ☐ NO	**Unaumwa/Umeumwa na shinikizo la damu lililopanda sana?** **Ameumwawa/Aliumwa na shinikizo la damu lililopanda sana?**	☐ **NDIO** ☐ **SIO**
Do you take drugs? Does the patient take drugs?	☐ YES ☐ NO	**Unatumia/Anatumia dawa?**	☐ **NDIO** ☐ **SIO**
Do you suffer from diabetes? Does the patient suffer from diabetes?	☐ YES ☐ NO	**Unaumwa na ugonjwa wa kisukari?** **Anaumwa na ugonjwa wa kisukari?**	☐ **NDIO** ☐ **SIO**
Do you take insulin? Does the patient take insulin?	☐ YES ☐ NO	**Unatumia/Anatumia insulini?**	☐ **NDIO** ☐ **SIO**
Which drugs do you take? Which drugs does the patient take?		**Unatumia/Anatumia dawa gani?**	
Do you have high cholesterol? Does the patient have high cholesterol?	☐ YES ☐ NO	**Umepata/Amepa tatatizo la kolesteroli?**	☐ **NDIO** ☐ **SIO**
Do you have leg ulcers? Does the patient have leg ulcers?	☐ YES ☐ NO	**Una/Ana vidonda mguuni?**	☐ **NDIO** ☐ **SIO**
Since when?		**Tangu lini?**	
Do you suffer from bowel diseases? Does the patient suffer from bowel diseases?	☐ YES ☐ NO	**Unaumwa/Anaumwa na magonjwa ya tumbo?**	☐ **NDIO** ☐ **SIO**
Do you have dry heaving? Does the patient have dry heaving?	☐ YES ☐ NO	**Unatapika/Anatapika?**	☐ **NDIO** ☐ **SIO**

Table 4b. The Patient's Pathological History (part 2)

Do you have diarrhea? Does the patient have diarrhea?	☐ YES ☐ NO	**Una/Ana tatizo la kuharisha?**	☐ **NDIO** ☐ **SIO**
Since when?		**Tangu lini?**	
Do you take drugs? Does the patient take drugs?	☐ YES ☐ NO	**Unatumia/Anatumia dawa?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from liver diseases? Does/did the patient suffer from liver diseases?	☐ YES ☐ NO	**Unaumwa/Anaumwa na magonjwa ya ini?** **Uliumwa/Aliumwa na magonjwa ya ini?**	☐ **NDIO** ☐ **SIO**
Did you get HIV? Did the patient get HIV?	☐ YES ☐ NO	**Una/Ana UKIMWI?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from muscle diseases? Does/did the patient suffer from muscle diseases?	☐ YES ☐ NO	**Umepata/Amepata magonjwa ya misuli?** **Ulipata/Alipata magonjwa ya misuli?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from neurological diseases? Does/did the patient suffer from neurological diseases?	☐ YES ☐ NO	**Umepata/Amepata magonjwa ya nyurolojia?** **Ulipata/Alipata magonjwa ya nyurolojia?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from thyroid diseases? Does/did the patient suffer from thyroid diseases?	☐ YES ☐ NO	**Umepata/Amepata magonjwa ya kikoromeo?** **Ulipata/Alipata magonjwa ya kikoromeo?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from tuberculosis? Does/did the patient suffer from tuberculosis?	☐ YES ☐ NO	**Unaumwa/Anaumwa na kifua kikuu?** **Uliumwa/Aliumwa na kifua kikuu?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from psychiatric disorders? Does/did the patient suffer from psychiatric disorders?	☐ YES ☐ NO	**Unamwa/Anaumwa na maradhi ya akili?** **Uliumwa/Aliumwa na maradhi ya akili?**	☐ **NDIO** ☐ **SIO**
Do/did you suffer from cancer? Does/did the patient suffer from cancer?	☐ YES ☐ NO	**Unaumwa/Anaumwa na kansa?** **Uliumwa/Aliumwa na kansa?**	☐ **NDIO** ☐ **SIO**

Table 4c. The Patient's Pathological History (part 3)

On the request of a speech therapist who was also a participant in the course, a further specialized patient report for language and communication problems was devised. The speech therapist had dealt with deaf and deaf-mute people in Uganda and Tanzania in previous medical cooperation stages, and she had noticed specific problems in dealing with her patients.

Actually, in many Sub-Saharan countries, deaf people tend to be marginalized and physically isolated by their family and the society at large. The perception of the deaf person's condition changes according to the local culture, but in East Africa, and more specifically in Tanzania, it is

particularly negative and families isolate a deaf child (e.g., schooling is avoided), in order to avoid social stygma to the whole family. This is often linked to the idea that deafness and other pathologies are originated by witchcraft and spirit possession (Batamula and Pudans-Smith 2017: 24; Lane 2005: 298). Still, in the last decades groups and associations started to operate to change the social consciousness of these pathologies; among them:

- the TASLI (*Tanzania Association of Sign Language Interpreters*), established 2006 'as part of the implementation plan of resolution made by participants of the world Association of the Sign language interpreters (WASLI) meeting held in Cape town South Africa in 2005'[7]
- the *Association of Sign Language Interpreters Lake Zone*,[8] based in Bukoba, Tanzania;
- the Anglican Diocese of Ruaha (Iringa, Tanzania)[9] founded in 2003 the *Neema Craft centre,* devoted to improve the life quality of people with disabilities and provide them with work opportunities and social integration.[10]

Our Patient Report for Language and Communication Problems was created anew with a close eye to functional communication and communicative goals and following the guidelines for the evaluation of communication abilities (Beukelman 1991; Chilosi 2014). The overall goal was to help formulate patient-specific therapeutic pathways.

[7] https://envaya.org/TASLI/history

[8] https://envaya.org/waka

[9] https://www.anglican.or.tz/index.php/hide-menu-2/29-diocese-of-ruaha

[10] https://www.neemacrafts.com/index.php

Language and communication problems/ **Matatizo ya kuongea na kuwasiliana**

Patient Report / HISTORIA YA MGONJWA

*(*to be filled with the patient's accompanying person)*

A. Patient's data /**Data zake mgonjwa**

1. What is the child's/persons's name / What is your/his/her name and family name / **Mtoto /Mtu anaitwa nani? (Jina lako/lake nani? Jina lako/lake la ukoo nani?)** .....
2. Male/Female / **Wa kike /Wa kiume** .....
3. Date of birth / **Tarehe ya kuzaliwa** .....
   How old are you/is he/she / **ana/una miaka mingapi?** .....
4. Place of residence: Where do you/ does he/she live? In a town or village / **Makazi ..... (Anaishi/Unaishi wapi? Mjini au kijijini?)** .....
5. Who looks after you/him/her / **Mtunzi wako/wake ni nani?** .....
6. Who lives with you/him/her / **Anaishi/Unaishi na nani?** .....

Who / **Nani?**	How old is he/she / **Ana miaka mingapi?**	What does he/she do / **Anafanya nini?**	What kind of problems does he/she have / **Ana tatizo ya aina gani?**
Mother / **Mama**			
Father / **Baba**			
Sister or Uncle / **Dada**			
Grandmother / **Bibi**			

7. Are his/her father and mother blood relatives / **Mama na baba wanatoka familia moja?** .....
8. Did his/her mother suffer from any health problem during pregnancy (fever, malaria, etc.) / **Je, mama alipokuwa mjiamzito alipata tatizo la aina gani la afya (homa, malaria na kadhalika)?** .....
9. Was the child born with a normal birth / **Mtoto alizaliwa kwa uzazi wa kawaida?** .....
10. Did the child cry at birth / **Mtoto alikuwa analia alipozaliwa?** .....
11. Was the child breastfed / **Mtoto alinyonyeshwa?** .....
12. Was the child vaccinated at birth / **Mtoto alipata chanjo wakati alipozaliwa?** .....
13. What do you think of his/her health? Does he/she have a normal weight and a normal growth *(on the basis of the growth curves issued by the dispensary)* / **Unafikiriaje kuhusu hali ya afya yake? Ana uzito wa kawaida? Ukuaji kawaida?** .....

Table 5a. The Patient's Report for language and communication problems (part 1)

14. Did you go to the dispensary to check his/her weight and growth? Do you have a certificate? /
Mmekwenda dispensary kucheki uzito na ukuaji? Karatasi unayo? .....
15. Child's development tables / **Chati za maendeleo ya mtoto**
    - When did the child start walking? During his/her first year? After his/her first year? /
      Alianza kutembea lini? wakati wa mwaka wa kwanza/ baada ya mwaka wa kwanza.....
      .....
    - When did the child start eating solid food (not just milk) /
    - **Alianza lini kula chakula cha kawaida? (sio maziwa tu) Miezi** .....
    - When did the child start uttering his/her first words /
      Alianza lini kutamka maneno ya kwanza? .....
    - When did the child start making sounds or point to what he/she wanted /
      Alianza lini kutoa sauti au kuonyesha/kupoint vitu alivyotaka .....
16. Did the child have childhood or other (malaria, fever, rubella, mumps...) diseases? /
Alipata magonjwa ya kitoto au mengine (malaria, homa, rubela, matubwitubwi...)?
    - If yes, which one? When? Why? /
      Kama ndio, ugonjwa gani? Lini? Kwanini? .....
17. Does or did the child suffer from / **Sasa anaumwa au aliumwa zamani na:**
    - Any kind of otisis? If yes, which one? When? Why? /
      Magonjwa ya masikio? Kama ndio, nini? Lini? Kwa nini?.....
    - Throat or neck diseases / **Magonjwa ya koo/shingo?**.....
    - Eye diseases / **Magonjwa ya macho?**.....
    - Nose diseases / **Magonjwa ya pua?** .....
    - Dental diseases / **Magonjwa ya meno?**.....
18. Did the child take medicinal products? Which ones /
Mtoto alimeza dawa? Dawa gani? .....

B. Pathologic History / **Historia ya patholojia**

1. Why did you come here? Which problems Il bimbo che problemi ha?
Kwa nini mmefika hapa? Mtoto ana tatizo gani? .....
2. Does anybody in his/her family have the same problem /
Yuko mtu mwingine kwenye familia anaye tatizo sawa sawa kama lake? .....
3. When did you realize that the child was in trouble /
Umegundua lini mtoto alipata shida? .....
4. Did you go to the hospital or the dispensary for this problem? What did the doctor say /
Mmeshaenda hospitalini au dispensary kwa shida hili? Daktari alisema nini? .....
5. Tell me please about the problems the child presents everyday /
Naomba unieleze shida gani mtoto hupata kila siku .....

Table 5b. The Patient's Report for language and communication problems (part 2)

C. The child's current condition / **Hali ya mtoto leo**

1. What do you think of the child's health? (fever...) /
   Unafikiriaje kuhusu hali ya afya ya mtoto? (homa...) .....
2. Does the child go to school? / **Mtoto anaenda shuleni?** .....
3. Does the child utter sounds or utter a word at a time? Does he/she have trouble speaking /
   Anatoa sauti au anatamka neno moja moja tu?/au ana tatizo la kunena au kuongea?
   .....
4. Is he/she able to explain his/her needs (defecate, urinate; hunger, thirst) /
   Anaweza kueleza mahitaji yake (kujisaidia, kukojoa, kusikia nja na kiu) .....
5. How does he/she communicate with people /
   Anatumia jinsi gani kwa kuwasiliana na watu? .....
6. Does he/she understand when people talk to him/her? Does he/she understand who they are /
   Anaelewa watu wanapowasiliana naye? Anaelewa ni nani watu wanaowasiliana naye?
   .....
7. When he/she communicates verbally, do other people understand? Are the words he/she utter understood by others /
   Anapoongea anafahamiwa na wengine? Yaani maneno anayotolea yanafahamiwa na wengine .....
8. Does he/she pronounce words well / **Anatamka maneno vizuri?** .....
9. Is he/she able to create sentences / **Anaweza kutunga sentensi?** .....
10. *(Functional communication)* Does he/she uses words dysfunctionally /
    Anatumia maneno bila mpangilio mzuri? .....
11. *(Communicative goal)* Does he/she want to speak and communicate /
    Anataka kuongea na kuwasiliana?
12. Does he/she always drool? Occasionally? /
    Hutoa udende? Au mara kwa mara?
13. Does he/she have any problem when he/she swallows? Does he/she eat any kind of food? Does he/she have problems when eating or anytime he/she swallows /
    Ana matatizo anapomeza chakula?/anakula kila aina ya chakula; ana shida wakati wa kula chakula au kila anapomeza? .....
14. *(Self care)* Is the child able to / **Mtoto anaweza:**
    - Go to the bathroom alone or make his/her problem clear /
      kujisaidia peke yake au kueleza hitaji lake? .....
    - Wash his/her hands / **kunawa mikono?** .....
    - Wash his/her face / **kunawa uso?** .....
    - Eat alone / **kula peke yake?** .....
    - Comb his/her hair / **kuchana nywele?** .....

Table 5c. The Patient's Report for language and communication problems (part 3)

- Use the toothbrosh / **kupiga mswaki?** .....
- Dress and undress / **kuvaa na kuvua?** .....
- Wash his/her whole body / **Kuoga?** .....

15. *(Social autonomy)* Is he/she able to / **Anaweza:**
    - Wash the dishes / **kuosha vyombo?** .....
    - Wash his/her clothes / **kufua nguo?** .....
    - Sweep and mop / **kufagia na kupiga deki?** .....
    - Cross the street / **kuvuta barabara?** .....
    - Use money / **kutumia hela?** .....
    - Cook / **Kupika?** .....
16. What kind of interaction does he/she have with / **Ana ushirikiano gani pamoja na:**
    - mother (family) / **mama (familia)**
    - friends / **wenzake**
    - other persons / **watu wengine**
    - at school /**shuleni**
17. What you and your family think of his/her health /
    Mnafikiriaje (wewe na familia yenu) kuhusu ugonjwa wake? .....
18. What do other people think / **Watu wengine wanafikiriaje?** .....

Table 5d. The Patient's Report for language and communication problems (part 4)

6. Testing the results and a tentative conclusion

It must be admitted from the onset that only very limited testing on the field has been carried out. What is needed are reports as the following one, coming from L. G., a professional nurse who had already done voluntary work in Kenya and who followed the course before going back into the field:

> "I reached the Sololo Mission Hospital in March 2017. I had already done voluntary work there in 2011, 2012 and 2014, and I knew the reception procedures at the local OPD: I therefore suggested to the resident doctor to use the physiological, pathological and family histories we had written down and translated into Swahili during the course in October-December 2016 (on the basis of the very reports used in the hospital I work at). The local medical doctor, a Burundi citizen who had done his medical studies in Italy, accepted my proposal [to test the new patient report sheets] and made available to the local Clinical Officer – who was very much resistant to change – a set of phtocopies to be used at the OPD.
>
> One day, a girl around 12 y.o. and various family members arrived in Sololo from Moyale (around 20 kms. far). She had acute pains in the pelvic region and could not urinate. She brought from Moyale an ecography but no medical report – the local doctor

> had not been able to identify the material shown in the ecography. This girl was the first patient who was administered the patient report sheets. Thanks to her personal medical history we could diagnose a haematocolpos.[11] We immediately performed bladder catheterization followed by surgery. Her clinical situation stabilizied.
>
> As long as I was in Sololo [approximately one month], the Clinical Officer used the new patient report sheets, sometimes not completely filled due to lack of data, but always accompanying the medical records."
>
> (L. C.; March 2017, Sololo, Kenya)

Obviously, much more feedback is needed.

How can rituals and practices in local healing, in case, be accommodated in the everyday life of a rural dispensary in East Africa? Are, e.g., ritual burnings and scars "wounds"? Is the medical volunteer expected to know and fully comprehend the different use and significance of the body across cultures? In these contexts, an interdisciplinary approach should take the centre of the stage and act as a glue between medical science and disease in its cultural dimension. The role of medical personnel in cooperation is currently being thoroughly reanalyzed and reconsidered thanks to the impact of the Global Health Education. In this paradigm, a multi- and transdisciplinary and pluri-methodological approach is advocated in order to benefit from both human and social knowledges and natural and biomedical sciences.[12]

The Turin course was just our first experiment in teaching an African language, a culture and what lies between them to medical personnel. It is an experiment to be hopefully repeated and improved in the future.

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[11] Blood pooling in the vagina.

[12] Literature on global health education has been increasing in recent years; from an incredibly vast bibliography we mention here Adams 2016 and Sklar 2016 and, on Kenya in particular, Mayo 2014. Cf. also the webpage of the Global Health Education Consortium (http://www.who.int/workforcealliance/members_partners/member_list/ghec/en/) and, for Italy, the webpage of the RIISG (**"**Rete Italiana per l'Insegnamento della Salute Globale"; *Italian Network for Global Health Education;* http://www.educationglobalhealth.eu/it/salute-globale/9-global-health/247-riisg-definizione-di-salute-globale).

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