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Care, Inequalities, and Health Justice: Interdisciplinary Perspectives on Global Health

by Alessandro Boccanelli, Mario Marasco, Laura Elena Pacifici Noja*

In an era deeply marked by overlapping health crises, persistent conflicts, and systemic inequalities, the field of global health is increasingly emerging as a contested space. It is a domain characterized by a constant tension between standardized, technical interventions – often designed in the Global North – and the situated, messy, and deeply human practices of care enacted in local contexts. This thematic issue of the «UniCamillus Global Health Journal» does not merely document this tension; it aims to inhabit it. By weaving together anthropological, historical, pedagogical, and philosophical perspectives with advocacy practices and social inclusion strategies, the contributions collected here offer a multifaceted reflection on how health is negotiated, organized, and transmitted across diverse territories, revealing itself as an inherently historical and situated product.

The articles in this issue, heterogeneous in method and scale, converge on a fundamental premise: health cannot be reduced to a biological fact or a bureaucratic metric. It is, fundamentally, a relational project. The authors challenge us to look beyond the structural fragilities of contemporary healthcare systems and to examine the "molecular" dynamics of care – the specific gestures, the educational encounters, the historical legacies, and the political struggles that shape the wellbeing of communities.

The issue opens with a strong focus on the pedagogical challenges of medical training, exploring how well future health professionals are equipped to understand the complexity of the human subject. Virginia De Silva proposes a reflective itinerary that bridges the gap between the ethnographic field and the university classroom. Drawing on her experience teaching medical anthropology to nursing students, De Silva illustrates the difficulty students face in grasping concepts that seem abstract or distant from their biomedical training. She argues for the use of "ethnographic vignettes" – such as the startling gesture for "yes" in Tigray or the figure of a traditional healer who learns from *National Geographic* – to trigger a productive culture shock. This pedagogical approach serves to deconstruct the assumed universality of biomedical categories, helping students recognize that the body itself is a culturally and historically constructed entity.

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* UniCamillus International Medical University of Rome.

In a complementary dialogue, the article by Alessandro Boccanelli and Laura Elena Pacifici Noja examines the structural integration of humanities into medical education through the lens of a seven-year experience at UniCamillus University. The authors argue that medicine, having a practical purpose focused on the human being, cannot be a “pure science” and thus requires a robust philosophical foundation. Their paper details an integrated curriculum where Moral Philosophy is not an add-on but a core component, designed to foster moral reasoning and narrative competence in future doctors. By engaging with topics ranging from the epistemology of care to the ethics of artificial intelligence, they demonstrate that interdisciplinary education is essential for navigating the “forest” of medicine, where patients must be encountered as unique narratives rather than interchangeable diagnoses.

Moving from education to history, Christina Savino offers a compelling re-reading of Camillo de Lellis in the context of Counter-Reformation Rome. Savino situates the saint’s work not merely within hagiography but within the gritty reality of a city plagued by malaria, floods, and social stratification. The paper highlights Camillo’s revolutionary intuition of “global healthcare” that attends to the whole person – body and soul – anticipating modern holistic models. Crucially, Savino traces the historical trajectory of this ideal beyond its inception. While grounded in the material response to the urban pathologies of early modern Rome – from the reorganization of hospital shifts to the physical cleansing of patients – the paper explores how this model of comprehensive nursing care expanded across centuries and continents, evolving into a foundational paradigm for modern global healthcare.

The intersection of health policies and community dynamics is explored in depth by Corinna Santullo, who presents an ethnographic analysis of immunization practices in Tigray, Ethiopia, between 2015 and 2019. Santullo deconstructs the notion of “vaccine hesitancy”’ by revealing the sophisticated mechanisms of persuasion and control embedded in the Ethiopian health extension system. Her analysis of the Women Development Army, operating through a capillary “one-to-five” network, shows how compliance is often manufactured through social pressure, the mobilization of shame (*yiluññta*), and the framing of the unvaccinated body as a threat to collective modernity. This contribution, based on fieldwork conducted just prior to the recent conflict in Tigray (2020-2022), serves as a vital document of the biopolitical infrastructure that underpins global health initiatives in the region.

Shifting the focus to disability rights and civil society initiatives, Hewan Mulugeta Asfeha and Roel van der Veen discuss the outcomes of the *Down Syndrome and Other Intellectual Disabilities Awareness Event* held in Addis Ababa in November 2024. The authors expose the pervasive stigma and misconceptions surrounding Down syndrome in Africa, often attributed to supernatural causes. However, rather than presenting a narrative of victimization, the article highlights the power of self-advocacy. By detailing the strategic outcomes of the event – including the *With Us Not For Us* initiative – they outline a concrete roadmap for shifting from a charity-based model to one grounded in rights, inclusion, and the active participation of people with disabilities in the policies that affect them.

The issue concludes with Marco Menon, who traces the genealogy of urban bioethics, distinguishing between its North American origins – focused on density, diversity, and disparity – and its radical reinterpretations in the Global South. Offering a distinct theoretical lens, he explores how Latin American scholars have politicized the field, viewing urban bioethics as a tool for resistance against biopolitical control, while also engaging with the European legacy of Fritz Jahr to include environmental concerns. Menon's contribution invites us to expand bioethics beyond the clinical encounter to address the very design of our living spaces, suggesting that the city itself is a fundamental determinant of moral and physical well-being.

Together, these six contributions offer more than a collection of case studies. They provide a methodological blueprint for a more just global health. They remind us that whether we are discussing the training of a nurse in Italy, the vaccination of a child in Tigray, or the planning of a "healthy city", we are always dealing with questions of power, history, and human dignity. It is our hope that this issue will serve as a tool for scholars and practitioners alike to navigate these complexities with critical rigor and ethical commitment.

From the Field of Research to a Field of Knowledge: Preliminary Reflections on a Lesson in Medical Anthropology

by Virginia De Silva*

Abstract
This article reflects on the pedagogical use of ethnographic material gathered in Ethiopia to teach key concepts in medical anthropology to nursing students. Drawing on field experiences with diverse healing figures, local nosologies, and culturally grounded interpretations of illness, the paper shows how biomedical training often assumes universal meanings for the dimensions of disease, aetiology, and therapeutic authority. By presenting ethnographic situations in which biomedical and traditional explanatory models diverge, the article highlights how conflicts arise from different interpretations of symptoms, accountability, and causality. Building on discussions of medical pluralism and the notion of *medicoscapes*, it argues that biomedicine represents one cultural paradigm among many. Recognizing this plurality helps future nurses develop cultural mediation skills essential for clinical practice in multicultural settings, fostering more effective communication and therapeutic alliances between professionals and patients.

Keywords
Medical Anthropology, Didactic Use of Ethnography, Medical Pluralism, Cultural Mediation in Nursing.

1. Introduction

This paper was conceived after more than three years of teaching cultural anthropology within a bachelor's degree program in Nursing at an Italian university. Given the profile of the students – future nurses – I chose to frame the course through the lens of medical anthropology.

I soon noticed how difficult it was for them to grasp concepts that seemed far removed from both their everyday experience and the rest of their academic training. The need to find meaningful answers to their questions – and, at the same time, to my own – led me to revisit an ethnography that, though distant in time and space, still speaks to us today.

Indeed, the materials gathered during our fieldwork never cease to tell us something new, if interrogated with a fresh gaze. Once accepted, they never become obsolete but rather capable of inspiring new paths of inquiry and reflection.

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Does it make sense, in 2025, to return to materials collected in 2010? For a long time, I was uncertain. Yet those "materials" – not only the recorded interviews, diaries, and fieldnotes, but also the embodied experience of research – remain valuable for rethinking key issues. These materials originate from my long-term fieldwork in Wukro, a mid-sized town in the Tigray region of northern Ethiopia, which for years represented a privileged ethnographic site for the study of local healing practices, community health initiatives, and the intersections between biomedicine and traditional medicine. Perhaps this return also stems from the need to remember, to stay connected to a field since I have not physically returned to my field site since 2018, except through memory and a renewed epistemic intention. I have often shared stories from my earlier research experiences with students and observed that weaving together anecdotes and "ethnographic vignettes", real people and events, with theoretical concepts helps them better understand what might otherwise seem abstract, lifeless notions.

The aim of this article, therefore, is to retrace that ethnographic experience in order to reveal its didactic potential.

Each paragraph focuses on an ethnographic episode used in class to illustrate key concepts in the medical anthropology course.

2. A Startlement for "Yes": Culture Shock as a Tool for Critical Deconstruction and Reconstruction

Standing before a group of first-year students, their faces marked by curiosity and doubt, one can almost read the question in their eyes: *What could an anthropologist possibly do for us and for our training?* Many of them are still unsure what an anthropologist actually does. Engaging such an audience requires effort. It calls for building a connection, a shared space of understanding and trust – a sort of pact, much like the one sought with informants in the field. Above all, however, it requires capturing their attention and showing them that we do indeed have something valuable to offer: a small treasure to hand over.

It is often difficult to explain that, beyond abstract concepts, what we are trying to transmit is a modest "toolbox" containing a set of intellectual instruments they can use to dismantle the shelves of assumptions and "natural" norms to which we are all accustomed. It is equally challenging to clarify that the aim of the course is not to provide a list of concepts or evaluative criteria, but rather to equip them with the critical tools to question those very concepts and criteria.

Irony is always a good way to build relationships. In my early classes, I often introduced key anthropological notions such as the body, *techniques of the body* [1], and *habitus* [2], through an episode that occurred during fieldwork.

During a conversation, my interlocutor suddenly looked startled. In our context, such a bodily reaction would be read as surprise or amazement. Yet, I had said nothing that could have provoked astonishment. Without revealing the outcome of that exchange to my students, I asked them to pose questions to which they were sure I would answer "yes" – for example, whether I was their anthropology professor, whether it was daytime, or whether we were in the classroom. Then, to their bewilderment, I "answered" by looking startled, just as my interlocutor had done. In Tigray, this bodily and vocal expression signifies assent.

The "banality" of such an episode was exactly what I wanted to use to awaken their sense of culture shock toward a reality so different from their own, while simultaneously prompting estrangement [3] from their everyday life. Realizing that even nodding does not mean the same thing everywhere allows students to recognize that what they perceive as "natural" behavior is, in fact, culturally contingent. The way we use our bodies to inhabit the world – and the very conception of the body itself – is socially, politically, and historically constructed.

This reflection is essential to understanding some of the key concepts of medical anthropology, such as the body as the "existential ground of culture and self" and *embodiment* [4], and Mauss's idea of *techniques of the body* as socially acquired ways of using the body [1].

In this way, young nursing students come to understand that the body is not – at least not only – the sum of organs and tissues represented by the anatomical mannequin that stands beside the lecturer's desk. Rather, it is the primary vessel of human ambivalence, where the biological and the social are inseparably intertwined [5].

This awareness also becomes useful for explaining the three dimensions of illness in anthropological thought. If the body is not merely an assemblage of organs, illness cannot simply be defined as biological damage or malfunction, as in the biomedical model. Illness becomes something that "human beings do":

> Illness is something that human beings *do* […] Illness can be read as a genuinely cultural practice, in which the body expresses itself through the historical repertoires of its cultural construction, positioning the subject in dissonant terms with respect to their social world. [6]

Illness, as a fundamental human event, is simultaneously the most individual and the most social of phenomena; biological disorder becomes a symptom of social disorder:

> At the same time everything about illness is social, not just because a certain number of institutions take it in charge at the different phases of its evolution, but because the patterns of thought which allow one to recognize it, to identify and treat it are eminently social: to think about one's illness is already to make reference to others. [7]

If both the body and illness are cultural products, then the act of healing must also be understood in all its complexity – as a "shared space for the co-construction of meaning between healthcare workers and patients" [8].

3. An Aleka and the *National Geographic*: Medical Pluralism

The model of biomedical training in a nursing degree implicitly assumes that nosologies, aetiologies, and, more generally, the meanings of "disease" must be interpreted exclusively through biomedical paradigms – paradigms that are often presented as universal, unique, non-ideological, apolitical, amoral, and transparent [9]. At the same time, it presupposes that only those who have followed a specific professional path – the biomedical one – are endowed with the legitimate authority to act upon bodies. In many contexts outside the Euro-American world, however, the power to heal is distributed among a plurality of social actors [10].

For this reason, the concept of medical pluralism becomes a fundamental theoretical tool that students must acquire in order to understand that the realities of illness and healing are decidedly more complex and varied. In Ethiopia, my field of research, multiple figures are recognized by the community as possessing healing knowledge and authority – *aleka*, *mergheta*, *debterà*, *mama*, as well as biomedical professionals.

Within the Tewahedo Orthodox Church, *aleka*, *mergheta*, and *debterà* represent different levels of religious and therapeutic expertise. Many traditional healers in Ethiopia acquire their knowledge during church schooling, often informally and in parallel with religious education. The highest rank is that of the *debterà*, a figure both respected and feared, believed capable of manipulating spirits and acting for both good and harm [11]. These healers combine herbal knowledge and spiritual techniques, illustrating how therapeutic competence in Ethiopia rarely fits neatly into a division between "secular" and "spiritual" healing – an overly simplistic distinction, as noted by Wondwosen [12]. Alongside these church-trained practitioners are the *mama*, elderly women renowned locally for their expertise in home-based remedies. Their treatments typically address a limited set of illnesses and rely on herbal preparations; unlike traditional religious healers, their knowledge is not acquired through formal study or apprenticeship but is transmitted within families, usually from mother to daughter.

Through the description and accounts of some healers I have met, I intend to show that not only does biomedicine not exist alone, but also that in contexts of medical pluralism, it is entirely coherent not to think of traditional medicine and biomedicine as separate and dichotomous compartments.

This logic is particularly evident in the case of Ato K., described below. His distinctive feature is that he is a healer who moves dynamically between different horizons and paradigms of care, without any contradiction, as the health-seeking behavior of patients has already demonstrated in many cases.

Ato K. – the youngest of the healers I met during my fieldwork – immediately struck me both with his attitude and his age. He spoke *Amharic*, having been born and raised in Bahr-Dar. It seemed that his vocation in life was "to fix things": he ran a small shop repairing computers and stereos, yet as we spoke, I discovered that this inclination toward repair extended also to bodies. "I know how to heal people", he told me.

He had studied as an *aleka* (see above) for four years within the Orthodox Church education system, where he began to take an interest in medicine. He explained that he used to write down remedies and discuss them with fellow students – an example, he said, of how one could access certain forms of knowledge not necessarily transmitted through kinship lines (Interview with Ato K., January 4, 2011).

His fascination with healing evolved into what he himself defined as a genuine scientific inquiry. He continued his apprenticeship not only under traditional practitioners but also through exchanges with biomedical professionals, expanding his knowledge of both theories and practices in every possible way – including by watching television channels such as *National Geographic*.

He often mentioned *National Geographic* as a source of learning, especially when episodes focused on diseases or medicine. For instance, he had deepened his understanding of *herpes zoster*, using the biomedical term rather than the local designation *Almazbalechera*, which refers to a similar ailment. His familiarity with biomedical language and reasoning was evident in the way he discussed pharmaceuticals and treatment methods, as well as in his linguistic choice to employ biomedical nosologies while still explaining their traditional equivalents. Thus, he spoke of *asthma*, *gastritis*, *impotence*, or *tumor* to refer to *kintaroot* – a term that does not have a direct biomedical equivalent. In some cases, *kintaroot* is associated with the biomedical category of *haemorrhoids*. However, in traditional medicine *kintaroot* can appear in different parts of the body – for example not only in the anus, but also in the legs or the hands. It should therefore be understood within its own local nosological frame. He also spoke of "blood circulation blockage" to describe the illness of a young man whose mouth was drawn to one side, a condition locally regarded as the result of an attack by an evil spirit called *ganien*.

So fluent was he in both cultural worlds that he navigated between them with great dexterity. When talking about HIV, for example, he said he preferred to use its traditional equivalent, *Amenmin* – an Amharic term meaning "the disease that makes you very thin" – because he was "able to treat it": its cure was described in ancient texts, but it was forbidden to claim publicly that one could cure HIV.

He thus dealt with *pathologies*, even when the illnesses in question, according to local cosmologies, were thought to originate from supernatural attacks. Yet his approach to healing focused deliberately on biological aspects. Whether a disease was called *ganien* or "circulatory blockage" made little difference to him – they were simply two ways of naming the same symptomatic manifestation.

For other healers, as for patients, negotiating whether a given set of symptoms belongs to a spiritual or a natural illness is a crucial step that shapes therapeutic choices and strategies. Ato K., however, followed a more biomedical logic – transforming symptoms into unambiguous signs and privileging biological manifestations over their cultural meanings in order to provide therapeutic responses.

Throughout our repeated encounters, he often stressed his distance from the religious and esoteric dimensions of traditional practices, and from conceptions linking illness to supernatural agents such as *evil eye*, *ganien*, or *Ide Seb*, which he dismissed as "traditional stuff":

> Those things, like fumigating with myrrh or incense sticks, or wearing the *Gelebia* [a garment typical of Muslims] – that's not for me. (Interview with Ato K., January 4, 2011)

His therapeutic style also reflected this orientation. He preferred an approach closer to that of biomedical professionals than to traditional healers. He said he prepared his own herbal medicines but had no hesitation in writing down the names and quantities of the herbs so that patients could obtain them themselves. He "prescribed" remedies on paper – "writing medicines like modern doctors do" (Interview with Ato K., January 4, 2011). For this reason, he believed other healers looked down on him, as they would never reveal their recipes to the community, in order to preserve their authority. In his view, since herbal manuals could even be found in the local markets and were therefore accessible to everyone, it made no sense to keep medicines secret.

His healing practices relied on the use of herbal remedies and faith in God. Although he disapproved of healers who, in his words, dealt with the "dark side" of religion – many of whom he considered satanic – he continually invoked the religious horizon and the divine as the ultimate source of healing and well-being.

Another ethnographic episode useful for introducing students to the topic of *medical pluralism* involved a different healer I met on a market day. When arranging our next interview, he showed me an appointment slip: he would be unable to meet the following week because he was scheduled for cataract surgery at the hospital. After spending hours discussing the importance and efficacy of traditional medicine, which he had practiced for years, his decision to undergo a biomedical procedure left me perplexed. Yet, within his interpretive framework, the interchangeability and coexistence of different therapeutic traditions did not signify contradiction or confusion but rather a rational and resourceful use of the options available.

As Fassin [13] noted,

> illness trajectories in search of diagnosis and treatment result from multiple logics – structural causes (systems of representation of illness, the individual's social status) and situational causes (economic changes, advice from a neighbor) – which render all attempts at strict formalization futile.

At this point, it is useful to recall the notion of *medicoscapes*, which offers a more process-oriented way of understanding medical pluralism. Rather than treating cultures, places, and bodies of knowledge as neatly bounded units – as some static interpretations of medical pluralism risk doing [14] – the concept of *medicoscapes* highlights the dynamic processes through which differences in medical systems are generated and sustained. In this sense, medicoscapes address a key limitation of classic medical pluralism, which tends to be descriptive rather than theoretically grounded [15].

Plural medicoscapes, therefore, are far more common than one might assume, and there is nothing irrational or contradictory about their coexistence. For young nursing students, understanding this means recognizing that biomedicine is merely one cultural paradigm among others – indeed, it is our own form of *traditional medicine*, the one we have been taught and trained to practice.

4. Explanatory Models

Kleinman [16] analyzed *explanatory models*, that is, the sets of notions used by those involved in the healing process to understand the cause and meaning of an illness and to develop knowledge useful for potential therapeutic actions. In the medical encounter, the interpretations and meanings attributed to a health condition by the healthcare provider – shaped by professional training – and by the patient – shaped by lived experience – often collide.

The biomedical claim to universality, both in the efficacy of treatments and in the classification of pathologies, is challenged by the evident arbitrariness of the *sign* in a context of medical pluralism such as the one I studied. Signs appear to convey self-evident truths; in reality, through the performative process of signification – generated in the interaction between one who signifies and one who interprets, and through the constant alternation of these roles [17] – signs reveal their contingent and cultural nature. As de Saussure demonstrated, the sign is the relationship between two entities: one present (the *signifier*) and one absent (the *signified*), to which the former refers. This relationship, however, is neither natural nor necessary – it is arbitrary.

The different theoretical frameworks coexisting within plural medical contexts such as my fieldwork research in Wukro offer multiple paradigms for interpreting not only illness but also, more broadly, "reality" itself. These frameworks become medical, moral, and interpretive models all at once. In their interplay and overlapping, they reveal what Aragona [18] calls the "myth of facts", that is, the illusory objectivity of evidence. Illness thus emerges in its true nature – as a social construct deeply tied to the way societies are organized and to their underlying theoretical models.

> In biomedical terminology, the *sign* maintains a close connection with what semiotics defines as *indexes* or *natural signals*. Just as one infers the presence of fire from smoke, disease is inferred from medical signs such as fever. Neither fever nor smoke are meaningful creations based on semiotic or cultural conventions; rather, they are natural manifestations. In this sense, the sign has the peculiarity of being itself a fragment of natural reality which, like the tip of an iceberg, reveals its own presence and enters the field of semiosis only insofar as there is an interpreter – someone who, upon observing fever, infers a specific disease. [19]

But what happens in a context where signs point to different meanings? In Wukro, where I conducted fieldwork, the arbitrariness of the sign constantly manifests itself – not only in the distinction between *sign* and *symptom* (the latter being the patient's expression), but also in the diverse interpretations and corresponding meanings that biomedicine and traditional medicine elaborate. Shortness of breath, chest tightness, and high fever are considered unmistakable signs of a *ganien* attack in traditional medicine. For a "biomedical" gaze, however, the same complex of symptoms would unmistakably point to *pneumonia*.

In the conflict between biomedical and traditional paradigms, which occurs in cases of "arbitrariness of the sign", i.e. when the patient or the patient's family interprets a complex set of symptoms differently from the biomedical professional, the request for healing and the therapeutic response become irreconcilable. This can lead to non-compliance and failure of the therapeutic alliance, with negative consequences for the patient's health.

Almost certainly, none of the students to whom I have recounted this ethnographic truth will encounter a patient whose interpretation of illness stems from traditional Ethiopian medicine or who attributes its cause to supernatural agents, but it is very likely that they will encounter personal interpretations of illness that differ from the biomedical one. Future nurses may find themselves in multicultural contexts, and it is important that they learn to listen to patients' accounts of illness and learn to be *cultural mediators* in healthcare settings, attempting to resolve conflicts and promoting understanding between doctors and patients.

For students, being confronted with such situations helps them understand how to act in multicultural clinical settings – how to engage with patients from different cultural backgrounds, to distance themselves from familiar concepts, and to approach those that seem distant.

5. Bringing It All Back Home: Concluding Notes

The social function of anthropology is to identify problematic situations, disseminate results, and take a stand [20]. Within a university course in medical anthropology, the outcomes of ethnographic research can thus serve to enhance the *emic* perspective, acknowledge the legitimacy of traditional healing figures, and foster greater compliance and dialogue between healthcare workers and patients in the contexts under study.

Moreover, such experiences can be productively reinterpreted *at home*, within the framework of what Seppilli [20, p. 12] called the "cultural calibration of healthcare services" – one of the "most complex and urgent critical issues" that Western health systems must face today. Understanding the cultural dimensions of health, illness, and care becomes a vital tool for future practitioners, enabling them to work more effectively across diverse healthcare settings. It also reveals that anthropology's vocation to *listen to voices*, to grasp other people's needs, and to dismantle one's own certainties is not merely a theoretical posture but an operational practice – a way to create shared spaces of encounter, negotiation, and cooperation in the everyday relationship between healthcare provider and patient.

Beyond the classroom, this pedagogical use of ethnography points to a broader epistemic responsibility: to cultivate reflexivity and critical empathy among health professionals, encouraging them to see each clinical encounter as a site of cultural translation. In this sense, teaching medical anthropology through lived field experiences – such as those conducted in Wukro – can become an exercise in reorienting care toward mutual understanding, where scientific knowledge and cultural knowledge are not opposed but mutually generative. Such an approach ultimately reminds us that anthropology's most enduring lesson lies in its capacity to turn distance into connection, and difference into dialogue.

6. Acknowledgements

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Teaching Moral Philosophy in a Medical University: Seven Years Experience at UniCamillus University

by Alessandro Boccanelli, Laura Elena Pacifici Noja*

Abstract
UniCamillus International Medical University opened its doors in 2017 and, from the outset, tried to imagine a new vision of medical studies, including an integrated course of Economics and International Social Politics as part of the student curriculum at the Faculty of Medicine. During the first year of Medicine students, besides usual topics as anatomy, physics, chemistry, study also topics as Moral Philosophy, usually classified as humanistic and not scientific. The aim of this choice was the idea of supporting the value of interdisciplinary studies for future doctors. Then Moral Philosophy and History of Medicine found their place in this integrated course.

Keywords
Faculty of Medicine, Moral Philosophy, Integrated Course, Interdisciplinary Studies.

1. Background

If the correct definition of "Moral Philosophy" is that of a philosophical discipline that deals with rationally describing and justifying the concepts of "good" and "right" that guide the actions of groups and individuals, it is clear that a faculty that wants to train good doctors cannot ignore sharing reflections on this subject with its students.

Medicine, as all other health professions, is not completely reducible to science. Even if it is built on repeated and wide observation of sensitive phenomena, and even if it tries to elaborate theories that explain them, as the Austrian philosopher Seifert points out [1], medicine is not a pure science, because it has a practical purpose. Nor is it a mere empirical science, because it presupposes a philosophical foundation *as much as* the other sciences. Actually, medicine requires a philosophical foundation *much more* than other sciences since its object is the human being. Indeed, for the most part, human beings are in the condition of suffering and in need of help. As Josef Seifert claims, to understand itself, medicine must find the answer to the question: who is man? And

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science is not enough to find this answer, since the idea of "human being" incorporates in itself a number of concepts: we need to both refer to the anthropological background and open to ethical questions.

As Sassower and Grodin sustain [2]:

> A unique relationship exists between physicians and philosophers – one that expands on the constructive potential of the liaison between physicians and, for example, theologians, on the one hand, or, social workers on the other. This liaison should focus on the scientific aspects of medicine, not just the ethical aspects. Philosophers can provide physicians with a perspective on both the philosophy and the history of medicine through the ages – a sense of how medicine has adapted to the social, cultural, and ethical needs of each period. This perspective, while emphasizing medicine as science, should not be limited to matters of methodology, or to criteria for distinguishing science from other intellectual pursuits, but should be concerned also with the history, sociology, and politics of science. Both physicians and philosophers stand to gain from a strengthening of their active liaison now as never before; but most of all, the public will be the beneficiary.

In this perspective the course of Moral Philosophy was born in UniCamillus University.

2. Necessity of Interdisciplinarity in Medicine

In the coming years, medicine and healthcare professions will face new and important challenges, such as achieving the international goals set out in the 2030 Agenda for Sustainable Development: 17 Sustainable Development Goals (SDGs) and 169 sub-goals, which have health improvement as a specific goal 3, together with the aim to end poverty and combat hunger, fight inequality and promote social and economic development, combat climate change and build peaceful societies by 2030.

So physicians will be not only required a thorough scientific knowledge, but also a broader knowledge of the constant bonds with philosophical and ethical concepts. In fact, as pointed out in some recent publications by the University of Stanford, "the core moral challenge of public health is balancing individual liberties with the advancement of good health outcomes, drinking water or compel people with active, infectious tuberculosis to be treated" [3].

The subject is oriented to the formation of human beings like our students, through philosophical and moral reflection and moral reasoning ability: student will develop attitudes and values – such as humility, tolerance, understanding, respect and openness towards others.

2.1. *Medicine Is Not Just Scientific Knowledge: The Goals of Medicine and the Concept of Care*

To be a doctor, it is not enough to have a solid scientific and technological education; one must also take into account that the treatment process is applied to human beings. In the first lesson of moral philosophy, we usually explain to students who are about to embark on their degree course that they are entering a sort of forest called Medicine. This forest is inhabited by animals that all look the same, called "patients", who may

wear a sign around their necks with the same diagnosis. This is not enough to "cure" them, unless it is transformed into "caring for" them: the process takes place through a thorough understanding of the context in which the disease developed and how the patient perceives and experiences his condition. This makes patients different from one another and therefore very difficult to achieve complete success in therapy if it is not "personalized" from a psychological and behavioral point of view. Hence the need for 'narrative medicine' that leads to mutual knowledge and trust. "Communication time is treatment time" is the rule that doctors must follow.
As described in the The Hastings Center Report [4]:

> The narrative ethicist imagines life as multiple points of view, each reflecting a distinct imagination and each more or less capable of comprehending other points of view and how they imagine. Each point of view is constantly being acted out and then modified in response to how others respond. People generally have good intentions, but they get stuck realizing those intentions. Stories stall when dialogue breaks down. People stop hearing others› stories, maybe because those others have quit telling their stories. The narrative ethicist›s job is to help people generate new imaginations that can restart dialogues.

2.2. *Medicine and* One Health *Vision*

Starting from the cultural and scientific assumption that the environment is the "common home" shared by humans with other living beings, One Health is an interdisciplinary and integrated approach to study, evaluate and address complex problems involving human health, animal and ecosystems.

One Health is more relevant than ever in times of pandemics and climate change. However, although the term now appears in countless official documents, One Health remains a scientific challenge:

- How to deal with complexity?
- How to develop a One Health approach to problems caused by pollution?
- How to insert the health component – necessarily with a One Health approach – into sustainability?
- How to include social and cultural factors in One Health, developing a multiscale approach?
- Above all, how do we translate science into action?

The subject introduces several main themes of Moral philosophy, by linking them to abilities for Moral thinking and Moral decision making, in a systematic and existential dimension.

As Almond [5] wrote also:

> There is a need to bring ethics and medical practice closer together, despite the risk and problems this may involve. Deontological ethics may promote sanctity of life considerations [...] against the quality of life considerations favoured by consequentialists or utilitarians; while talk of respect for life and the value of life may point to more qualified ethical positions [...].
> For a respect-for-life position, dismissing a utilitarian cost-benefit outlook as too simplistic; but an unqualified fixed principles approach is also ruled out, both because of its unacceptable consequences in individual cases and also because of its reliance on the slippery slope

> argument which, it is argued, is logically and psychologically deficient. The case of genetic engineering provides an example in which the notion of respect may operate, but in which broad general principles also apply.

3. Our 7 Years' Experience

The Moral Philosophy course at the UniCamillus University aims to orient students, starting in their first year, toward a vision of medicine that is strongly patient-centered and focused on human relationships. The course explores the role of information exchange through narrative medicine and emphasizes the necessary empathic relationship, the importance of respecting diverse cultural approaches, and the ethical adaptation of doctor-patient communication in the digital age. Topics covered include the complexity of healthcare organization, the evolution toward chronicity and the importance of palliative care, as well as the implications of genomic research and the revolution brought about by the introduction of artificial intelligence in the medical profession. The course also addresses the importance of multidisciplinary collaboration, the challenges of approaching rare diseases and research in this field, and the need to develop international collaboration projects given the globalization of knowledge, resource inequality, and migration. The methodological objective is to address the challenges posed by Western technological-scientific societies in order to understand whether, and how, they can be addressed and on the basis of which ethical-anthropological assumptions and criteria. Students are encouraged to examine their own views in the light of the traditional approaches. Although students are never required to agree with any position expressed in this class, they are required to demonstrate a sufficient understanding of the ideas presented in subject contents.

We started our classes in 2017, as soon as the new UniCamillus University of Health Sciences opened. The first year students were 120 and the teaching program is listed in the Table 1.

We can divide the teaching periods in a pre-Covid period, Covid and post-Covid (Table 2).

In the pre-Covid period the 120 students in the Moral Philosophy course were divided into 17 working groups, each assigned a topic. The group's tasks included completing research on the topic, preparing a presentation in class, presenting their work using predefined and uniform graphics, discussing the project in class with an invited expert at each opportunity, and answering questions from fellow students. After the lecture given by the students themselves, the group was required to prepare a paper according to agreed-upon editorial guidelines to contribute to the final draft of a volume entitled *Health and Ethics* [6]. Therefore, the course did not include a traditional exam; evaluation was based solely on the quality of the work completed, the presentation in class, and the material produced.

The students, involved in the work, effectively conducted a "quality competition" between groups by producing high-quality teaching materials, distributing impactful infographics among their colleagues, and presenting the topics covered, including theatrical role-playing. The teaching method's results were consistent with some of the crucial activities of a medical

Table 1. *Moral Philosophy teaching program.*

The Contract
The Errors of the Past and the Empathetic Relationship
The Time of Communication
Differing Cultural Approaches to Medicine
Evidence-Based Medicine and Narrative-Based Medicine
Narrative Medicine in the Digital Age
The Complexity of Health Organisation
Shared Care Planning and Simultaneous Palliative Care
The Epidemiological Transition and the Cure of Chronicity
Collaboration Between Different Care Professions
Hiv, Infectious Diseases and Vaccinations
Genome
Orphan Diseases and Medical Research
Coma and End of Life
Nutrition and Therapeutic Obstination
Transplants
Female Genital Mutilation
Health and Migration
International Projects, Cooperation and Ethics
Health and Ethics in the Use of Social Media
Ethics of Human Enhancement
Ethics of AI And Tele-Medicine
Health as a Human Right
Ethical Issues in Global Health

Table 2. *Number of Moral Philosophy students per academic year.*

2018/2019	n. 120 students
2019/2020	n. 180 students
2020/2021	n. 300 students
2021/2022	n. 420 students
2022/2023	n. 422 students
2023/2024	n. 600 students

UNICAMeetings
Fundamentals in Health Professions

Confelectures
Directors Prof. Alessandro Boccanelli and Prof. Laura Elena Pacifici Noja

16 MAGGIO h 16-18
Ethics and mental health in a bio-psycho-social approach
Emanuele Caroppo Psychiatrist, Department of Mental Health, Rome

17 MAGGIO h 14-16
Artificial intelligence in Medicine
Marco Trombetti Pi-Campus
Barbara Carfagna Journalist

17 MAGGIO h 16-18
Public Health in Sub Saharian Africa: an overview
Gianluca Russo Infectious Disease Researcher Dpt of Public Health and Infectious Diseases, Sapienza University of Rome

19 MAGGIO h 14-16
Public Health in Sub Saharian Africa: an overview
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24 MAGGIO h 16-18
Artificial intelligence in Medicine
Marco Trombetti Pi-Campus
Barbara Carfagna Journalist

25 MAGGIO h 14-16
Ethics and mental health in a bio-psycho-social approach
Emanuele Caroppo Psychiatrist, Department of Mental Health, Rome

25 MAGGIO h 16-18
Children right and ethics
Elena Bozzola Pediatric Hospital Bambin Gesù, Rome

26 MAGGIO h 14-16
Bioethics and immigration: Health care for the immigrant patients
Giancarlo Ceccarelli Infectious Diseasse Specialist, Azienda Policlinico Umberto I – Rome

31 MAGGIO h 14-16
Digital Culture, mindsets, organisations: a digital sociology perspective
Donatella Padua Social Sciences - Unicamillus

Aula Magna, UniCamillus Congress Hall
Via di Sant'Alessandro 26, 00131 Roma

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Figure 1. *Manifesto for a series of Confelectures per academic year.*

professional: group work, research, preparation of teaching materials, presentation of work, discussion of the investigation, and writing a publication. The course was highly appreciated by the students, who ultimately placed it first in the teaching rankings required by the University. The student satisfaction rate has always been above 90%.

During the pandemic, much of the teaching shifted to online teaching. This led to methodological changes that have become more established over time.

We adopted different types of online learning:

- Real time online classes;
- Recorded lessons;
- Demonstration videos.

The online teaching had some advantages but mainly disadvantages. Among the advantages the increased possibility of interaction, without embarrassment to ask questions in the chat box. When lessons were recorded, they could be revisited later, students could decide when to see them in the comfort of their own environment. On the other side, in case of recorded lessons, students can feel un-pressured and lazy, not watching the lecture, without interactivity, with unanswered questions.

In the post-pandemic and more recent period, there has been a significant increase in the number of enrollments in the medical degree course, up to the current number of 650. Students have been divided into three channels, and this has made uniformity of instruction and interaction between teachers and students more difficult. We have introduced a new teaching format, to bring all students together on a monthly basis: the Confelectures (Figure 1) Confelectures are lectures/lessons held within the Moral Philosophy course in collaboration with invited experts. Given the commitment required of these experts and their professional relevance, Confelectures were scheduled on unified channels, with the intention of extending the invitation to all healthcare professionals in all years of the course. In any case, the lectures were recorded, with the permission of the speakers, to serve as teaching material for reuse. Furthermore, the study of moral philosophy has supported an interdisciplinary approach to various topics that intersect with health, such as migration and migration medicine.

3.1. *Results and conclusion*

Through the Moral Philosophy course, students are guided in understanding the importance of ethical evaluation of any topic that may affect health.

From the teacher's perspective: two targets have been reached. First to stimulate the curiosity in a field completely unattended at the faculty of medicine and second to create their "own philosophical system" that they will later use as physicians.

From the students' perspective: to start a relationship of collaboration and discussion on different point of view regarding values.

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Camillo de Lellis and the Ideal of Global Healthcare

by Christina Savino[*]

Abstract
This paper is devoted to Camillo de Lellis and his contribution to medical care and nursing as we know it today. While Camillo's life and history have been addressed in biographies, this paper aims to highlight two specific aspects of Camillo's work: its relationship to the urban context and the urban hospital network and the concept of global healthcare, that would later become a Camillian ideal.

Keywords
Camillo de Lellis, St. Camillus, Nursing, Urban Context, Urban Hospitals, Global Healthcare.

1. Introduction

Since antiquity, healthcare and nursing have been inspired by the highest respect for human life. Therefore, this arduous task has been carried out mainly by religious people and orders throughout history. In the 1st century AD St. Paul sent to Rome a notable woman and deaconess, named Phoebe, to provide assistance and hospitality to those in need. In the 4th century AD, following the first Council of Nicaea, St. Basil the Great established the first *xenodochium*. This early hospital-city featured separate buildings for the poor, the sick, and strangers, providing accommodation for nurses and doctors. Subsequently, infirmaries were established within monasteries, such as those founded by St. Benedict in Montecassino and Salerno; it was from these early healthcare facilities that the first hospitals would evolve. The oldest functioning hospital is considered to be St. Bartholomew's Hospital in West Smithfield, London, founded in 1123. In Counter-Reformation Europe, the role of Christian spiritual congregations in healthcare and poor relief remained crucial. A leading figure in this field was St. Camillus (Camillo de Lellis, 1550-1614) [1]. Due to his profound humanitarian commitment, Camillo de Lellis is highly venerated within the Catholic Church. He was beatified (1742) and then canonized (1746) by Benedict XIV. Between the 19th and 20th centuries, he was adopted as patron Saint of the sick and the hospitals (1886); nurses (1930); and military healthcare (1974). His relics are preserved in the

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church of St. Mary Magdalene, a few steps from the Pantheon, in Rome. A statue representing him stands in the central nave of St. Peter's, alongside others of founders of religious orders. A church dedicated to him was built in the Sallustiano district at the behest of Pius X, between 1906 and 1910, and elevated to minor basilica by Paul VI, in 1965.

The life of St. Camillus, a giant in the Counter-Reformation – as well as literally, as he was taller than two meters! – was an adventurous one. Born in Chieti to a good family of the local aristocracy, Camillo took up the military profession at a very young age following in the footsteps of his father, Giovanni de Lellis, an officer in the service of the Spanish crown. With his father Camillo left for a campaign of the long-running Ottoman-Venetian wars, facing violence, danger and illness of both body and soul. While stationing in the marshes, near the mouth of the Tronto, he contracted malaria. Later on, he suffered an injury to the right foot: an itchy ulcer, which later became infected and spread, until it progressively corroded the flesh of his entire leg. Also, he became a gambler. Driven by necessity he began assisting in hospitals, but then formed a company of nurses, with whom he took on the task of serving the sick, similarly to what other confraternities and clerical orders, such as the Fatebenefratelli of Giovanni da Dio, were doing at the time.

Since the last century, Camillo and his company have been the subject of numerous studies that have outlined their remarkable contribution to nursing [2]. However, it is still possible to emphasize two important aspects of Camillo's work particularly relevant to this Journal, namely the relationship between healthcare and environment, and the concept of global healthcare, that would later become a Camillian ideal.

2. Healthcare and the City

First and foremost, the term environment in Camillo's life covers the city of Rome. Camillo arrived in Rome in 1571, at the age of 21, to be treated for the wound he had sustained while stationing in the Marche region. At the time of his arrival, Rome was a large, cosmopolitan city, full of contrasts, swinging between opulence and poverty, and very unhealthy. During the 16th century, indeed, Rome was plagued by multiple urban diseases [3]. More or less serious outbreaks of plague raged alongside acute forms of typhoid fever and, of course, syphilis. Moreover, the city was affected by flooding. Torrential floods descended from the Alban Hills and the Volscian Mountains, inundating the plains, eventually stagnating and creating marshes. The Tiber's floods submerged the lowest parts of the city, covering squares with slime and filth, transforming them into gigantic stinking pools. The flooded areas facilitated the breeding of *anopheles* mosquitoes, which transmitted malaria. Floodings and epidemics were followed by famines that weakened the population, causing locals, particularly farmers, to abandon their settlements and move away spreading infectious diseases.

Since antiquity, malaria has been known as a fever, often intermittent, causing headaches and chills, typical of marshy areas surrounding urban settlements. Also, Hippocrates linked malarial fever and misery with certain seasons (late summer and autumn) [4]. Malaria's arrival in Rome, probably in the first century AD, was a turning point in European history. It went down in history as an "Italian disease'", as its name, reflecting a pathological concept of a miasma suspended in the air causing epidemics, attests. In the days of Camillo, malaria, both epidemic and endemic, was devastating many areas of Italy. In addition to the Tronto valleys, where Camillo himself contracted it, the Po and the Adige valleys were affected; and so, on the Tyrrhenian side, the Maremma area; in the countryside surrounding Rome, the Roman Campagna, and the coast between Ostia and Anzio. Authoritative and abundant evidence attests to the poor environmental conditions in Rome [5]. Luigi Mocenigo, reporting to the Venetian Senato in 1560, wrote that in summer "the foreigners who come to Rome [...] almost always run the risk of illness or death" ("i forestieri che vengono in Roma [...] quasi sempre corrono pericolo d'infermità o morte"). Shortly after Camillo's arrival in Rome, a Medici ambassador wrote, regarding those who had moved to the countryside, that: "all those who have changed their climate have either died or fallen seriously ill" ("tutti quei che hanno fatto mutazione d'aria o sono morti o ammalati assai").

In the following decade things did not improve. According to historian Fernand Braudel, a resurgence of malaria took place in the summer of 1581 [6]. Pope Sixtus V – elected in 1585 and extremely active in the field of urban and sanitary planning – worked hard to solve the situation. On 28 March 1586, he hired the architect Ascanio Fenizi of Urbino to reclaim the Pontine Marshes. Shortly after, however, an anonymous chronicler noted that: "The Pontine Marshes that were drained last year [...] have returned to their original state". That year, in August, Sixtus V died of malaria, as did his successor, Urban VII – who happened to cover the shortest pontificate in the church history (15-27 September 1590).

In the city, Camillo experienced the *healthcare environment, too*, as he was admitted to San Giacomo degli Incurabili – an historic hospital in Rome, located between via del Corso and via di Ripetta, in the Campo Marzio district [7]. His first stay at San Giacomo lasted from March 7 to December 31, 1571; from the 1st April onwards, however, it was for work as Camillo's name shows up among those of the employees. At the end of the year, he was dismissed for negligent conduct, as well as for his compulsion gambling which often distracted and led him to the banks of the Tiber to play with the *barcaroli*. At the beginning of 1572, he left and wandered around Italy for years; he returned to enlist in the Ottoman-Venetian War experiencing once again harsh conditions like dysentery, hunger and even cannibalism. After the peace settlement that was signed on 7 March 1573 Camillo briefly returned to Rome, to gamble away all the earned money and even his cloak. He was reduced to begging.

Two years later, when the worst seemed to be over thanks to a construction work at the monastery of the Capuchins in Manfredonia, the sore on his foot reopened, and Camillo was forced to return to Rome, hoping to be readmitted to San Giacomo by virtue of the indulgence granted for the Jubilee Year of 1575. At the time his second stay at the hospital begun. From 23 October to 18 November 1575 he was treated; from 19 November 1575 to 20

June 1579 he worked, attaining the position of nurse, and then of wardrobe keeper. This second stay at San Giacomo was an entirely positive experience. It came to an end only because Camillo was able to do his novitiate in Abruzzo. However, a new infection of the wound brought him back to San Giacomo, where he entered in mid-October 1579. Once again, he was first treated, then appointed superintendent, until September 1584. In this period, Camillo's diligence, honesty and discipline earned him appreciation and attracted indispensable donations to the hospital. Of the greatest importance were those by Cardinal Antonio Maria Salviati (1537-1602), who made rebuild the structure of San Giacomo from the ground up in 1579.

Camillo's service at the hospital is attested by three registers, which reveal not only his managerial skills, but also his thoughts and views about health and assistance in the healthcare environment. The hospital was the third oldest in Rome, after Santo Spirito in Sassia and San Giovanni in Laterano. Established in the 14th century, during the pontificate of Nicholas V (1447-1455), and placed under the protection of Santo Spirito, it was entrusted first to the Society for the Poor and Sick (Compagnia di Carità verso i poveri e gli infermi) of S. Maria del Popolo, then, from the end of the 15th century, to the Society of the Divine Love (Compagnia del Divino Amore) founded by Caterina da Genova and later led by Ettore Vernazza. With the bull *Salvatoris nostri* (1515) by Leo X, it was re-founded, that is, transformed into a rest home for the long-term and incurably ill, without distinction of social class and sex, and with a particular focus on syphilis. Elevated to the status of *arcispedale*, it became a reference for all hospitals for the incurably ill in Italy and Europe and for all the charitable congregations founded over the years.

The hospital service, however, endured many problems in relation to healthcare. The Society of the Divine Love came to a standstill following Vernazza's death, in 1524, and ceased altogether after the sack of Rome, in 1527. Two years later the hospital passed to the Capuchin order, but the monks were not prepared to treat the sick. Nor were the laypeople working in the house, who were uneducated and unskilled – if not criminals serving their sentences. The service was terrible. The hygiene of the hospital and the patients was neglected. Persons with fever were left aside to fend for themselves, without food or water, or mistreated – tied up, beaten, even buried alive. The priests supposed to administer the sacraments, too, showed fear or disgust for this environment and the incurably ill.

3. Global Healthcare

The healthcare in the hospital and its issues were tirelessly monitored by Camillo, who often intervened. He corrected those responsible, instructed them, dedicated himself personally to the most serious cases, established a weekly distribution of Communion. Slowly his project of devoting himself to monastic life and founding his own order dedicated to the care of the sick was taking shape. Camillo's brothers would combine the skills of healthcare workers with the qualities of spiritual fathers. They would offer global healthcare and nursing by attending for the whole person, including body and soul. The focus of their service was the patient, regarded as a master to be served with humility and courage.

Camillo shared his project with a group of companions in prayer and in caring for the sick, whom he asked to serve those in need with the highest devotion, “with the same love a mother has for her only sick child”. These words were written by Camillo in the *Rules*, composed between the end of 1584 and the beginning of 1585 [8].

The *Rules* mainly concern the tasks and methods to be followed in hospital service. Two cornerstones are the good governance of the hospital and the commitment to assist the incurably ill. The work required by the *Rules* was arduous, but Camillo himself carried it out, as he warmed the feet of the sick before putting them to bed, patiently deloused his patients, gave them a warm bath, and powdered them with aromatic herbs. The healthcare provided by Camillo’s brothers would be free, and they would be obliged to live in poverty and prevented to accept donations for their service. Also, they had not to force patients to do anything against their will, not even to receive the sacraments, and in particular confession.

When submitted to the Congregation of Bishops and Regulars for approval, the *Rules* met with considerable resistance. But now to the papal throne had ascended Sixtus V, who was born a poor farmer’s son, and *a* Franciscan from a young age. From the very beginning of his pontificate, Sixtus V had dealt with the problems of Rome and promoted reforms, including the strengthening of the urban hospital network. As he planned to renovate the old hospitals and to build new ones, the recruitment of an adequate staff for the standards and health emergencies of the time was required. This made the moment favourable for Camillo’s project, which obtained the papal approval to establish his Company of Ministers of the Sick with the *breve* of 18 March 1586. Shortly after, Camillo was received in a private audience by Sixtus V in the Vatican. On that occasion he asked to be allowed to sew a red cross onto the black cassocks as distinguishing badge for his Ministers, and this request was officially approved, too, with the *breve* of 18 June.

But Camillo’s project had only begun and was too ambitious to be confined within the hospital of San Giacomo. At the end of December 1586, Camillo and the Camillians moved to the church of Santa Maria Maddalena in Campo Marzio and the surrounding village. The new housing was combined with a new hospital, Santo Spirito. Thereafter, the Camillians’ activities and fame grew so much, that they started receiving requests from outside Rome. The first request came from Naples, where a new house was opened in October 1588.

The charitable work of the Camillians gave hope for their elevation to a major order: a formal request was presented to the Sistine Congregation *Pro sacris ritibus et caeremoniis*, but the process was interrupted by the death of Sixtus V. His successor Urban VII had a very short pontificate, as already mentioned, and in the meantime Rome went through a new epidemic – it was typhus – causing acute fevers and numerous deaths. This created the epidemiological emergency scenario contemplated by Camillo’s *Rules*. The Camillians greatly supported the civil administration by providing first aid and rescue. Their work impressed the new pope, Gregory XIV, who recognised the Camillians as an order of regular clerics in the bull *Illius qui pro* *gregis* of 21 September 1591.

The next pope Clement VIII, previously an opponent to the elevation to order, also became grateful and benevolent towards Camillo, who was elected General of the Order on 8 December 1592, while Cardinal Salviati officially became protector of the Order from 1593. Salviati would later oppose Camillo's idea of further extending the charitable work of the Order, but Camillo convinced him. On 14 June 1594 Camillo arrived in Milan to offer the services of the Camillians to the *Ca' Granda*, founded by Francesco Sforza in 1456, and prototype of the new kind of hospital administration. The management requested six Camillians to provide care for the body and soul of the *Ca' Granda*'s patients. Camillo left there thirteen. By August 1594, he was already in Genoa in order to open a new Camillian foundation.

Camillo's drive towards expanding hospital – that perplexed Cardinal Salviati – caused a serious rift in the Order, since most of the Camillians mainly inclined towards spiritual assistance and considered themselves overwhelmed by physical tasks such as feeding, making beds, cleaning the hospital and caring for the hygiene of the sick. Tasks of this kind would demoralize and depress the spirit of the fathers. But Camillo had laid down his *Rules* and in his view the nurse was a total caregiver and a servant of the sick, hence the impossibility of separating spiritual comfort from physical care. To defend his view, he continued to travel throughout Italy establishing teams of Camillians in several hospitals. He always upheld his ideal, even in his final years that he spent in retreat at Santo Spirito. Shortly before his death, between June and July 1614, he wrote and distributed a letter-testament where he reaffirmed the principles and ethics of his Order: never take care of the spiritual without the physical ("che non si pigli mai cura dello spirituale assoluta, senza il corporale").

4. Afterlife

Camillo's project was continued after his death in a world-wide perspective. In the 18th century, the Order crossed the ocean to establish new missions and provide healthcare in South America. In the 19th century, two female congregations were established: the Camillian Sisters and the Daughters of St. Camillus. From now on, women contributed to the Camillian project, bringing their own experience and dispositions to the ideal of "maternal" care. In the 20th century, healthcare took on a global dimension, reaching the Far East, Kenya and Central Africa, the Caucasus and Haiti.

Rome, the city where it all began, never ceased to remember and honour Camillo's work. At the end of the 1960s, the Second Vatican Council established a new constitution for the order: thus, in many parts of the world, including Brazil, Austria, Colombia and Peru, associations of lay men and women inspired by the Camillian project and committed to nursing were formed. Camillo's enduring legacy seems to hover over San Giacomo, which Cardinal Salviati bequeathed to Rome with the stipulation that it be used as a hospital. In 2008, the Lazio region decided to close San Giacomo, and in 2019 it was announced that it would be reused as a luxury property. Oliva Salviati, however, descendant of the Cardinal, appealed for the reopening of the hospital, and in 2023 the appeal was upheld by the Court of Cassation [9].

Camillo de Lellis' ideal of a comprehensive nursing care deserves to be remembered and celebrated both in the cultural context of the 16th century – a century of great scientific discoveries concerning world and humankind – and in the history of nursing, for it laid the foundations of modern healthcare and anticipated future advances of assistance to the sick of the modern age.

Notes and References

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Down Syndrome in Africa

Lessons Learned From the November 2024 *Down Syndrome and Other Intellectual Disabilities Awareness Event,* Addis Ababa, Ethiopia

by Hewan Mulugeta Asfeha, Roel van der Veen*

Abstract
Down syndrome is a genetic disorder that affects around one in 1000 births worldwide. There is an overwhelming level of misconception in Africa regarding Down syndrome, which is often attributed to supernatural causes and as a punishment from God. Families hide their children with Down syndrome to avoid the scorn and discrimination from their community which consequently results in these children unable to access their basic needs of life including education. This paper will summarize the proceedings of the November, 2024 *Down Syndrome and Other Intellectual Disabilities Awareness Event*, the lessons learned, the gaps identified and also highlight proposed ways to move forward. The Down Syndrome and Other Intellectual Disabilities Awareness Initiative was established by Deborah foundation, a local non-profit based in Ethiopia in collaboration with the African Union and other international partners. In November 2024 a high profile event was held, centered on the message of self-advocacy and abilities beyond disability which also resonated with the 2023 World Down Syndrome Day slogan, "With Us Not For Us". The relevant changes achieved through the event are the changes in the knowledge and perception of event participants, the strengthening of networks between organizations working on Down syndrome all over Africa, empowerment of people with Down syndrome, clear identification of barriers to enhanced quality of life for people with Down syndrome and other intellectual disabilities. Through the lessons learned from the event, the initiative was able to develop a five-year strategy that will be able to alleviate barriers outlined above.

Keywords
Persons with Disability, Lessons Learned, Down Syndrome in Africa, Intellectual Disability.

1. Background

Globally, the prevalence of Down syndrome is estimated to be around one in 1000 births [1], these rates could be 2-3 times higher in low and middle income countries [2]. Down syndrome is a genetic disorder that occurs when there is an abnormal extra third copy of chromosome 21 and has three genetic variations, trisomi 21, the most common accounting for 95% of the cases, the second, translocation type and the third, mosaic type which causes less overt physical signs and symptoms [3]. Down syndrome can

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affect almost all organs of the body resulting in changes to one's physical features, cognition, immunity and organ development. Down syndrome is the most common genetic cause of intellectual disability [4] and is also associated with a long list of clinical conditions including congenital heart defects [5]. Social disadvantages including stigma and discrimination also contribute to the poor quality of life of people with Down syndrome in Africa [6].

In Africa, Down syndrome is often attributed to supernatural causes and divine punishment which pushes families to hide their children, denying them access to social interactions, education, and healthcare. Furthermore, the syndrome is also wrongfully attributed to the failings of the mother which results in divorces, single motherhood and loss of income to the household [6,7]. Hence, improving the quality of life of people with Down syndrome requires a comprehensive approach that includes raising awareness and combating the stigma in addition to facilitating access to quality healthcare and education [8].

2. The Origins of The Down Syndrome and Other Intellectual Disabilities Awareness Initiative

During the 2023 World Down Syndrome Day event, organized in Addis Ababa by Deborah Foundation, an Ethiopian NGO founded by a prominent family in 2019 after the birth of their daughter Deborah who has Down syndrome [9], valuable contacts were made with the Netherlands Embassy in Addis Ababa to the African Union (AU). The Embassy was impressed by the size and nature of the event (emphasizing abilities, instead of disabilities), and illustrating the foundation's capability to implement large scale projects not only in Ethiopia but also in Africa.

So the Foundation and the Embassy set out to create this initiative that aims to improve the lives of people with Down syndrome in Africa. The group grew to include other Embassies (Ireland, Italy, Germany), the European Parliament and the AU. AU Commissioner Minata Samate Cessouma of the department of Health, Humanitarian Affairs and Social Development, became much involved and the Godmother of the initiative. The various parties to the initiative put together their energy and finances to make the event possible.

The event took over ten months of planning and involved reaching out to relevant stakeholders, forming committees, discussing possible systems of implementation, planning out event content, and securing funding.

3. Event Proceedings

Day-1: Awareness Raising Conference, November 07, 2024.

The event attended by 350 participants, took place at Africa Hall, UNECA, the birthplace of The Organization of African Unity and was specifically chosen for its historic significance. The conference included speeches by Commissioner Sumate, Deborah foundation representatives and Ambassador Parfait Onanga-Anyanga, Special Representative of the Secretary-General to the African Union who all conveyed a message of unity and a call to action in creating an inclusive Africa for all individuals regardless of disability. Cultural dance performances were also presented followed by speeches and poems by people with Down syndrome, illustrating the importance of Self-advocacy, access to healthcare, education and social services.

Day-1: Down-and-Up Exhibition, November 07, 2024.

There were a total of 30 art pieces displayed by fifteen artists with Down syndrome and other intellectual disabilities. This segment allowed participants to network and reflect on the ability beyond disability of individuals with Down syndrome when they are given the opportunity.

Day-2: Practitioners Day, November 08, 2024.

The event, attended by 40 relevant stakeholders, was held at the Deborah Foundation compound and included a tour and the practitioners day forum. Presentations were made by self-advocates with Down syndrome from Kenya and Uganda, who shared their experience living with disability in Africa. A PhD student from the Netherlands, and the founder of Melu'e Foundation also offered valuable insights on the caregiver experience. The participants were then divided into focus groups to further breakdown the barriers faced by persons with Down syndrome and suggest solutions to better circumvent those barriers. The identified barriers from the focus group are as follows: lack of awareness and stigma, inadequate data, delayed diagnosis, lack of access to quality healthcare and special needs education services, lack of employment opportunities and lack of inclusive approach to policy making.

Suggested actions in the short-term include: awareness raising campaigns, engaging religious/traditional leaders, and organizing caregiver support groups. Additionally, long-term actions focused on inclusive policies, capacity building for healthcare, and education providers were proposed. Through this process the initiative was able to develop a five-year strategy.

4. Impact of the November 2024, *Down Syndrome and Other Intellectual Disabilities Awareness Event*

The impact of the event was monitored through utilizing two evaluation methods 1) focus group discussions, regarding the effectiveness of Day-1, which concluded the event a success in creating awareness and conveying the importance of inclusion and self-advocacy. 2) An online post-event questionnaire administered to 20% of Day-1 participants, as shown in Table 1.

Empowering People with Down Syndrome

The Day-1 conference was attended by 56 individuals with Down syndrome, of which over 30 were able to showcase their talents through dance performances, speeches, poems and art. The event provided a platform for these individuals to advocate for themselves, feel empowered, and be involved in the decision making process on topics that directly impact their lives.

Strengthening of Networks

The Initiative had established communication with 15 non-profit organizations supporting people with Down syndrome across Africa during the planning stage. Subsequently, the event was attended by representatives of five Ethiopian and two foreign Down syndrome NGOs, and representatives from the UN, AU and multiple embassies. The event concluded with pledges from the participants for future collaborations, exchange of best practices, and support for the initiative's five-year strategy.

Table 1. *Summary of demographics, knowledge, perspectives, and impact of the November 2024 Down Syndrome and Other Intellectual Disabilities Awareness, Day-1 event at Africa Hall, UNECA, Addis Ababa, Ethiopia.*

Category	Metric	Response Breakdown	Percentage (%)
Demographics	Caregivers of people with Down syndrome	32	45.71%
	Professionals in the field (Doctors, Psychologists)	7	10%
	Teachers	19	27.14%
	Deborah Foundation staff	4	5.71%
	Individuals with Down syndrome	4	5.71%
	Other (Government official, Private business owners)	4	5.71%
	Total	70	100%
Knowledge Assessment	Correctly identified Down syndrome as a genetic condition	55	78.6%
	Recognized all key challenges faced by individuals with disabilities	66	94.29%
Perspectives	Agree/Strongly agree: Equal access to education/employment	67	95.7%
	Agree/Strongly agree: Communities should be more inclusive	67	95.7%
	Agree/Strongly agree: Governments should implement stronger policies	68	97.14%
	Agree/Strongly agree: Healthcare professionals have sufficient training	29	41.4%
Event Impact	Felt more informed about inclusion rights	65	92.85%
	Felt that advocacy efforts can lead to positive change	68	97.14%
	Interested in future initiatives	70	100%

5. Conclusion and Future Steps

The Main Lessons Learned

Through the November, 2024 event of the initiative, it became clear that there is still a lot to be done to raise awareness and combat the stigma associated with Down syndrome in Africa, however, self advocacy and events such as these play a crucial role in addressing those issues. Additionally, the event also revealed the importance of collaboration between organisations working in this area across Africa as well as involving the private sector, government bodies and other international organizations to make sustainable changes that positively impact the lives of people with Down syndrome.

The achievements of 1 year of cooperation between Deborah Foundation, the African Union Commission, several European Embassies and the representation of the European Parliament in Addis Ababa have given this core-group the confidence to continue working towards its greater objective: to ultimately improve the lives of Africans with Down syndrome and other intellectual disabilities, as well as of their caretakers, around the continent. Based on the discussions on Day-2, a strategy was written for the years 2025-2030 that will assist in achieving the Sustainable Development Goals by 2030, all under the banner of "Leave no one behind" [10].

To achieve this overarching objective, the Strategy distinguishes 5 sub-objectives: 1) to raise awareness further, across Africa; 2) to help implement the AU Guideline on Disability Inclusion [11]; 3) to strengthen existing African organizations and networks working in this field, and help create new ones; 4) to increase knowledge and organize systems for exchange of best practices in Africa, and connect these to relevant systems outside Africa; and 5) to mobilize resources, and make improvements in the various relevant fields.

The initiative hopes to launch its Five-year Strategy officially, and to attract sponsorship, at the upcoming World Disabilities Summit in Berlin, Germany, April 2025. This should give the initiative the broader attention it needs to continue to improve the lives of Africans with Down syndrome and other intellectual disabilities, and their caretakers.

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Vaccinating the Body, Immunizing Dissent

Persuasion and Control in Ethiopian Immunization Policies

by Corinna Santullo*

Abstract

This article examines how vaccination practices in northern Ethiopia (Tigray) are shaped by the interplay between persuasion, community pressure, and institutional control. Drawing on long-term ethnographic fieldwork conducted in Mekelle and surrounding rural areas (2015-2019), it analyzes how Health Extension Workers (HEWs), the Women Development Army (WDA), and their *one-to-five* system structure everyday encounters around immunization. Through interviews, observations, and case studies, the article shows how mothers' decisions to vaccinate emerge less from individual autonomy than from community expectations, emotional persuasion, and forms of grassroots surveillance. Local explanatory models of illness, religious interpretations, and fears of social stigma intersect with state-driven public health agendas. The analysis highlights how biomedical rationales, moral obligations, and political narratives of modernity combine to construct vaccination as a civic duty, while non-adherence is framed as a threat to collective well-being.

Keywords

Vaccination Policies, Community Mobilization, Health Extension Program, Women Development Army, Tigray.

1. Introduction

This article draws on a long-term ethnographic fieldwork conducted in Mekelle and the Tigray region of northern Ethiopia between 2015 and 2019, through several extended stays. The research was carried out among local communities and institutions responsible for organizing and monitoring vaccination practices. It focused primarily on the urban context of Mekelle – headquarters of the main regional health and governmental institutions – while extending to nearby rural areas through fieldwork alongside *Health Extension Workers* (HEWs), whose main task is to promote vaccination awareness in collaboration with other local actors.

The investigation, based on qualitative interviews, focus groups, and informal conversations held in health centers, hospitals, and schools, explored how vaccination policies are interpreted, negotiated, and enacted in everyday life. Special attention was paid to mothers, the main targets

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of public health campaigns, and to how persuasion, social pressure, and institutional surveillance converge in shaping adherence to immunization.

The research was conducted immediately before the Tigray war (2020-2022), a conflict that devastated the region and further undermined access to basic health services. Although the structural model of Ethiopia's vaccination system – centered on Health Extension Workers (HEWs) and, as discussed below, on the Women Development Army (WDA) – has remained largely intact, its effectiveness has been severely affected by insecurity, famine, and disrupted health infrastructure.

This paper examines the practical implementation of vaccination strategies in Ethiopia, showing how the "decision" to vaccinate oneself or one's children emerges from the interaction of persuasive and supervisory mechanisms carried out by territorial actors. It argues that compliance is socially constructed through community-based health strategies that operate beyond formal control, embedding persuasion within informal networks of community relations. In this sense, surveillance and persuasion work together to establish vaccination as a social norm, while non-adherence becomes framed as a moral and public health threat to collective well-being.

2. Vaccination Policies and Strategies in the Ethiopian Context

Starting from the early smallpox eradication campaigns, international programs and prevention plans were developed through collaboration among agencies such as the World Health Organization (WHO), GAVI (the Global Alliance for Vaccines and Immunization), and UNICEF (the United Nations Children's Fund). These initiatives sought to harmonize vaccination strategies across countries and reduce inequalities in access to immunization services.

Smallpox was the first disease for which active immunization was widely practiced, beginning in 1796, the year Edward Jenner discovered the smallpox vaccine. In 1967, the WHO launched a global vaccination campaign to eradicate the disease, which was officially declared eliminated in 1979 [1].

Among the strategies promoted by these international bodies, the Expanded Program on Immunization (EPI) occupies a central position. Established in 1974, the EPI was a large-scale vaccination initiative aimed primarily at children in developing countries. Ten years later, it was standardized to include six antigens – diphtheria, tetanus, pertussis, poliomyelitis, tuberculosis, and measles – and was introduced in Ethiopia in 1980, with the ambitious goal of achieving 100% vaccination coverage of all children under two years of age within the following decade [2].

In 2004, to strengthen the performance of the EPI and ensure continuous improvement, the Ethiopian Ministry of Health and the Ministry of Education launched the Health Extension Program (HEP). Entirely funded by the state, the HEP represents a strategy of healthcare decentralization based on redistributing institutional functions across both rural and urban areas. It introduced a new model of community-centered healthcare focused on preventive education and local participation. The program also expanded the health workforce nationwide by training and deploying 30,000 Health Extension Workers (HEWs) throughout the country.

HEWs were assigned to Health Centers and Health Posts, the two main infrastructures of Ethiopia's primary healthcare system. *Health Posts* are community-level first-aid facilities designed for populations living in rural areas more than five kilometers from major treatment centers. *Health Centers*, by contrast, provide basic preventive and maternal care services, including pre- and postnatal assistance, and typically serve between 15,000 and 25,000 people.

HEWs operate through community-based and household-based strategies whose effectiveness lies primarily in door-to-door interaction and mass communication initiatives aimed at promoting vaccination, hygiene, and family health education. The HEP has become the most important institutional framework for achieving the Millennium Development Goals (MDGs), particularly those related to reducing maternal and child mortality. The MDGs, launched by the United Nations in 2000 and concluded in 2015, have since been replaced by the Sustainable Development Goals (SDGs), which frame global health strategies within a broader agenda of sustainability and equity. The health policies and community networks discussed in this article now operate – at least conceptually – within this new sustainable development framework. However, the armed conflict between the Ethiopian federal government and the Tigray regional state [3, 4], has profoundly affected the region's social and institutional fabric, interrupting the work of many health centers, extension workers, and community volunteers. While the institutional structure described here has formally remained in place, its restoration after the war is still slow and uneven, especially in rural areas that were most severely impacted by the conflict.

Despite the significant improvements achieved by HEWs in vaccination coverage, hygiene, and reproductive health, challenges soon emerged in reaching every household and maintaining permanent health education for citizens. To address these logistical constraints and strengthen the HEWs' capacity to enhance community self-care, the government institutionalized a volunteer movement of women aged 18 to 55 known as the Women Development Army (WDA).

Officially recognized by the Ministry of Health, the WDA is a nationwide community movement aimed at improving public health conditions. Within it, Women Development Groups (WDGs) were established as grassroots expressions of civil society dedicated to maternal and child health. Over time, this "army" became the cornerstone of community participation in Tigray, working closely with HEWs and playing a decisive role in reducing maternal and infant mortality.

Its main activities include:

- Mobilizing pregnant women to attend regular prenatal checkups;
- Promoting childbirth within healthcare facilities;
- Supporting community-based ambulance systems;
- Providing psychosocial support within the community.

By 2010, the Tigray region counted 29,546 WDGs (25,580 in rural areas and 3,966 in urban areas), encompassing 774,264 WDA members (661,508 rural and 112,756 urban). Each group is composed of 25-30 women, who elect a main leader through a voting process. These groups are further divided into five- or six-member subgroups, each with its own leader, forming an extended hierarchical network known locally as the *one-to-five* system, which operates in every *ketema* – the smallest administrative unit – and is coordinated by a steering committee at the *tabia* – a subcity administrative unit encompassing several *ketema*.

Each month, WDA leaders report data and results to the HEWs; the two branches of the network then meet to reassess tasks and reformulate both individual and team-based goals, directly tied to the national development agenda and the pursuit of the global development frameworks, particularly in the field of maternal and child health.

Within this process, women act simultaneously as promoters and beneficiaries of the program – active agents in managing specialized knowledge and fostering a form of empowerment grounded in collaboration, participation, and shared responsibility. This model of co-participation reflects an ideal of equitable resource redistribution and the strengthening of shared capacities for collective health. As I will show through the ethnographic accounts presented below, these dynamics emerge clearly in the everyday practices of HEWs, WDA members, and mothers.

3. The Influence of Networks Between Persuasion and Control

The Ethiopian state, through multiple forms of coordination among local actors, has implemented a series of strategies relating to acceptance, control, and verification of vaccination practices. As the ethnographic cases presented below suggest, these strategies often operate as systems of persuasion designed to produce a systematic – and largely unconscious – acceptance of vaccines. By this I mean that, beyond any value judgment, and with a focus on understanding local articulations of vaccination policies, the established model of territorial organization forms a network of power primarily aimed at monitoring social adherence to immunization. The subsequent sections illustrate how, in a context of pervasive medicalization, subjectivation [5] can hardly be understood as an autonomous and conscious exercise of freedom of choice – in this case, the freedom to be vaccinated or not.

The work of awareness-raising and monitoring proceeds through a pyramidal organization that begins from the grassroots level, where *Women Development Armies* (WDAs) operate in the field and report to *Health Extension Workers* (HEWs), responsible for their respective catchment areas, the names of mothers who have not yet brought their children for vaccination. This preparatory phase usually precedes vaccination campaigns and involves the *Women Development Group* (WDG) leaders conducting a five-day inspection across the household compounds in their assigned area, recording the number, age, and names of the children scheduled to receive immunogenic antigens.

During an extraordinary vaccination campaign against meningitis A, I was able to observe several days of such patrols in a rural area near Mekelle – difficult to reach by local transport and arduous even on foot. These days of *mobilization* began at sunrise and ended before sunset, ensuring that every compound in the area – sometimes located far apart – was reached.

At the next level of the hierarchy are the HEWs, who, through their constant presence at the doorsteps of potential 'draft dodgers' of the vaccination campaign, act to ensure that the latter appear at the *Health Centers*, which then report vaccination data to the Tigray Health Bureau.

All of my informants (whose names in the following interviews are pseudonyms) shared a common view. They linked a noticeable change in public awareness of the importance of immunization – and the widespread acceptance of vaccines – to roughly a decade ago, coinciding with the consolidation of HEW and WDA activities.

> Interview with Nigisti, HEW (06/10/15):
>
> "Today no one refuses vaccines for religious or traditional reasons. In the past, mothers were afraid of the needle and of injections because of religious beliefs – they thought the OPV [Oral Polio Vaccine] was a bad practice. They said, 'it makes me fall into *mugurae*' [*mugurae* refers to any involuntary movement of the body, a song, or a dance caused by an evil spirit]. Sometimes they believed that through the vaccine they were being injected with *buda* [the evil eye]. But now this no longer happens – we are a modern country. Even if people sometimes don't understand or accept things quickly, if you keep persuading them, eventually they believe!".

In Mekelle, the term *vaccine* often becomes synonymous with the polio vaccine, as since 1988, when all WHO member states committed to eradicating poliomyelitis, numerous mass vaccination campaigns have been launched for the administration of OPV. Since the beginning of the initiative, reported polio cases have decreased by more than 99%, from an estimated 350,000 cases in 1988 to 1,285 cases in 2007 [6].

Before the introduction of the HEWs, non-compliance with vaccination was mainly linked to the local explanatory model of *injection*, in which the connection between vaccination and prevention was not yet embedded in community practices or worldviews. It also reflected a tension between the local etiology of *almsi* and its biomedical correlate, poliomyelitis.

In many rural and peri-urban areas around Mekelle, injections are still believed to aggravate illness or even cause death when a person is afflicted by *buda* (evil eye) or *ideseb* (a condition caused by envious individuals whose negative emotions can make others ill) [7].

Until a few years ago, treatment for *almsi* – attributed to the presence of a *zar* spirit – was carried out by mothers within the domestic sphere or by traditional healers. As one of them, Solomon (interview, 11/09/15), explained, the treatment involved food offerings to the spirit and tying a *kitab* (amulet) around the child's neck to prevent further attacks by the *zar*.

The *zar* complex in Ethiopia refers to a broad pantheon of possessing spirits [8, 9, 10, 11]. The *kitab*, moreover, reveals a striking linguistic and conceptual parallel with the Amharic word *kitabet* (vaccine). Both derive from the same root and are linked to protection and prevention. The *kitab* is a protective amulet prepared by healers who wrap local leaves, pieces of parchment inscribed with prayers or magical formulas from the *asmat* (a body of sacred literature invoking the true names of God), and the name of the wearer in a strip of leather. Among these protective texts are the healing scrolls, known in Amharic as *yä branna ketab* – literally "written on the skin".

The goal of eliminating cultural beliefs regarded as "backward" by health workers repeatedly emerges in conversations with HEWs. This stance also exposes the asymmetric relationship between the health network and community members, insofar as it positions biomedical knowledge as superior to local explanatory models. In this process, persuasion functions as a rhetorical, paternalistic, and coercive tool of awareness raising. The stated aims of health extension workers coincide with the directives established by the Health Extension Program (HEP) – notably, the improvement of health-seeking behavior – in order to produce healthy and, as Nigisti puts it, "modern" citizens. In Ethiopia, the rhetoric of modernity – across health, technology, and politics – has become both an aspiration and a moral code, a watchword and a promise of salvation.

HEWs explain the importance of immunization by appealing to the emotional sphere, aiming to induce a state of alert and anxiety. They often draw on memories of severe illnesses that afflicted a neighbor's child who had not been vaccinated, since ways of thinking about epidemics are anchored to iconic images of past plagues.

> Interview with Tsehai, HEW (21/09/15):
>
> "Today, no one refuses vaccines. If a woman does refuse, I show her a picture of a paralyzed child and say: 'If you don't vaccinate, your child will die!' If she still doesn't come to the Health Center, I go back to her house! Vaccination is not an obligation – it works by agreement! We return to homes again and again, we say: 'you must vaccinate your child!' again and again, until she is convinced – until she agrees".

Among the principal tools of persuasion is suggestion, which orients and conditions recipients' choices and behaviors.

> Interview with Abeba, HEW (03/11/15):
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> "We have to explain the danger of diseases. We do this by showing images of children with poliomyelitis and tuberculosis; we teach them that if they don't vaccinate their children, they will become like the ones in the picture. We provide health education, we have a schedule of visits, and we go house-to-house with these images".

Because major epidemics mark individual and collective memory, the photograph of a paralyzed child functions as a semiotic image: it triggers a double, concatenated effect – immediately recalling the specter of *almsi* (Tigrinya word for poliomyelitis, locally glossed as 'the disease that paralyzes children') and making the risk of non-immunization starkly visible.

Stored in personal and collective memory, the recollection of past pestilences – recalled through the concreteness of a deformed body – erupts into the present so forcefully that it becomes the key lens through which the vaccine is reconfigured as salvific. What further sustains adherence is the door-to-door method, an instrument to manage and expand consent. Entering domestic spaces – interrupting everyday life day after day – is part of a persuasive script that seeks to weave an aura of intimacy, proximity, and recognition, so that health promoters are seen not only as institutional agents but also as members of the community.

> Interview with Tamirat, HEW (06/11/15):
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> "I go into their homes and greet them! If there is a woman who has just given birth, I start with our traditional blessing: 'I am grateful that Saint Mary assisted you during your pregnancy'. If I go to a rural area, I dress like a farmer! Here women do not wear trousers, so I wear a dress! I approach them exactly as the rest of the community does. Then I ask: 'How are you? How are your children?'. At first, farmers respond harshly – they are not persuaded quickly. But I return the next day, and the next, and so on".

As this ethnographic testimony shows, empathy emerges as one of the ethical principles expected to guide HEW conduct, grounded in practices of proximity and culturally attuned interaction.

Gossip – whether real or presumed – remains a form of social control, an indirect power, and a deterrent against vaccine non-compliance, driven by the fear of negative repercussions on one's reputation within the community. This tactic leverages *yiluññta* (Amharic), a capacious emotional repertoire centered on shame triggered by actual or anticipated negative judgment from others. In Tigray, the equivalent term is *sikfta* [12]. In Mekelle's society this is a constant fear of compromising one's public image: *yiluññta* is "like a mosquito" whining softly in the ear; it is a reminder that others are watching and judging you [13, p. 660].

Illustrative here is the story of Hiwot, a young mother encountered during a BCG vaccination session in a rural area while I accompanied health staff transporting the vaccine in a small cooler. BCG – an anti-tuberculosis vaccine included among the basic antigens – can only be administered on specific days because, unlike other immunogens, it is not a single-dose vaccine: each vial provides twenty intradermal doses and, once reconstituted, should be discarded within six hours.

> Interview with Hiwot (06/01/16):
>
> "Why do you ask me about vaccines? I think they are a good thing; otherwise HEWs would not walk so far to come to my house and tell me to vaccinate my children. They were vaccinated at birth and I thought that was enough… but after a while the HEWs began coming to my door to tell me about new vaccines. They came more and more often, and when they didn't find me at home, they spoke to my neighbors. I had no time to take my children to the Health Center. I am a widow, with a livestock enclosure and animals to look after. At some point they stopped coming – and my neighbors stopped talking to me. One morning I noticed a zebu had escaped my pen and fallen into a ravine. I asked all my neighbors for help to pull it up, but no one seemed to listen. I cried because the animal was hurt – and here a zebu costs a lot of money. Then I saw a neighbor – my childhood friend – coming. I ran to her to show what had happened; she didn't even look at me, saying that if I wasn't a good mother, I couldn't be a good herder either! I asked why she would say that – my children had always been good and she knew it! She replied that the HEWs had told her I hadn't brought my children to be

> vaccinated and that I would make everyone sick: the children, the animals, and all my neighbors' children! That is why I am here today. I am a good mother, and my community must know it; my children can play with the others again – they will no longer be dangerous; they will be normal with the vaccine. I can trust them, and they must trust me".

A common influence technique is to instill within the neighborhood the idea that a mother who avoids vaccinating her child is not a good parent. To avoid gossip and guilt, recalcitrant parents often yield to pressure and conform to the prevailing rule.

As these interview excerpts suggest, women often comply with vaccination more in response to community expectations than out of personal critical conviction. Hiwot's words also clarify a now widespread local conception: while the unvaccinated body might appear "natural" or "normal", among many of my interlocutors it is instead the vaccinated body – into which a modified pathogen has been introduced – that is considered unaltered, incorrupt, or incorruptible. The unvaccinated child is simultaneously exposed to disease and a potential threat to others – a contaminating and contaminable body.

HEW oversight unfolds through two modalities of control: (1) centralized, formal control from above, and (2) informal, reciprocal control at the community level. The first involves ongoing institutional supervision of HEW performance by the relevant Health Centers; in parallel, health professionals monitor the activities of the WDA, who – as noted – collect information on candidates for the vaccination draft. Formal control also relies on codified instruments such as the vaccination booklet, which records household data – number of children under five and vaccines received. This document functions as a tool that serves both surveillance and accountability: beyond preventing anyone from slipping through the lists of vaccine candidates, it also attests to the HEW's work. By writing the date when women should present their children for vaccination, the health promoter also proves her presence in each household, as explained by Genet, a HEW.

> Interview with Genet, HEW (06/10/15):
>
> "I write the date of vaccination so mothers can remember it – and how would the Health Center know I came to this house if I don't write anything or leave them this slip? When they go there, they have to show it!".

Informal control, by contrast, is enacted at the neighborhood level through a kind of grassroots surveillance in which community members report to HEWs or WDAs those who have missed vaccination – most often due to forgetfulness rather than resistance. In this way, HEW intervention forms part of a broader logic of capillary control: vaccination is perceived as a social norm, and non-adherence as a transgression that undermines the well-being and public health of the community as a whole. Health professionals frequently stress the need for coordination across territorial levels to ensure adherence, as noted by Mahari, a Health Center coordinator:

> "The *balemegezati* must be tracked down by the WDA and the community so that the HEWs can report them to us and bring them here". (22/11/15)

In Amharic, *balemegezati* (defaulter, delinquent) – applied to those who evade vaccination – carries a moral judgment, signaling a failure to meet the moral obligation of the vaccination social contract. Through community responsibility at multiple levels and organized initiatives of outreach and propaganda, these practices have fostered a sphere of influence – a dominant network of pro-vaccine supporters within the community.

4. Dialectics of Power, Consent, and Conflict

In the field of vaccination, relationships of power and authority intertwine between the state, systems of expertise, and citizens [14]. Health workers deployed by the state were tasked with achieving the former Millennium Development Goals (MDGs) and, later, the Sustainable Development Goals (SDGs). Their work was therefore also part of a broader process aimed at making the country more attractive to foreign donors and investors. In this sense, the concept of the state at the service of the individual in good health replaces the concept of the individual in good health at the service of the state [15, p. 41].

The goal of improving vaccination coverage thus appears closely linked to the exercise of medical authority and control. This can be measured by reflecting on the sphere of rights and freedoms expressed through the notion of *informed consent*. According to my interlocutors, the antigen protects not only against exanthematous diseases such as *deramal* (measles) and acute conditions like *almsi* (poliomyelitis), but also against *eneweshin*, a broad nosological category of spiritual illnesses that affect children and are attributed to supernatural causes.

Although the dissemination of vaccination information formally falls within the duties of the HEWs, most of the mothers I interviewed during routine immunization days demonstrated no real knowledge of vaccines. Even though the statute regulating HEW organization encourages the promotion of informed consent – as several health workers told me in principle – my field research revealed that almost all the mothers interviewed were unaware of the vaccine names, the diseases they prevent, and possible side effects.

Information provided to parents is rarely explained in greater detail within public schools, where vaccinations are often carried out during extraordinary campaigns, such as the meningitis A campaign I observed during fieldwork. The parents' lack of knowledge is further compounded by that of teachers, as illustrated in the following interview with Semret, a primary school teacher.

> Interview with Semret (Teacher, Lem Lem Da'ero School, 30/10/15):
>
> "Usually, the doctors come to this school once a year to give vaccinations. Last year they didn't come – maybe because there were no diseases. They never tell us which vaccine it is or for what illness; they just come and tell us there's a vaccination, and ask us to gather the children. This time I know what it is – it's the meningitis vaccine; they're giving it everywhere in the city! Maybe because there's so much sun and, with the heat and the drought, the disease appears… Parents are usually not informed that a vaccine will be given at school; they don't have to give their consent. When they do know, they never

> ask anything – the responsibility lies with the doctors! In fact, yesterday one child was vaccinated twice, once at the Health Center and again at school, because the parents didn't know the doctors would come here to vaccinate everyone".

Asserting that responsibility and competence belong exclusively to doctors and HEWs confirms the assumption that only health professionals can know and decide what is best for patients. The doctor-parent relationship thus materializes as the ratification of the former's authority and the alienation and disempowerment of the latter, often deprived of the possibility of expressing critical thought.

Through observation and dialogue with those involved in the immunization process, it became clear that decisions about vaccination are unilateral, directed entirely by health promoters and professionals in pursuit of political consensus. Yet, given that complete reliance on biomedical therapeutics has been directly proportional to Ethiopia's successful vaccination coverage, certain questions arise – about the actual need or desire for informed consent among communities, and about the very relevance of reflecting on freedom of choice as self-determination independent of external influence.

Perhaps it is within a nascent form of dissent toward immunization, now emerging among young urban students, that an answer may be found, as Aberash, a 22-year-old student at Mekelle University, explained during our conversation.

> Interview with Aberash (11/12/15):
>
> "For some time I've been asking myself questions about vaccines. These weeks they're vaccinating against meningitis – on the radio, on TV, everywhere they tell us to get vaccinated, but they don't tell us anything else. For example, why do they vaccinate only people up to 29 years old? Online I read that vaccines can be harmful in some cases – so why don't the government and the doctors explain it? Maybe there are interests behind it that they don't want to tell us about… Think of the tetanus vaccine: I never received it at school or university, while girls did. I thought it might be a contraceptive method injected into young women without their knowledge to achieve the Millennium Development Goals, to control births. I thought of not getting vaccinated, but my neighbor is a WDA member, and I couldn't refuse".

Consent toward vaccination in Mekelle is therefore not a fixed or homogeneous phenomenon, especially if we consider how, in Aberash's account, uncertainty, fragmented information, and mistrust shape young people's reflections on vaccines. This emerging landscape of doubts – fueled less by structured opposition than by informational gaps – helps explain why forms of hesitation are beginning to surface. This should not surprise us, particularly in light of the broader international debates on vaccination skepticism, including the radicalization of dissent documented in Europe and in Italy [16, 17]. Although the HEWs' immunization strategy has so far achieved more than 95 percent coverage in Mekelle, the increasing lack of transparency and the opaque political maneuvers that blur both ends and means have become key reference points around which young people are polarizing and uniting symbolically.

Young students like Aberash – thanks also to new communication technologies – have begun to articulate forms of resistance against the perceived annihilation of their autonomy and the fear of being manipulated by power. It is for this reason that the ambivalences and tensions simmering within society, and the complex relationship between state and citizens, between information and freedom of choice, cannot be ignored. Decision-making processes must be understood as political processes, situated within specific configurations of power, historical-social contexts, and cultural traditions [18].

5. Conclusions

Throughout the article, I refer to certain military metaphors used by health workers themselves – terms such as *campaign*, *draft*, or *mobilization* – which circulate widely in local discourse about immunization and shape how vaccination practices are imagined, organized, and enforced. These metaphors find legitimacy not only in the fact that vaccination programs can be regarded as among the most powerful weapons in the political arsenal of public health, but also in the very essence of the immunization strategy implemented by HEWs – as an expression of control and population management aimed at eradicating predictable and preventable diseases. The work of HEWs and WDAs thus takes on a performative dimension, in which the act of speaking – the use of metaphor, analogy, and comparison – becomes a linguistic and persuasive instrument through which action is realized: the inoculation of the attenuated pathogen. Through these networks, biomedical knowledge becomes operational through its performative use, not primarily as a means of diffusing knowledge, but as a way of inducing interlocutors to adhere to the vaccination.

The image of a child crippled by disease, shown to the parents of those enlisted in the *vaccination draft*, constitutes a crucial element in the mediatization of the immunogen. It not only displays, with striking clarity, the threat of what would be faced by violating the social contract of vaccination, but also gives a face – a dramatic concreteness – to parental fears, while simultaneously reaffirming a promise of salvation for their child, achievable through the “gift” of the protective substance. The parables of epidemics such as poliomyelitis are fixed in print to be remembered, reinforcing the fear of their resurgence. Yet, while each epidemic within scientific discourse becomes an opportunity for advancing biomedical knowledge, such knowledge must also contend with the ripple effects these events have across the local world.

Systematic biomedical practice, through herd immunity, produces a redefinition of norms and social order, and establishes a selective distinction between the body normalized by inoculation and the body of the unvaccinated. Vaccination thus assumes the character of an initiation ritual, in which the introduction of the substance strips the individual of their dangerous potential toward others – paradoxically becoming “natural” once rendered artificial by the reforming matter. The “other” becomes the unvaccinated person – an obstacle and a threat to social coexistence, and therefore alien to the communal order.

The application of a standardized and universal immunization program, while ensuring high coverage, seems to conceal the latent link between adherence and surveillance. The individual body thus appears to become a function of biopolitical planning, a moment in which the transformation of the collective body takes on the physiognomy of an administrative act. Within the issue of mass immunity, relations of power between states, networks, and communities remain central, as does the unidirectionality of the doctor-patient relationship.

At the same time, the threat of epidemic disease remains imminent – especially in the African context, where inequalities shape the very definitions and trajectories of life, illness, and death, and every outbreak of tuberculosis or meningitis reaffirms the importance of vaccines.

However, if on the continent the state of epidemic emergency – continually claiming lives – has become an almost constant dynamic that calls for swift interventions, this does not justify the underlying assumption that, in order to vaccinate the body, one must inevitably immunize critique.

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Perspectives on Urban Bioethics: A Preliminary Overview

by Marco Menon*

Abstract
This paper offers a preliminary philosophical introduction to the concept of urban bioethics, tracing its origins, theoretical developments, and interdisciplinary implications. The analysis does not aim at exhaustiveness but serves as a conceptual groundwork for a broader and future study. Focusing on urban bioethics as a theoretical perspective rather than an applied discipline, the paper examines how the term "urban" reconfigures the scope and structure of bioethical inquiry, suggesting a transformation rather than a mere specification of general bioethics. The discussion is articulated in three sections: the first presents the initial formulation of urban bioethics in the United States, developed mainly through two New York conferences; the second explores its politicized reinterpretation by South American scholars; and the third highlights recent perspectives emerging from a European-Asian dialogue initiated at a Croatian conference. The conclusion synthesizes the transversal themes identified and outlines the key philosophical and interdisciplinary questions that remain open for future research within this emerging field.

Keywords
Urban Bioethics, Bioethics, Ethics, Urban Health, Built Environment.

1. Introduction

At the turn of the 1990s and 2000s, the concept of "urban bioethics" emerged in the U.S. bioethical debate. The principal motivation behind this initiative was the intent to engage with bioethical issues specifically pertaining to the urban environment. Of particular concern were the profound social and economic disparities among different segments of the urban population, and the pivotal role these underlying conditions play in shaping individual health outcomes. At first glance, urban bioethics might appear to be a sub-discipline of bioethics; however, the history of its origins and subsequent development in Latin America and Europe suggests that the matter is far more complex.

The aim of this paper is to provide a preliminary overview of this emergence and evolution from a philosophical perspective. The characterization of this reconstruction as preliminary is due to two reasons, which also explain the absence of any claim to exhaustiveness.

First, the present reflection serves as a prelude to a broader and more comprehensive study that will, as will become evident, be necessarily inter-

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disciplinary in nature. Second, given the specific character of the philosophical approach adopted here, the focus will be directed exclusively toward the elaboration of urban bioethics as a theoretical field or perspective. Accordingly, based on a review of the existing literature, priority will be given to contributions that explicitly address the possibility and necessity of an urban bioethics. The central concern, in fact, is to understand how the distinction between a "general" bioethics and a bioethics qualified by the adjective "urban" has been justified; how the addition of this adjective may imply a structural transformation of bioethics rather than a mere specification; and in which directions such a transformation may guide future research. Consideration of more applied or specialized studies will therefore be confined to this latter aspect.

Regarding the methodological approach, this research does not employ a systematic or semi-systematic literature review; rather, it adopts a conceptual analysis. The aim is not to provide an exhaustive account of all existing literature on the subject, but to highlight the diversity of theoretical perspectives and conceptual frameworks developed to give urban bioethics a coherent structure and a certain degree of disciplinary and methodological autonomy. For this purpose, the following indications are considered sufficient. The search focused on occurrences of "urban bioethics" in the titles and abstracts of scientific publications. Master's theses and dissertations were excluded, though they may be considered in a future, more extensive study. In consulting the main databases (PubMed, Scopus, Google Scholar), no temporal or linguistic restrictions were applied. The results were then supplemented with bibliographical references found in the collected works, whenever these were deemed relevant to the aims of the study.

The reconstruction will be presented in three sections, followed by a conclusion. The first section outlines the initial theoretical formulation of the concept of urban bioethics, which originated in the United States, specifically through two conferences held in New York. The second section explores the development of this concept by South American scholars, who interpret urban bioethics in a distinctly political sense. The third section examines the research perspectives that have emerged from scholarly dialogue between European and Asian researchers, stemming from a conference held in Croatia. The concluding section will summarize the overarching themes of urban bioethics and identify the theoretical questions that remain open, both from a philosophical standpoint and within the framework of interdisciplinary dialogue.

2. Bioethics and The City

The earliest known reference to "urban bioethics" appears in a *Foreword* written by Elizabeth B. Cooper and Benjamin C. Zipursky [1] for a special issue of the «Fordham Urban Law Journal» published in 1997. The volume brings together the papers presented at the conference *Urban Bioethics: A Symposium on Health Care, Poverty, and Autonomy*, held in February of the same year at the Fordham University School of Law. The event was structured around three panels corresponding to major areas of inquiry – "allocation of resources, mandatory HIV testing, and physician-assisted suicide" [1, p. 664]. These topics were thus united under the heading of "urban bioethics", described as "an attempt to merge […] different fields: bioethics and healthcare policy, on the one hand, and the critical study of the legal rights of urban and disadvantaged populations, on the other" [1, p. 663].

This definition already conveys an awareness that the urban dimension possesses distinctive features which, although overlapping with areas explored by other disciplines, nonetheless warrant specific and interdisciplinary attention. In particular, the authors note that it is striking how the contributions "recognize that these issues are especially difficult framed within this context of widespread poverty, a difficulty that is only amplified by the enormous diversity of race, gender, class, age, and disability within urban communities" [1, p. 664]. Two characteristics, therefore, appear to distinguish the urban context from others: poverty – and, consequently, the extreme vulnerability of socially marginalized populations – and the profound diversity that fragments urban populations. Although the papers collected in the journal issue focus primarily on the topics mentioned above and do not further elaborate on the concept of urban bioethics, several defining features nonetheless emerge from the *Foreword* with sufficient clarity.

However, it was an article published in 2000 by V. Ruth Cecire, Jeffrey Bulstein, and Alan R. Fleischman [2] that first introduced the concept of urban bioethics and outlined it systematically, explicitly contrasting it with traditional bioethics. According to the authors, traditional bioethics has been guilty of neglecting the urban context and the specific forms that bioethical issues assume within it. This neglect is not merely a matter of content – of addressing previously overlooked issues – but also of method: the urban environment demands that its problems be approached through a distinctive methodology. Consequently, urban bioethics cannot be understood as a simple extension of classical bioethics to questions beyond the clinical and laboratory domains. Three salient features, the authors note, distinguish the urban environment: "the magnitude of extant poverty; the multiplicity, urgency, and severity of related social problems; and the uneasy coexistence of citizens and immigrants across a wide economic and cultural spectrum" [2, p. 1]. The nature of these problems compels a reconsideration of the very philosophical and moral foundations of classical bioethics, traditionally rooted in liberal individualism – a critique that will recur throughout the broader debate on urban bioethics.

The authors therefore identify three tensions that characterize the urban condition: these oppose "the desire to be responsive to urban pluralism and the need for moral cohesion", "the practices of democratic politics and the often conflicting demands of justice and equity", and, finally, "the coercive potential of public health mandates and individual autonomy prerogatives" [2, p. 5]. In the first case, the role of urban bioethics is to mediate among diverse value claims, determining in each instance the extent of moral diversity a society can sustain while avoiding the twin dangers of oppression and anarchy. In the second, its task is to analyze issues of resource distribution, particularly in cities historically marked by immigration and the presence of vulnerable populations. In the third, urban bioethics is charged with assessing public health measures that restrict individual freedom for the sake of the collective good. This final tension is especially acute at a structural level, precisely because in Western societies – and particularly in the American context – moral life is shaped by the primacy of individual liberty. It is within this framework that the principle of autonomy, otherwise central to classical bioethics, must be carefully qualified in light of the common good. The urban environment, by virtue of its density, is precisely where such public health dilemmas become most visible.

Cecire, Blustein, and Fleischman conclude their article by outlining the salient features of several major ethical frameworks, assessing the limitations and potential of each in relation to the concerns of urban bioethics. Among the frameworks analyzed – namely social contract theory, deliberative democracy, utilitarianism, communitarianism, and feminism – it is particularly the second and the last that most closely align with the aims of urban bioethics, although the authors refrain from assigning clear primacy to any single approach. The contribution of deliberative democracy lies in its capacity to offer a means of managing disagreement that both values diversity and enhances the legitimacy of the collective deliberations reached by the community. Conversely, the feminist framework makes it possible to articulate aspects of urban life such as vulnerability and interconnectedness through its relational perspective, which sets it apart from the individualism characteristic of classical bioethics.

The themes discussed by Cecire, Blustein, and Fleischman were further developed in a special issue of the «Journal of Urban Health», which gathered the papers presented at a national conference held in December 1999 at the Center for Urban Bioethics, established the previous year by the New York Academy of Medicine. The introductory article to the issue, *Bioethics in the Urban Context*, authored by Alan R. Fleischman, Betti Wolder Levin, and Sharon Abele Meekin [3], begins by identifying density and diversity as the defining features that distinguish the urban environment from the rural one – an aspect that, according to the authors, gives rise to an "interplay of extremes" in the coexistence of poverty and affluence within the same cities. This disparity affects not only the health of different social groups but also that of the population as a whole. It exemplifies one of the many socioeconomic dimensions neglected by traditional bioethics, which has often been criticized for its predominant focus on individual rights at the expense of the broader urban context. The specificity of urban life, by contrast, calls for close attention to the interactions and tensions among social groups and to the ways in which cultural, racial, and socioeconomic factors shape the health of individuals and communities alike.

Of the eight articles that follow, three focus explicitly on the concept of urban bioethics and on the type of theoretical framework within which it should be situated and further developed. Jeffrey Blustein's *Setting the Agenda for Urban Bioethics* [4] seeks to establish the terms of discussion for urban bioethics and to clarify in detail what constitutes its distinctiveness, given that the mere addition of the adjective "urban" does not, as in other comparable cases, immediately imply a theoretical critique of "classical" bioethics. Blustein contends that, on the contrary, urban bioethics entails a profound critique and transformation of traditional bioethics. In this respect, his comparison with feminist bioethics proves particularly illuminating: the aim is not merely to address previously neglected issues, but to fundamentally reshape the "philosophical and conceptual framework" underlying bioethics – beginning from the concrete realities of urban life.

Let us briefly revisit Blustein's proposal, which largely refines and expands upon themes introduced in the 2000 article co-authored with Cecire and Fleischman, demonstrating how attention to specific problems of the urban condition entails, as noted, a transformation of bioethics itself. First, Blustein emphasizes that classical bioethics has focused almost exclusively on the right to medical care, neglecting the socioeconomic determinants of health. These determinants, however, account for the profound disparities in health status among different communities. Bioethics must therefore address them directly, abandoning the assumption that the sociopolitical dimension of health falls solely within the domain of other social sciences. Second, bioethics is called upon to develop the philosophical and moral foundations of public health, freeing itself from the dominance of the liberal model centered on individual decision-making, which has consequently reduced the moral dimension to patient autonomy. Third, the extreme abstraction of the physician–patient relationship must be replaced by attention to its concrete conditions. In the urban context, this relationship is particularly affected by the transience of social bonds, which structurally impedes the formation of durable relationships of trust between doctor and patient. The fragmentary and often poverty-stricken character of urban social relations thus undermines the therapeutic alliance. Urban bioethics, in this respect, must evolve to assess the salient features of urban life in practical terms and formulate corresponding proposals. Fourth, the profound cultural diversity of the urban environment requires, as previously noted, that bioethics relinquish the falsely neutral character of its principles and actively engage with a multicultural context aimed at fostering strategies of mediation. This entails balancing respect for the individual with respect for their community of belonging, avoiding both the imposition of a typically Western-American individualistic-liberal model and the subsumption of individual claims within a preconceived cultural identity.

In response to this final challenge, Blustein draws on an earlier insight, invoking the resources of deliberative democracy as an alternative to the "monologue" of traditional bioethics. To this, however, he adds another dimension, again drawing a parallel with feminist thought: the transformation of bioethical inquiry into a genuinely dialogical practice. This approach avoids the mere application of universal principles to particular cases without sufficient attention to the radical plurality of urban realities that bioethics must inevitably confront. A truly dialogical approach requires openness to "previously unseen perspectives" and calls for the cultivation of "virtues as responsibility, self-discipline, sensitivity, respect, and trust" [4, p. 19].

Albert R. Jonsen's *Social Responsibilities of Bioethics* [5] similarly critiques the overly narrow scope of traditional bioethics, explicitly calling for its integration into the broader domain of genuine social ethics and urging it to move beyond the confines of the clinical and individual moral universe. Jonsen traces the development of traditional bioethics, highlighting its neglect of the urban context and advocating for the formalization of urban bioethics within an ethical framework grounded in social responsibility. This integration forms the core of his proposal, which is more explicitly theoretical than Blustein's, who, as noted, addressed several specific applied domains of a transformed bioethics. Jonsen, by contrast, proposes a philosophical and moral framework capable of addressing the specificity of urban bioethical problems, grounding it in the notion of responsibility as developed by the theologian H. Richard Niebuhr. For Niebuhr, "the idea of responsibility was the most fundamental ethical notion"; he conceived of responsibility as the key to understanding human action as a response to an act that the agent, in turn, perceives as a call for a reply. Human action thus forms a web of reciprocal responsiveness, within which each person's moral task – or vocation – is to sustain this responsive community. Commenting on this conception, Jonsen observes that "Persons who live in great cities are perpetual responders" [5, p. 27].

Responsiveness is therefore identified as the criterion of good action, insofar as it corresponds to conduct that perpetuates and nurtures responsiveness itself. As Jonsen notes, "Many moral problems of urban life arise from stifling of responsiveness" [5, p. 27]. This principle, while universal, aligns closely with the realities of urban life and proves highly relevant to the issues that define urban bioethics. A final, decisive aspect concerns the nature of the responsive community represented by the city, which is, in fact, a community of strangers. Herein lies the central challenge: sustaining and maintaining the "responsivity among strangers" [5, p. 28]. In attempting to connect the proposals of Blustein and Jonsen, one can observe that Niebuhr's ethical principle of responsibility or responsiveness provides the foundation for the dialogical practice advocated by Blustein, while simultaneously offering a coherent framework within which to situate the various urban issues he examines.

Partly diverging from the theoretical proposals of Blustein and Jonsen, Bruce Jennings's *From the Urban to the Civic: The Moral Possibilities of the City* [6] offers a political reformulation of urban bioethics, proposing instead the term "civic bioethics". This divergence, however, represents a deepening rather than a rupture. For Jennings, an urban bioethics conceived merely as the application of classical bioethical categories to urban issues is neither sufficiently innovative nor genuinely radical. Such an approach would fall short of the rethinking already called for by other scholars – one that, in Jennings's view, must take a distinctly political direction. Jennings grounds his proposal for a civic bioethics in the classical distinction between *urbs* and *civitas*. The *urbs* traditionally denotes a space of commercial and economic exchange, whereas the *civitas* refers to the political and moral community formed by citizens living together in pursuit of the good life. By contrasting these two poles of classical political thought, Jennings effectively compares two moral universes: that of liberalism, which reduces the city to a site of exchange and transaction, a means for the satisfaction of individual interests; and that of democratic republicanism, which conceives the city as the fullest expression of human moral realization – the locus of the common good and the good life.

Building on this fundamental distinction, Jennings explicitly critiques bioethics – and urban bioethics in particular – for remaining, even at the level of terminology, within the individualistic moral universe of liberalism. He instead proposes grounding civic bioethics in a theoretical framework informed by democratic and communitarian values. Within the liberal moral universe, primacy is given to the characteristics that distinguish individuals from one another – that is, to personal interests and capacities, which are realized through economic exchanges and transactions. Self-affirmation, in other words, occurs by means of social relations. By contrast, in the democratic moral universe – within which civic bioethics must be conceived – priority is given to what individuals share in common, to the features that unite them. Individuals realize themselves within civic life, the only sphere in which they can achieve a full experience of humanity.

Jennings places particular emphasis on the notion of transformational agency, a theoretical move that renders the adoption of the conceptual tools of deliberative democracy, as proposed by Blustein, not merely a methodological choice but a new philosophical foundation for bioethics. This becomes especially evident when Jennings justifies his position in light of the moral demands of public health in the urban context. In such circumstances, responding through the categories of classical (liberal) bioethics – framed around the individual – proves insufficient; instead, it is necessary to mobilize conceptual resources capable of articulating the common good. The latter, in turn, would remain a purely abstract notion were it not embodied within a public and institutional space. In other words, no form of bioethics can adequately address the moral challenges of the city if the city is conceived and reproduced merely as *urbs* rather than understood and lived as *civitas*. One of Jennings's concluding statements captures this idea with remarkable clarity: "Urban bioethics as I urge us to construe it, is about the justice of economic redistribution; it is about political deliberation concerning the ends of life and the nature of human flourishing, including health and well-being; it is about active, participatory citizenship that is a practice of civic responsibility as much as it is a stronghold of protective rights" [6, p. 102].

As a concluding act of the "North American moment" in urban bioethics, consider the 2004 article by Blustein and Fleischman, *Urban Bioethics: Adapting Bioethics to the Urban Context* [7]. While this contribution primarily serves to weave together the threads of earlier discussions, offering a synthesis of the various challenges to which urban bioethics is called to respond, it also introduces reflections that had previously remained more implicit. First, the authors expand the scope of urban bioethics to encompass environmental issues – specifically, the assessment of the consequences of urban development. In this context, the built environment and its impact on the health of urban populations assume central importance. They also more clearly identify the key characteristics of the urban environment itself. Although, as they note, no two cities are alike, all share features that distinguish them from suburban or rural settings, and these features shape the particular bioethical problems that arise in urban contexts. These defining features are density, diversity, and disparity.

With respect to these three dimensions, Blustein and Fleischman largely reiterate positions articulated in their earlier works, maintaining that bioethics must adapt to the challenges emerging from urban realities and transform itself accordingly – though without emphasizing, as Jennings does, the deeply political implications of such a transformation. In this sense, it may be said that in offering a definition of urban bioethics that would become both influential and frequently cited in subsequent years [17, 45] – "Urban bioethics situates bioethical concerns in the urban context, adding a new dimension to the discipline of bioethics as traditionally conceived and practiced" [7, p. 1202] – they firmly situate it within the larger domain of ethics, albeit a public and urban ethics, while simultaneously "neutralizing" its more radical implications. Indeed, it was against this form of disciplinary delimitation that Latin American scholars in the following decade would argue, further radicalizing Jennings's position and situating urban bioethics within a theoretical framework that integrates biopolitics and decoloniality.

3. *Bioética Urbana* from the Global South

The first contribution to introduce the concept of urban bioethics in the Latin American context is the 2012 article by the Brazilian scholar Erick Luiz Araujo de Assumpção, *Por uma bioética urbana. Reflexões sobre o desalojo da comunidade/bairro Pinheirinho* [9]. Although much of the article focuses on a specific case study, which cannot be examined in detail here, the theoretical framework it develops contains all the elements of a programmatic statement – making explicit the theoretical premises virtually implied in a previous article co-authored with Fermin Roland Schramm [8]. At a preliminary level, it is important to briefly outline the Brazilian bioethical debate, within which two main currents can be distinguished: the bioethics of protection and the bioethics of intervention. The former constructs the State as an agent of protection for susceptible or vulnerable populations; the latter addresses situations of conflict related to bioethical issues in contexts of poverty and exclusion, seeking more adequate responses [16]. Both, according to Araujo, "are founded on the claim for a legitimate State [...] as a defender of the interests of the most disadvantaged populations" [9, p. 42, my translation]. Araujo contests this premise. He does not view the State as a legitimate defender of vulnerable populations, but rather as an "agent of vulneration" that inflicts nearly irreparable harm upon susceptible groups in the name of protecting private property and capital. From the outset, his version of urban bioethics is thus situated within urban conflicts between local communities and the State. In such a context, the categories elaborated by traditional Anglo-Saxon bioethics – whose limitations have already been noted – prove largely inadequate. Moreover, given Brazil's cultural, social, economic, and political reality, the individualistic categories of Anglo-Saxon bioethics and their claim to universality reveal an irreducibly colonial character. The limitation, therefore, is structural.

Araujo's theoretical move – only sketched here but later developed with greater force – consists in reclaiming the original idea of bioethics introduced by Van Rensselaer Potter in his pioneering work, which was soon set aside in favor of narrower biomedical concerns. Potter's project conceived bioethics as a "science of survival" – an approach that Araujo reformulates in urban terms, making urban bioethics the field devoted to studying urban conflicts that threaten the survival of specific communities and vulnerable collective forms of life. The crucial difference from North American urban bioethics lies in Araujo's view of the State as the principal agent of vulneration, whose interventions often entail the active weakening or destruction of collective forms of life (the case study presented by Araujo provides an emblematic example of this phenomenon). In this context, any appeal to the protective role of the State proves futile. The authentic vocation of urban bioethics, he writes, is "to become an instrument at the service of legitimate urban resistance movements. This challenge takes shape as the search for possibilities of action beyond the State and the market". Urban bioethics, Araujo continues, "must be used within social movements to clarify conflicts and to contribute to a broader recognition of the legitimacy of their struggles" [9, 10, p. 50, my translation].

A second programmatic contribution from Latin America was published in 2014 by the Argentine scholars Laura Sarmiento and Diego Fonti, entitled *Bioética urbana: desafíos de un campo emergente* [10]. Their approach shares several points of contact with that of Araujo, whose main theses they develop primarily from a theoretical standpoint, resulting in a higher level of abstraction. Sarmiento and Fonti begin by noting that the holistic character of Potter's original bioethical project was not preserved in the subsequent development of Anglo-Saxon bioethics. Once again, the narrowness of its scope (limited to biomedical and research contexts) and its moral-philosophical framework (guided by liberal individualism) are criticized. Such a form of bioethics proves inadequate when confronted with the urban dimension of life and the multiplicity of collective subjectivities that inhabit and shape it. The innovation introduced by Sarmiento and Fonti lies in the pronounced Foucauldian turn they give to the conceptual structuring of urban bioethics – a dimension that was implicit in Araujo's work but is here explicitly articulated. The crucial insight derived from Michel Foucault reveals how public health policies and urban planning function as forms of population control, organizing collective life through disciplinary dispositifs that regulate ways of living. In this sense, urban bioethics is constructed as a kind of graft onto the theoretical trunk of biopolitics, functioning as a specific development of it. Its vocation, once again, is to articulate the claims and perspectives of the plural and collective subjectivities that constitute urban life. As the authors write, "An Urban Bioethics that is aware of the interests and power relations implicit in various forms of intervention, while remaining attentive to the claims and subjectivities affected by them, will enable bioethics to broaden its scope of action – by developing a shared platform for discussion, a framework for analyzing the legitimacy of claims, and a model of debate appropriate to an era of moral pluralism" [10, p. 112, my translation].

The dimension of urban bioethics is therefore both public and local, responding to the concrete issues that affect the material conditions of reproduction and survival of specific subjectivities in urban environments. Sarmiento and Fonti focus particularly on the effects of the dominant capitalist-extractivist model of development, which commodifies space and privatizes common areas, producing a forced homogenization that erases the plurality of life forms previously inhabiting those spaces and thereby generating impoverishment and marginalization. Urban bioethics, they argue, should give voice to the forms of resistance that persist in opposition to the extractive logic of capitalism, valuing them as collective forms of subjectivity. For this reason, it is necessary to rethink classical principles, moving beyond individualism and adapting them to the plural realities of urban life. The authors conclude by proposing four action-oriented concepts that should characterize Latin American urban bioethics: autonomy, legitimacy, justice, and creative resistance.

In 2015, Araujo published a brief yet conceptually rich article of great relevance to the present discussion. In *Fragments of Urban Bioethics: An Essay on Power and Asymmetry* [11], the Brazilian scholar explicitly returns to Potter's thought, systematically expanding what, in his 2012 article, had been only a preliminary and embryonic appropriation. He begins by observing that urbanization has become a planetary phenomenon and that urban transformations now affect and reshape human existence in all its dimensions – both material and immaterial. These processes are marked by a clear asymmetry of power between those who make decisions and those who suffer their often adverse consequences. From this asymmetry arise conflicts that cannot be contained within the narrow scope defined by traditional Anglo-American bioethics. Araujo seeks to expand both the concepts of ethics and health, drawing on the foundational threads of Potter's original bioethical vision, in which the need to develop an urban bioethics was already implicitly anticipated, even if not explicitly named. Referring to one of the earliest North American definitions of the field – specifically, that of Jonsen [5] – Araujo explains that the adjective *urban* is not intended to delineate a new subfield, but rather to "create an intrusion" [11, p. 99] that transforms the entire bioethical framework. Here, the first key Potterian concept reappears: bioethics as a bridge. Yet in this case, the bridge is not between disciplines, but between different forms of existence, their practices, and their knowledges. These forms of life themselves become the subjects of survival – survival being, in Potter's view, the ultimate concern of bioethics as a "science".

Thus, the domain of bioethics is simultaneously expanded and redefined: it no longer concerns only the clinic or the laboratory, but urban environments; it no longer pertains solely to health, but to urban forms of life and their entire material and immaterial worlds. At this point, Araujo introduces a second essential Potterian notion – that of wisdom, understood as the capacity to make good use of knowledge. Within the context of urban bioethics, wisdom is directed toward the survival of plural collective forms of existence and toward their just and balanced coexistence. For this to be possible, the very forms of life endangered by knowledge must themselves participate in the decision-making process: the nature of wisdom in urban bioethics is thus collective, not individual or exclusionary. Whereas Sarmiento and Fonti drew on Potter primarily to highlight the limitations of North American bioethics – before rearticulating urban bioethics through the Foucauldian lens of biopolitics – Araujo performs a parallel theoretical operation, but one rooted firmly in Potter's conception of global bioethics. The latter is reinterpreted – or, one might say, applied – to the context of urban conflicts, in which the health and survival of multiple interdependent forms of life are at stake.

Since 2016, Sarmiento – this time as sole author – has returned to the topic with a substantial number of publications, including a doctoral dissertation [13, 14, 15, 16]. For reasons of space, it is not possible here to fully engage with her overall contribution to the debate; I will therefore focus on one work, selected for its elaboration of the theoretical framework of urban bioethics. From this perspective, *Bioética Urbana al cuidado de la vitalidad colectiva de los territorios* [12] is particularly significant, as the ideas previously outlined in her joint work with Fonti receive here a broader and more systematic formulation. Sarmiento's discussion begins with an analysis of the negative consequences of capitalism – specifically, the extractivist model of development – which fall with particular severity on already vulnerable populations. These groups lack the means to mitigate the environmental damage caused by pollution, unlike the dominant social classes. As a result, the quality of life of vulnerable populations deteriorates further, thereby widening the gap between social classes. Sarmiento conceptualizes these territories as "sacrifice zones", that is, places that extractivist capitalism accepts as degraded and "emptied out" in order to sustain its own model of development. The price paid by vulnerable populations is extremely high, for what is lost is not only territory but also the material and immaterial practices and values that emerge from it. In this sense, territories are stripped of their identity and flattened to conform to the homogenizing logic of global capitalism.

An intriguing consequence of the homogenization of territories brought about by capitalist development is the gradual blurring of the distinction between urban and non-urban areas. Sarmiento observes that this process gives rise to a hybrid formation, which she terms *rururbanidad* (rururbanity). This notion designates a new form of collective subjectivity that resists the extractivist model and emerges from the ongoing reconfiguration of "living territories" – dynamic spaces whose vitality cannot be reduced to the logic of homogenization and which, for that reason, pose a threat to capitalist development. The close interweaving of territoriality and the forms of life inhabiting it manifests as a process of co-determination, in which territory shapes life and life, in turn, shapes territory. Consequently, control over territory entails control over the bodies that inhabit it and, by extension, over the forms of life that emerge from it.

In Sarmiento's view, the connection between power and bioethics becomes almost self-evident, grounded in an integral conception of health – not merely as the absence of disease, but as a condition inseparable from the vitality of territories and their inhabitants. In this sense, her approach aligns with Potter's bioethics, as already observed in Araujo's contributions: the "science of survival" does not concern the human species alone, but encompasses the multiple forms of life and collective subjectivities that arise within the territories they inhabit. Since capitalism admits only one viable form of life – flattening or annihilating all others that exceed its preconfigured model – it constitutes a genuine threat to survival itself. Urban bioethics, in turn, assumes the role of a critical reflection on this global conflict, articulated through the irreducible multiplicity of its local instantiations. In the spirit of Potter's bioethics – of which Sarmiento's proposal can now be seen as a continuation – the definition of urban bioethics as a rigidly delimited discipline becomes problematic. If urban bioethics is to serve as a bridge between collective and plural subjectivities, their diverse and locally grounded forms of knowledge, the territories they inhabit, and the conflicts that traverse them, it cannot adequately meet these challenges by remaining confined within disciplinary boundaries – that is, by adhering to a self-contained and impermeable methodological framework. On the contrary, urban bioethics must constitute itself as a transdiscipline: it must open to dialogue among different forms of knowledge, cross disciplinary borders, engage in their mutual contamination, and thereby become a form of "open rationality". To echo the title of another of Sarmiento's works, urban bioethics thus becomes *una transdisciplina militante*, a militant transdisciplinarity [14].

To confirm their key role in shaping Latin American urban bioethics, Araujo and Sarmiento edited in 2020 a collective volume bringing together twelve essays by South American scholars, significantly titled *Bioética Urbana desde el Sur Global. Territorialidades bioéticas emergentes* [23], a title intended to highlight a crucial feature shared by the perspectives gathered therein. It is not possible here to fully engage with the complexity and richness of the contributions collected in this volume; we can only offer a few considerations aligned with the strategic purpose of the present discussion, which focuses on the construction of the theoretical framework of urban bioethics.

From this standpoint, the various authors in the volume appear to use the theoretical framework originally outlined by Araujo and Sarmiento as a platform from which to develop their respective arguments – whether more theoretical or more applied in nature. As noted, despite their differences, Araujo and Sarmiento share a significant convergence in situating urban bioethics within the broader context of Latin American bioethics, whose main currents (the bioethics of protection and the bioethics of intervention) have already been briefly outlined. Both radically politicize urban bioethics by placing it in direct continuity with biopolitics – especially Sarmiento, who has developed a distinctly Foucauldian version of urban bioethics. It is also noteworthy that Araujo and, later, Sarmiento sought to reconnect with an author who, although part of the Anglo-Saxon sphere, was never fully assimilated into the development of traditional bioethics: Potter and his "original" conception of bioethics, which later evolved into global bioethics precisely to distinguish itself from the broader Anglo-American movement. The two South American scholars, by creatively appropriating key elements of Potter's project and combining them with their distinctive biopolitical interpretation, offer the broader Latin American research community a dynamic and generative theoretical platform. Evidence of this can be seen in the character of the contributions included in the volume they edited. Although diverse – and at times animated by a certain centrifugal force – these contributions reveal a strong underlying theoretical coherence grounded in a shared set of assumptions.

The various authors share a particular concern for the plurality of subjectivities, which cannot be reduced to the categories of traditional Anglo-Saxon bioethical thought. They also exhibit a pronounced anti-capitalist stance, accompanied by a commitment to articulating social conflicts in favor of vulnerable populations, thereby positioning urban bioethics as a tool in the service of urban social justice. For all of them, the forms of resistance that emerge from below – however diverse in their expressions – are of paramount importance. This configuration of theoretical elements and political sensibilities renders the framework developed separately, yet in a spontaneously convergent manner, by Araujo and Sarmiento particularly fertile, both for the development of case studies [26, 27, 28, 30, 31, 32, 33] and for further theoretical expansion through dialogue with other schools of thought capable of contributing to the articulation of the complexities of urban life [24, 29, 34, 35].

We shall limit ourselves here to a single remark, as it concerns the theoretical framework of urban bioethics and represents an innovative point relative to what has been discussed so far. It refers to a thesis presented in the chapter co-authored by Araujo and Schramm, *Ética Médica, Bioética e Bioética Urbana: herança e variação* [25]. Revisiting the idea of bioethics as a bridge between disciplines, the two authors emphasize that its unique character lies precisely in this connective capacity, which entails a form of crossing with two key implications: first, making public the ethical issues that arise within specialized fields; and second, "preventing the monopolization of problematization" [25, p. 78, my translation]. Urban bioethics thus becomes an activity that pertains to the public dimension – no longer an exclusive or exclusionary domain – and one that can and should be practiced by the public itself, that is, by a collective subjectivity. This theoretical move makes evident a dynamic already implicit in previous discussions – namely, the intrinsically political dimension of urban bioethics – and disrupts traditional bioethics' academic monopoly over the treatment of ethical issues, both in theory and in practice.

All things considered, the theoretical foundation derived from the "Araujo-Sarmiento convergence" appears to be already well consolidated. The particular sociopolitical and cultural conditions from which it emerged, as well as the autonomy and theoretical specificity it has acquired over a few years of development, suggest that it is legitimate to speak of a distinctly Latin American – or Global South – form of urban bioethics. This body of thought may appropriately be referred to simply by its original name, *Bioética Urbana*, in order to distinguish it from its Anglo-Saxon counterpart.

4. Further Developments in Urban Bioethics

A third significant stage in the debate on urban bioethics took place in Europe. In 2019, the Department of Social Sciences and Medical Humanities at the Faculty of Medicine, University of Rijeka, hosted an international workshop entitled "Urban Bioethics: From Smart to Living Cities. Bioethical Debate, Reflections and Standards" [20, 21]. The papers presented on that occasion were subsequently published in 2020 in a monographic issue of the journal «Jahr – European Journal of Bioethics» (as in previous cases, the discussion here will focus exclusively on certain passages from these contributions that are particularly relevant to the theoretical development of urban bioethics). The journal itself takes its name from the German theologian Fritz Jahr, recognized as the first to have coined the term bioethics (in German: *Bio-Ethik*) in the 1920s. This detail is not incidental, as the Croatian research group led by Iva Rinčić, Amir Muzur, and others has for years been engaged in a project aimed at re-evaluating Jahr's work within the broader context of constructing a distinctly European bioethics [22]. Rinčić, however, appears to play a central role in the urban bioethical endeavor, as confirmed by an interview conducted with her by the Ukrainian scholar Hanna Hubenko in 2019 [19]. In that interview, Rinčić provides her definition of urban bioethics. We can immediately observe that, on one hand, her conception lacks the distinctly militant connotation characteristic of Latin American *Bioética Urbana*; yet, on the other, it remains oriented toward the civic approach already outlined by Jennings, while maintaining a strong focus on environmental issues: "Urban bioethics, as we see it, is [a] branch of general bioethics devoted to (bio)ethical research and applications related to city, including health and medicine, but also going broader in terms of themes and topics (energy, natural resources, traffic, architecture, safety…)" [19, p. 243]. Rinčić's research group ideally continues the work undertaken in an earlier project, *European Bioethics in Action*, which developed a list of bioethical standards intended as guidelines for policymakers. Their current aim is to produce bioethical standards specifically designed for the urban dimension.

A comprehensive and articulated overview of this initiative, and of the theoretical framework underpinning it, is provided in a programmatic contribution by Iva Rinčić, Robert Doričić, Sun-yong Byun, Chan Kyu Lee, and Amir Muzur, entitled *From mere Urbanity to Urban Bioethical Standards: An Invitation to a Broadening of Bioethics* [38]. The article offers a preliminary historical reconstruction of the development of urban bioethics, showing how it forms part of a broader movement aimed at expanding traditional bioethics. This movement intersects, among other things, with a renewed interest in the urban dimension and a widening of the scope of inquiry along the lines of the "forgotten founders" of bioethics: Fritz Jahr and Van Rensselaer Potter. The authors note that, despite occasional references and the sporadic engagement of moral philosophy with urban issues, bioethics as a field has remained largely deaf to this call. Their review of the existing urban bioethical literature – covering both the North American and Latin American debates – nonetheless highlights the limited global impact of these otherwise valuable contributions, which have remained relatively isolated.

One of the defining features of the authors' proposal lies in their effort to construct urban bioethics on the theoretical foundation provided by Jahr's bioethical imperative. According to this quasi-Kantian principle, every living being should be respected and, whenever possible, treated as an end in itself [22]. This foundation is appropriately updated with new theoretical elements and reconsidered in light of phenomena such as environmental crises, climate change, emerging digital technologies, and artificial intelligence – factors notably absent from the approaches previously discussed, yet exerting a decisive impact on the health and life of not only human beings but all living forms. Indeed, it is from Jahr's thought that this attention to all forms of life derives – an aspect that makes this strand of urban bioethics a more ecological and environmentalist version of the perspectives examined so far, with the possible exception of Blustein and Fleischman [7]. Following Jahr's original theoretical framework, while also drawing substantially on Potter's ideas and his notion of global bioethics, Rinčić *et alii* develop a vision "directed towards an ethical approach to all living beings, and more broadly, to space in general (as opposed to narrow human interrelationships in medical and health issues)" [38, p. 153]. Their research, which – as already noted – builds on the earlier *European Bioethics in Action* project, aims to elaborate a set of urban bioethical standards serving as "directives for the optimal relationship between *homo urbanus* and their own health and the well-being of other forms of life" [38, p. 154]. In this sense, it seems legitimate to speak of a distinctly "European" version of urban bioethics – one defined not so much by cultural or geographical belonging as by its theoretical lineage, which traces back to the European founder of bioethics, Fritz Jahr.

Building on this foundation, the remaining contributions to the journal's monographic issue extend and deepen the discussion by exploring various aspects within the scope of urban bioethics. Focusing on case studies from different urban contexts [37, 43], these works demonstrate the fruitfulness of the conceptual framework of "European" urban bioethics – one attentive to the living and health conditions of all forms of life, not solely human life. These contributions broaden the domains of inquiry rather than the theoretical construct of urban bioethics itself. For this reason, it is appropriate here to limit ourselves to a few brief observations on what appear to be the most promising lines of research, particularly in light of the most recent technological developments.

First, as highlighted by Michael Cheng-tek Tai in his article *The Future is Urban – An Urban Bioethics Perspective* [39], urban bioethics must incorporate the issue of sustainable urban development. Urban planning thus becomes a central concern, with urban bioethics assuming the dual task of providing both a philosophical foundation and a critical stimulus. As Tai notes, "for a bioethically viable urban city, some particular measures in regard to human wellbeing and the ecological balance must be considered in urban planning such as the issue of land availability, infrastructures of a new city, ecosystem, cultural, hygienic, and educational domains" [39, p. 165]. Given that urbanization is a global phenomenon expected to affect at least two-thirds of the world's population by the middle of this century, the proposal advanced by Hanna Hubenko in her contribution *Urban Bioethics: The Architect of a Healthy City* [40] is particularly compelling. Among other suggestions, Hubenko argues that urban bioethics should engage with the notion of "terraforming", introduced by the North American theorist Benjamin H. Bratton. This concept involves "transforming the planet to the condition acceptable for human habitation. Bratton believes that in the context of the coming climate catastrophe, only a planetary scale change can prolong our life on Earth as we know it" [40, p. 180]. The term terraforming is usually applied to planets such as Mars, which must be adapted for human habitation before potential colonization. Paradoxically, in light of the current environmental crisis, it is our own planet that now requires terraforming, and, as Hubenko implies, this process must begin with cities. Bratton's proposal thus elevates the issue of (urban) design to a planetary level, and its ultimate aim – "to prolong our life on Earth as we know it" – resonates with Potter's original idea of bioethics as a science of survival. Moreover, remaining faithful to Jahr's bioethical imperative, urban environments must be reimagined not only to suit human needs but also to accommodate all forms of life that must coexist with humanity in a state of balance.

This brings us to a second crucial point. As Jeffrey K. H. Chan argues in *The Urban Ethics of an AI-Powered Planetary Urbanization* [42], the process of global urbanization is occurring in parallel with the emergence of artificial intelligence. Consequently, the development of urban bioethical principles capable of critically overseeing and interrogating this convergence – one with profound economic, environmental, and therefore political and social implications – has become an urgent necessity. Yet this concern extends beyond health and well-being. What is at stake is the very agency of the human being. As Chan observes, "if urbanization can shape people's well-being and capabilities, and if such capabilities can be further enhanced or constrained by AI-powered technologies, then the convergence of AI-powered technologies and planetary urbanization presents an unprecedented window to advance, or conversely to diminish the human condition in significant ways" [42, p. 213]. Crucial in this regard is the issue of data and privacy. Data can generate disparities and new forms of power and control; at the same time, they can provide a basis for citizen empowerment and serve as a precise guide for policy interventions aimed at enhancing sustainability, reducing emissions, and ultimately contributing to the overall well-being of all forms of life inhabiting the urban environment. In this respect, one of the key tasks of urban bioethics is to regulate and ethically justify the collection and management of data [41, 44]. The complexity of this operation can only be briefly alluded to here, as it entails a potential shift in the foundation of morality – from modern individual self-sovereignty to a collective subject, such as the population, or even the environment itself.

5. Conclusion

This contribution has provided a preliminary overview of the origins and development of the concept of urban bioethics. The idea first emerged in the United States – unsurprisingly, perhaps, in the context of New York City ("The City", as it is often called). Its emergence was motivated by a general dissatisfaction with traditional bioethics' excessive focus on clinical and laboratory settings. Attention to the social and economic determinants of health led scholars to recognize the urban environment as deserving of specific ethical consideration. This shift in focus prompted a reconsideration of the very theoretical premises of bioethics. It soon became evident that the typically individualistic and liberal framework of classical bioethics was inadequate for understanding and articulating the issues that characterize urban environments and the ethical dilemmas that arise within them. The main attempts to give urban bioethics a coherent theoretical form have drawn on conceptual tools from various traditions, including feminist thought, deliberative democracy, and the Christian ethics of responsibility. One of the most significant theoretical moves in this regard has been the politicization of urban bioethics. As discussed, this politicization may take the form of grounding bioethics within democratic theory, resulting in what has been called civic bioethics. In the South American context, however, such politicization assumes a more radical and distinctive character. Here, it is indeed appropriate to speak of *Bioética urbana* to refer to Latin American theoretical production. In that context, urban bioethics emerges from an explicitly anti-capitalist critique, structured along Foucauldian lines of biopolitics, while also creatively reappropriating key elements of Potter's foundational conception of bioethics. Finally, in the European context, urban bioethics has been theorized through a renewed engagement with Fritz Jahr's thought and his bioethical imperative, systematically broadening its scope to encompass all forms of life.

These are broad research and dialogue contexts, marked by internal complexity and tension, which have nonetheless been tentatively distinguished here according to the theoretical features that most clearly set them apart. The intention is by no means to reduce them to a lowest common denominator, as this would risk distorting the actual substance of these contributions. However, by way of conclusion, it is possible to identify some trajectories that these three "currents" share – currents which, it must be emphasized, are far from monolithic or internally coherent. Their distinctive identity is, and remains, the result of an interpretative abstraction. That said, certain common traits do emerge. Chief among them is a shared, vocal dissatisfaction with traditional bioethics and its individualistic–liberal framework. This is a defining feature of both North American and Latin American urban bioethics and appears to be the implicit premise in the European variant. This dissatisfaction constitutes the critical dimension of urban bioethics' very *raison d'être*. The constructive dimension, which unites all these strands, lies in the attention paid to the urban condition – understood in an integrated and global sense, encompassing both environmental and socioeconomic factors. It is urban life itself that is brought under bioethical scrutiny; and, as noted, the object of inquiry inevitably acts back upon the observer, rendering the adoption or development of a new theoretical framework a recurring theme across all the authors considered. From this perspective, an interesting feature is the recovery of the two "forgotten founders" of bioethics – Potter and Jahr – respectively in the Latin American and European contexts. Both figures remain largely absent from the North American discussion (except for the occasional reference to Potter in footnotes).

There are many possible lines of inquiry that could emerge from further research in this field. It is important to note that such investigations will necessarily need to be interdisciplinary – or even transdisciplinary, to adopt Sarmiento's suggestion. Urban bioethics, whatever its theoretical framework, must engage with the social sciences, environmental sciences, urban health, urban planning, urban design, and architecture. One task that must therefore be addressed concerns the development of ways to operationalize urban bioethics within an interdisciplinary context. It must also take into account digital technologies and artificial intelligence, which, as noted earlier, not only have environmental and socioeconomic impacts but also possess the capacity to shape both human behavior and the urban environment itself. In connection with this, urban bioethics seems well positioned to make a promising contribution to the ongoing debate linking urban health to spatial resilience and spatial justice [46]. These are topics that exceed the limited scope of the present discussion but that undoubtedly warrant further investigation. Here, it is only possible to gesture toward this necessity, articulating it in the form of an inevitably incomplete list.

I will conclude with one final observation from a philosophical standpoint, which is the perspective from which this overview has been written. As has been shown, urban bioethics engages in a transformative dialogue with various disciplines. Perhaps its greatest risk lies in being wholly absorbed by each of them in turn, thereby losing its substance and distinctive identity. While it is true that urban bioethics must be transdisciplinary and function as a bridge – thus remaining faithful to Potter's original vision – it must also preserve a certain internal coherence at the theoretical level, so that one can meaningfully speak of "urban bioethics" rather than seeing it dissolve into political theory, environmental ethics, public ethics, and so on. Urban bioethics must remain inseparable from the city – which is never an abstract entity, but always a specific city – and must become a meta-theory of local, urban wisdom. This, inevitably, exposes it to the risk of relativism. Avoiding that risk is, in all likelihood, the most pressing philosophical challenge facing urban bioethics today.

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