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# Health education and medical anthropology in Europe: the cases of Italy and Spain

## Educación sanitaria y antropología médica en Europa: los casos de Italia y España

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**ABSTRACT** The aim of this article is to compare the development of health education in Italy and Spain from the point of view of the role played by medical anthropology in both countries. The context is provided by the changes in the concept of health education advocated by the UN technical agencies, especially the World Health Organization and Unesco, during the second half of the twentieth century. Despite their many similarities, Italy and Spain underwent different political evolutions over the last century. Therefore, it is interesting to compare both cases and the influence the social sciences had in health education initiatives. In order to assess the role of medical anthropology, the 1958 launch and the development of the *Centro Sperimentale per l'Educazione Sanitaria* (Perugia, Italy), which was at the forefront of health education in Europe until the 1990s, was re-constructed through oral sources. After a brief description of the scant initiatives regarding health education existing in the Spain of the dictatorship, the influence of the Perusine anthropologists on Spanish health education during the democratic transition is evaluated.
**KEY WORDS** Anthropology, Medical; Health Education; History, 20th Century; Italy; Spain.

**RESUMEN** El objetivo de este artículo es comparar el desarrollo de la educación sanitaria en Italia y España desde el punto de vista del papel jugado por la antropología médica en ambos países, en un contexto marcado por los cambios en el concepto de educación sanitaria que propugnaron los organismos técnicos de las Naciones Unidas, en especial la Organización Mundial de la Salud y la Unesco, durante la segunda mitad del siglo XX. A pesar de sus similitudes como países, Italia y España tuvieron evoluciones políticas muy diferentes durante el siglo pasado, por tanto, es interesante comparar ambos casos y la influencia que tuvieron las ciencias sociales en las iniciativas de educación sanitaria. Para valorar el papel de la antropología médica, mediante el uso de fuentes orales, hemos reconstruido la puesta en marcha, en 1958, y el desarrollo del *Centro Sperimentale per l'Educazione Sanitaria* (Perugia, Italia), que estuvo en la vanguardia de la educación sanitaria en Europa hasta los años noventa. Tras una breve descripción de las escasas iniciativas sobre educación sanitaria en la España de la dictadura, evaluamos la influencia de los antropólogos perusinos en la educación para la salud española durante la transición democrática.
**PALABRAS CLAVES** Antropología Médica; Educación en Salud; Historia del Siglo XX; Italia; España.

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## INTRODUCTION

> *Health education is a social intervention aimed at the conscious and permanent change in attitudes in order to address health problems. This discipline presupposes the knowledge of the cultural heritage of the group and the identification of its subjective interests, and requires overcoming group resistances to intervention.* [Translation of the original: *L'educazione sanitaria è un intervento sociale, che tende a modificare consapevolmente e durevolmente il comportamento nei confronti dei problemi della salute. Essa presuppone la conoscenza del patrimonio culturale del gruppo discente e la focalizzazione dei suoi interessi soggettivi, e richiede la rimozione delle resistenze opposte dal gruppo stesso all'intervento. (*Alessandro Seppilli, 1964)][1]

In this article, we analyze the development of health education and the role played by social sciences, especially anthropology, in its development in Italy and Spain between the end of World War II and the Jakarta Conference on health promotion held in 1997.[2] Health education was developed in that period focusing on specific guidelines aimed at promoting the participation of citizens, social collectives, neighbors, workers, ethnic minorities and indigenous peoples. At that time, the project demanded an articulation with empirical sociology and social and cultural anthropology. Italy and Spain are interesting cases because health education was to develop in political contexts that evolved inversely. In Italy, fascism, which started in 1924, shifted to democracy after World War II. In Spain, the democratic system was disrupted by fascism in 1936 and was not restored until 1977. In Italy, the *Centro Sperimentale per l'Educazione Sanitaria* (CSES) [Experimental Center for Health Education] in the city of Perugia (Italy) was launched at the end of the 1950s, becoming a benchmark institution in the development of European health education and active in promoting participation. Its guiding principles impacted the health education proposals conducted in Spain from the 1960s onwards, once the period of isolation imposed by Franco's dictatorship was over, and during the so-called "democratic transition" that began after dictator Francisco Franco's death in 1975.Using the resource of oral history, we analyze here the development of the Perusine center in the context of the evolution of health education at the global level, considering that no other history exists to help us understand this evolution. Further on, we analyze how the CSES proposals were recovered in the Spain of the democratic transition, after the failed attempt to implement them in the Spanish educational system during the sixties. Finally, we study how the historical trajectory of the CSES, since its creation to the Jakarta conference, has contributed to explain the evolution of this topic in the international agenda.

An important part of this article includes a series of audio and video interviews and a focus group conducted in March 2014 with some foundational members of the CSES: Maurizio Mori (who died in 2016), Maria A. Modolo, Anna Ferrari, Tullio Seppilli (who died in 2017), and Lamberto Briziarelli.

## POPULARIZATION OF HEALTH AND HYGIENISM IN ITALY AND SPAIN

Since the end of the 18th century, Italy and Spain, similarly to all other European states, have developed health strategies which include the popularization of health and public health policies. According to George Rosen's research,[3] the health policies of France, the United Kingdom and Germany have become points of reference in the evolution of the "medicalization process." However, the specific features of these countries do not necessarily correlate with the events that occurred in more peripheral countries, and thus, it is not possible to automatically extrapolate those chronologies and models.

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Every modern State has cultural specificities – which include politics, laws and even the economy – and thus, adjustments of a dialectical nature are made to these general processes both within the state framework and at the regional scale. Principal adjustments include the non-homogeneous and non-coetaneous implantation of capitalism, the chronology of the development of modern constitutionalism and the effects of both on the cultural consequence that we know as the "medicalization process," which includes different types of actions ranging from legislation to the influence of social communications media and the daily practices of health professionals and institutions. The "cultural" nature of such a process would explain its varied evolution in terms of state, regional and local variables. In the Italian and Iberian peninsulas – Spain and unified Italy – this evolution is interesting due to the features that both countries share: their regional cultural complexity, their uneven development of capitalism, certain political variables and the pace at which the medicalization process developed.

However, Spain and Italy are very different. The former evolved from an imperial State that until 1714 included the south of the Italian peninsula, Sicily and Sardinia. From 1812 onwards, it began a slow transition process towards modern constitutionalism, which was not consolidated until the end of the 1830s, under a model inspired by French Jacobinism. Conversely, unified Italy is a modern *res publica* project, the union of areas with very diverse regional traditions and cultural policies. The Italian Enlightenment implemented specific health policies in several of its territories[4] whereas social medicine in Spain did not formally develop until the end of the 19th century.[5] Both countries share substantial regional differences regarding the development of capitalism – such as the north of Italy, Catalonia and the Basque Country – along with underdeveloped regions such as the southern region of Italy and the south of the Iberian Peninsula. Moreover, they also share the fact that the health conditions of the working classes and the agrarian proletariat at the beginning of the 20th century were poor or very poor, depending on the area.

In both peninsulas, from the 17th century onwards, a remarkable number of books in vernacular languages about the popularization of medicine were published. These books offered practical solutions to health problems or were a collection of the misleading superstitious practices or popular prejudices that could be obstacles to "good practices" based on reason and medical knowledge.

By the end of the 18th century, the density of physicians in both peninsulas was remarkable, due to the existence of the municipal *conductio,* a contract that dated back to the late Middle Ages between the local municipality and the physician, which in Italy gave rise to the figure of the *condotto,*[4] and would end up becoming a public officer in Spain. The day-to-day of these local physicians was charged with the weight of transmitting knowledge regarding personal and public hygiene, as well as a relative capacity to influence politically in favor of the dissemination of hygiene practices, partly using ethnographic tools – medical topographies and social medical reports – to bring the situation into relief. During the 19th century, contents related to physiology and notions of hygiene began to be included in the primary education setting. Finally, both countries used mass propaganda resources, especially from the first half of the 20th century, although an in-depth study on the subject was only conducted in Spain.[6]

With respect to the cultural diversity understood as an obstacle to medicalization, the cases of Italy and Spain before 1945 did not follow identical patterns, despite them both being unitary states. In Italy, the political commitment of many *condotti* with the new kingdom, especially in the peasant regions, led them to develop a keen interest in the popular knowledge related to health and disease[7,8,9,10] and gave rise to the development of folk medicine.[11,12] Their interest was consolidated by the practical value that the *folklore di guerra,*[13,14] acquired during the First World War, when the military

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recruitment brought to the forefront the need to manage the huge cultural and especially linguistic diversity in Italy within the context of a unitary state. Italian anthropologists decided to use the name *demologia* ("demology") to describe the history of popular traditions and the cultural wealth and diversity of their *demos*,[15,16] a concept very similar to that of the *pueblo español* ("Spanish people") proposed by the Spanish republican folklorists of the 19th century,[17] which responded to the need to both know and protect that history. In both cases, it was an attitude different from that adopted by France with its cultural homogenization policies imposed "from above." Before the Second World War, Gramsci's theorization regarding the significance of folklore as subaltern culture[18,19] responded to the political and cultural debate related to diversity and implied an acknowledgment, not just as a survival of the past, but as a dynamic reality dialectically articulated with the Great Cultural tradition. Such recognition of the value of cultural diversity was not negated by Italian fascism (1922-1943), which distinguished the cultural and political *popolo* [people] from its biological *razza* [race]:

> *A healthy people must have a healthy race. The people's health is a guarantee of race, because the victory of fascism depends on a healthy race. It is interesting, because Italian fascism refers above all to the world of peasants, that is, according to Mussolini the virtues and abilities of the Italian race are those of the peasants: a modest, stable and productive way of working that still preserves the ancient traditions and values of the Italian race.* [Translation of the original: *...un popolo sano deve avere una razza sana. La salute popolare diventa una garanzia della razza, perché la vittoria fascista passa attraverso una razza sana ed è interessante perché poi il razzismo italiano fa riferimento al mondo contadino soprattutto, cioè le doti e le virtù della razza italiana sono quelle dei contadini secondo Mussolini, un lavoro continuo, umile, stabile, produttivo, che mantiene solo nel mondo contadino le antiche tradizioni dei valori della razza italiana.* (Seppilli T, 2014, min. 16:05, II)]

The idealization of peasant life as the melting pot of the Italian *razza* impacts the ideal construction of the peasantry present in coetaneous Spanish fascism,[20] but does not exclude its articulation with modernity – in fact rather quite the contrary:

> *The populist side of fascism promotes health surveys, vacation, organizations through which the labor union can negotiate with the employers, and sometimes even win.* [...] *During fascism the "mutuas"* [support institutions] *were created for workers who had no health coverage, as not all of us had coverage…* [Mussolini] *had opened many hospitals and launched campaigns against malaria and tuberculosis. Hospitals were public and there could even be more than one in a province, but there was only one psychiatric hospital per province.* [Translation of the original: *Il lato populista del fascismo porta a inchieste sanitarie, di vacanza, le corporazioni in cui il sindacato operaio può dialogare con quello padronale e qualche volta vince.* [...] *Nel fascismo sono nate le mutue con alcune professioni che non erano coperte, non tutti ce l'avevano* [...] *ha creato molti ospedali, ha fatto campagne soprattutto contro malaria e contro tubercolosi. Gli ospedali sono sempre stati statali potevano essercene anche più di uno in ogni provincia, mentre quelli psichiatrici erano provinciali.* (Seppilli T, 2014, min. 39:00, II)]

Thus, the implementation of occupational accident insurance and the opening of the *Cassa nazionale di previdenza per la vecchiaia*[4,21,22,23] were understood as agents of propaganda seeking to consolidate the hegemony of the regime.[24] The influence of Italian fascism on the Spanish regime is acknowledged[20,25,26] in the modernization of

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the peasantry[27] as well as in the field of labor and trade unions[28] in social action[29,30] and, mainly, in the Compulsory Sickness Insurance (SOE) [*Seguro Obligatorio de Enfermedad*].[33,36] Italian fascism did not imply breaking ties with the State – as Primo de Rivera's dictatorship did (1924-1930) – and part of the social actions of fascism continued in the republican Italy of 1947.[34]

In the Spain before 1931, health policies were quite modest due to the economic weakness of the State,[5,34] with the exception of specific sectoral and regional actions. The Second Republic (1931-1939) made a remarkable effort to develop public health[36] and a new compulsory primary education, which included "school hygiene" until 1938.[37] During the Civil War, with several areas coexisting under the constitutional government, Francoist Spain defined itself as a "New State," inspired primarily by the Portuguese *Novo Estado*. With the republican defeat, the State as it was understood disappeared and was replaced by another entity that was organized around a single political party, the *Falange Española Tradicionalista de las Juntas de Ofensiva Nacional Sindicalistas* (FET de las JONS), which later became the National Movement [*Movimiento Nacional*], uniting all the sectors that had supported the *coup d'état*. The health professionals and teachers most deeply committed to republican ideals fled into exile, were purged, or subsisted in various ways. The free and compulsory education implemented by the Second Republic was not reestablished until the end of the sixties.[37]

Franco's Spain intended to crush the cultural diversity of the country and impose the ideal of "Through the Empire to God" [*Por el Imperio hacia Dios*],[17,20] with a discourse centered on the Great Tradition, and dismissive of "regional peculiarities." Hence, the Museum of the Spanish People [*Museo del Pueblo Español*] project, founded by the Republic, was suspended and folklore and ethnology studies were associated with prehistory, anchored in the concept of German positivist folklore of the 19th century. Therefore, there were no equivalents to the Italian studies in "demology", but rather a cultural and academic marginality of folklore.[20,25,38]

Francoism sought to impose itself on the popular classes through cultural hegemony, which was mostly in the hands of the Church and certain organic intellectuals[20,39] who were not necessarily fascists. Many of them combined their membership in the *Falange* with Catholic thought, especially after the defeat of the fascisms in 1945. This organic discourse considered folklore and cultural diversity as "*costumbrismo*" [a depiction of everyday manners and customs] and as "survivals" – matters not to be taken into account in public actions. Folk medicine, developed in Spain and prompted by Italian folk medicine during the first half of the 20th century, was awarded the same judgment. Studies devoted to the popular management of health and disease continued to address these matters as "superstitions" that medicine and science should acculturate, as fossils of a past that only hindered the medicalization process. The contributions to folk medicine appearing in periodical publications were included in the curiosities or medical humanities sections.[40] An exception to this is the interesting manual *Folk medicina* [Folk medicine] by Antonio Castillo de Lucas, which was also aimed at physicians.[41]

The fact that Spanish doctors considered folk medicine as a "survival"[42] is explained by the hegemonic nature of a distinctly organicist clinical medicine, and by the absence of empirical sociology, which was incompatible with the official scholastic sociology, and of social and cultural anthropology, absent from the university until the 1970s. However, the international literature of this latter field, which was translated into Spanish mainly in Mexico and Argentina, was known to some doctors. Many others had access to the information in the original languages of publication. Nevertheless, the relativism of empirical social sciences clashed with the ideological assumptions of the Francoist culture and national Catholicism, not fitting into the schemes advocated by clinicians, who practically ignored the international developments in sociomedical sciences.[43]

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These were disciplines belonging to the realm of the "humanities" that a learned physician should eventually become familiar with, though they did not have any practical implementation in the hegemonic disease-centred approach. This medicine was endorsed by the regime as an instrument of social propaganda, in order to gain the support of the masses. Therefore, it can be considered that both in Francoist Spain and fascist Italy

> *... only a part of power is coercion, and another part is violence; no power can be sustained if it does not have a part of hegemony* [Translation of the original: *il potere è solo in parte coercizione, solo in parte violenza, nessun potere si mantiene se non ha un lato di egemonia*. (Seppilli T, 2014, I)].

Antonio Gramsci's writings on folklore,[19] the role of organic intellectuals,[18] the *questione meridionale*[44] [the Southern question] and his views on subaltern peasant cultures as a product of articulations and transactions tied into – despite the theoretical distance between Marxism and British structural functionalism – were an attempt to understand and value popular knowledge and, on this basis, to open up major channels of communication in the field of health education. From 1945 onwards, this would help to establish a dialogue among Italian Marxist anthropology, British cultural anthropology and the public health specialists committed to the new health education projects. However, in Spain, this dialogue was not possible due to the incompatibility existing between the ideologists of the regime, Marxism and cultural relativism, as well as the consideration of popular knowledge as "survivals" with validity only among ignorant people. We will examine this matter one step at a time. First, we will provide an overview of the global panorama of health education before the Jakarta conference. Second, we will address the Italian case and then proceed to the Spanish case.

## From the San Francisco Conference (1945) to the Jakarta Conference (1997): the global hegemony of local participation in health

The idea of a new "health culture" developed between 1945 and the World Health Organization (WHO) conference in Jakarta in 1997[2] – with the participation of the Food and Agriculture Organization (FAO), UNESCO and UNICEF in their respective fields of competence. This idea was based on a discourse of social participation at the local scale and was key in the education field and later in the health promotion field, so as to be extensively spread to rural areas, neighborhoods, workplaces, and in schools.[45] Italy immediately joined the project,[4] while Spain, despite its efforts to conceal the delay, took a decade to join due to its international isolation resulting from its fascist political profile. Francoist Spain continued to be an uncomfortable international partner. Many international recommendations did not reach the Spanish citizenry because of their ideological incompatibility with the regime.

This period was also characterized by the increasing role played by mass communications media. Initially, written information (newspapers and magazines)[49] prevailed; however, very rapidly, radio and television[50] (from 1960 onwards) took over.

In 1951 the *Union Internationale pour l'Education Sanitaire de la Population* (UIESP)[51] was founded as a consequence of:

> *... the meeting of people of different origins: an American man, a Russian woman, an Italian man (Canaperia) and a French man that was returning from Africa. A group of individuals not defined politically but influenced by post-war reconstruction* [Second World War], *which led them to create this international union, a popular feeling against the devastation caused by war and dictatorships. The Anglo-Saxon world that had defeated Germany and Japan was vested with an idea of freedom that would later lead to the Cold War, tearing everything*

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> *apart. However, at the time of the Yalta agreements and immediately after, with the driving force of the British Labor government, which was key to victory, Churchill won the war but lost the elections. The Labor Party came to power and Beveridge drafted the plan. And it was then that this story began, this international group that founded the UIESP within the WHO in support of people's freedom over their health.* [Translation of the original: ... *dall'incontro fra persone di diversa natura: un americano, una russa, un italiano (Canapera) e un francese che tornava dall'Africa. Un gruppo di soggetti non politicamente definiti, ma ispirati alla ricostruzione del dopo guerra. Questo fu quello che spinse questi personaggi a creare questa unione internazionale. Era un sentimento popolare contro i disastri della guerra e delle dittature. Il mondo anglosassone che aveva sconfitto la Germania e il Giappone, sulla scia della vittoria, fu investito da un'idea di libertà, che poi finirà quando, con la Guerra Fredda, si rompe tutto. Ma al momento degli accordi di Yalta e subito dopo sulla spinta del governo laburista inglese che fu la chiave di volta, Churchill vince la guerra ma perde le elezioni. E il partito laburista prende il governo, con Beveridge che fa il piano. E lì c'è questa storia, questo gruppo di persone internazionali che presso l'OMS fonda la UIESP per la liberazione delle persone sulla salute.* (Briziarelli L, 2014, min. 23:54)]

The role of the UIESP's conferences was indeed relevant for almost half a century, largely because of the unrelenting professional commitment of its members who advocated for a health education model that aimed to establish criteria of horizontality rather than hierarchical models based on imposition. Moreover, the search for commitments with local social agents was emphasized, employing a philosophy that could be called participatory. These ideas coincide in time with "participatory action-intervention" methodologies, as well as with the experiences of the so-called "therapeutic communities" in mental health. As Briziarelli comments in his interview, it is a confluence characterized by a period of radical democratic reconstruction after the defeat of fascist regimes, which also coincides with the beginning of the massive spread of European welfare states. Furthermore, it also corresponds with the wide hegemony of social democracy and Christian democracy in Europe.

The goal of health education, as it was then understood, was to advance toward citizen empowerment on the basis of local, integrative work attentive to cultural diversity, had the support of ethnographers and social scientists,[52] coordinated by the WHO and its regional offices as well as, the FAO food-related issues and UNICEF and UNESCO in educational matters.[53] In the educational field, the outdated concept of "school hygiene" was replaced by that of "school health education." To that end, institutions were required to adapt themselves to an education and health that respected local attitudes and knowledge based on ethnographic and historiographic records. This was becoming increasingly common in America,[54,55,56,57] but not in Europe, due to the absence of a professional applied anthropology.[46,58,59]

The WHO Conference[60] in Alma-Ata in 1978 formalized the pivotal role of primary health care; however, it was the 1986 Ottawa Conference[61] that incorporated the health promotion and education agenda that had been developed in the last quarter of the century and which was based on the construction of healthy public policy, the creation of environments that supported health, the reinforcement of community action, the development of personal skills and the reorientation of health services. A decade later, this task list was revised:

> Comprehensive approaches to health development are the most effective. Those that use combinations of the five [Ottawa] strategies are more effective than single-track approaches. Particular settings offer practical opportunities for the implementation of comprehensive

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> strategies. These include mega-cities, islands, cities, municipalities, local communities, markets, schools, the workplace, and health care facilities. Participation is essential to sustain efforts. People have to be at the center of health promotion action and decision-making processes for them to be effective. Health learning fosters participation. Access to education and information is essential to achieving effective participation and the empowerment of people and communities.[2]

In practice, Jakarta implied a substantial change in direction,[62] placing less emphasis on local aspects and highlighting individual responsibility and the role of communication and the media, which would later have consequences in Italy and Spain.

## The *Centro Sperimentale* of Perugia and health education in democratic Italy

> *There were two unique features of the center: the first was that health education was strongly linked to services, especially education and health services, it was not just an activity characterized by good will. The second was that working towards health education implied working towards health reform, that is, toward a new health system.* [Translation of the original: *Le singolarità del centro erano due: la prima è che l'educazione sanitaria è fortemente legata ai servizi, non è una attività di buona volontà, in particolare al servizio scolastico e sanitario. La seconda è che lavorare per l'educazione sanitaria significava implicitamente lavorare per la riforma sanitaria, per un nuovo sistema sanitario.* (Mori M, 2014, min. 04:00)]

The publication in 1945 of *Cristo si è fermato a Eboli* by the doctor Carlo Levi[63] and *La questione meridionale* by Gramsci[44] incorporated popular culture into the agenda of the *Repubblica Italiana,* in part through the Secretary General of the Italian Communist Party [*Partito Comunista Italiano*] (PCI), Palmiro Togliatti:

> *... with the driving force of the WHO and of post-war left-wing movements, the* Comitato di Liberazione Nazionale in Alta Italia *submits an initial proposal for a national health service, just after the Beveridge Plan. Based on a project of the* Convegno San Pellegrino*, a first draft of the* Servizio Sanitario Nazionale *is issued, in which people's participation is contemplated.* [Translation of the original: *... sotto le spinte dell'OMS e dei movimenti di sinistra subito dopo la guerra, il Comitato di Liberazione Nazionale in Alta Italia, formula una prima proposta di servizio sanitario nazionale, subito dopo il piano Beveridge. E poi in un progetto del Convegno San Pellegrino emerge una prima linea d'idea di Servizio Sanitario Nazionale, in cui c'è dentro l'idea della partecipazione della gente.* (Briziarelli L, 2014, min. 03:11)]

The proposal of the Italian left was associated with a long-term project in which Ernesto de Martino (1908-1965), an anthropologist and historian of religions, would play a relevant role. De Martino was then a member of the PCI and one of the foremost Italian intellectuals. According to Seppilli, his comrade and former student:

> *A controversy had arisen in* Società*, the theoretical journal of the* [Italian Communist] *party, regarding the significance of the subaltern classes, of popular culture. Together we constructed this initial tentative structure of Marxist anthropology in Italy, which later on led to, from an empirical point of view, the important research conducted by De Martino.* [Translation of the original: *Era cominciata la polemica su Società, sulla rivista teorica del partito* [PCI]*, sul significato delle classi subalterne, della cultura popolare, costruimmo insieme questa prima struttura di un tentativo di*

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> *antropologia marxista in Italia che poi portò, da un punto di vista empirico, alla grande ricerca di de Martino.* (Seppilli T, 2014, min. 23:33, I)]

Shortly before, in 1948, Panizzini's *Medicina popolare in Italia*[64] and De Martino's *Il mondo magico*[65,66] had been published. While Pazzini still accepts magic as "pre-technique," De Martino considers it a social practice of resistance and not a "survival," a sort of *bricolage* necessary for everyday life. Being familiar with it was crucial for understanding local culture and implementing medicalization strategies that accepted its efficacy:

> *Addressing the topic of popular medicine was too general, we had to define the social class and the conditions under which it operated. A research field rooted in the 19th century emerged, but it developed in a new direction, because we were working under the assumption that popular medicine was not superstition, but had an empirical basis. Ritual became part of its efficacy*. [Translation of the original: *Lavorare all'idea della medicina popolare era un po' generico, bisogna vedere quali classi sociali in quali condizioni. Venne avanti un settore di ricerche che aveva le radici nell'ottocento, ma andava sviluppandosi in una nuova direzione, perché noi lavoravamo nell'ipotesi che la medicina popolare non fosse superstizione, avesse delle basi empiriche. La ritualità era una parte dell'efficacia.* (Seppilli T, 2014, min. 35:06, I)]

De Martino, in *La terra del rimorso,* incorporated social workers and psychiatrists,[67] which was exceptionally rare in Europe. The new *Repubblica* wanted to solve the problem of citizens' access to health services, especially those in the subaltern groups:

> *In London, in 1995, there was an international meeting focused on post-war countries. One of its attendees was the doctor from the province of Perugia. In this meeting, the possibility of building health education centers in the different countries was established. In Italy a center was founded in Milan (that lasted a few years) and another in Perugia* [...] *which found a supportive environment because Alejandro Seppilli was then at the Institute of Hygiene in the University of Perugia* [...] *The aim was to incorporate the center into the university and the local entities (municipalities, provinces and regions).* [Translation of the original: *Nel 1951 a Londra ci fu un incontro internazionale con attenzione ai paesi post guerra. A questo convegno partecipò il medico provinciale di Perugia. In questo incontro si stabilì che si potevano costituire dei centri di educazione sanitaria nei vari paesi. In Italia se ne fondò uno a Milano (durato pochi anni) e uno a Perugia* [...] *che trovò ambiente favorevole perché all'Istituto d'Igiene dell'Università di Perugia, c'era Alessandro Seppilli.* [...] *L'intenzione era quella di avere dentro l'università e gli enti locali (comuni, provincia, regione).* (Modolo MA, 2014, min. 17:00)]

In the next two decades, the Italian health education model was based, in practice, on two institutions: one that was located in Milan and was mainly oriented toward "*social communication, radio and signage*" (Briziarelli L, 2014 min. 14:00), and the other in Perugia, which assumed a different role, as it mainly promoted concerted action with local left-wing authorities:

> *... following the international guidelines of the 3rd World Conference on Health Education held in Rome (1954), along with the doctor of the Province of Perugia and with the support of Carlo Alberto Canaperia, General Director General of the Ministry in Rome* [...] *Canaperia created the Italian Council of HE* [health education]*, of which* [Alessandro] *Seppilli was one of the most important figures. Papaldo, a professor from Rome, was the president.*

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*He limited himself to promoting HE on the radio, the newspapers and in advertising signs; however, there was no specific project. The difference introduced by Seppilli from the start was making great efforts in training personnel for this specific function, adopting person-centered models, building direct rapport with people, working with people by establishing contact with general practitioners, midwives, and nurses, in this model that was to become the CSES model, but which did not reach great consensus in the rest of the country. The model of the Perugia center was different from that of the Population Education Center in Milan. In Perugia, the choice was to use bidirectional communication media and to seek contact with people. This was the great difference that characterized our model and which started to be outlined under the direction of Modolo, Maurizio Mori, Ferrari and others. Our commitment was to create a model for the training of our professionals that could be transferable in a bidirectional bond with people, that could include group work, and group discussion as an instrument.* [Translation of the original: ... *sulla scorta delle indicazioni internazionali della III Conferenza Mondiale di Educazione Sanitaria a Roma (1954), insieme al medico provinciale di Perugia, con l'influsso di Carlo Alberto Canaperia, Direttore Generale al Ministero a Roma* [...] *Canaperia aveva creato il Comitato Italiano di ES (Educazione Sanitaria) di cui* [Alessandro] *Seppilli era una delle persone importanti, il presidente era un Prof. romano Papaldo, però si limitavano a ragionare di ES con messaggi attraverso radio, giornali, manifesti, a mandare in giro segnali, ma non c'era un progetto. La differenza che introduce Seppilli da subito fu quella di fare un grosso sforzo formativo del personale per questa specifica funzione, adottando modelli di approccio nei confronti della gente, un approccio diretto con la popolazione, lavoro con la gente attraverso il contatto con i medici di base, con le ostetriche, con gli infermieri, in questo modello che diventerà il modello del CSES che però non trovavano nel resto del paese un grande consenso. Il modello del centro era diverso dal modello del Centro di Educazione della Popolazione a Milano. A Perugia la scelta era quella di utilizzare mezzi di comunicazione bidirezionale e cercare il contatto con la gente. Questa era la grande differenza che caratterizzava il nostro modello che cominciava a delinearsi sotto la direzione della Modolo, Maurizio Mori, Ferrari e altri. Il nostro impegno fu quello di creare un modello di formazioni degli operatori che fosse trasferibile nei rapporti con la gente di tipo bidirezionale, lavoro di gruppo, discussione di gruppo come strumento.* (Briziarelli L, 2014, min. 12:39)]

Milan and Perugia represent two complementary strategies in the development of international health education. To choose one or the other often depended on the profile of their founders and their social and political commitment as well as their commitment to health. In the Perusine case, the initiative came from public health specialist Alessandro Seppilli (1902-1995):

*He spoke German, he was born under the Austro-Hungarian government and had studied German for the Physiology exam. He was culturally very German, and very Austrian in his way of life, rigid regarding schedules, work and manners of doing things. He was a liberal and became a socialist when he returned to Italy. He was even a liberal in spirit. I was very close to him, we traveled abroad together; he was very much interested in social problems; however, in his political training, he was closer to the liberals than to the socialists. He was a libertarian, a liberal in the 19th century sense of the word, but he was very open-minded and respected other*

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*people's opinions. He was an aristocrat and paid little attention to ignorants – not the poor, but the stupid. However, he believed that those having important things to say had to be listened to, and this was the reason why he was open to opinions and to discussion* [...] *Being traditionally a hygiene specialist, in the 1950s he implemented a policy of political openness regarding the social side of medicine and hygiene, under the influence of the innovations that were taking place in the international world of the WHO and the leftist movements that were shaking up the country after the war. While Seppilli was the socialist mayor of Perugia, he absorbed these cultural elements and incorporated them into the Institute of Hygiene both as teaching material for the students, and also as a parallel challenge to develop educational and research activities. Initially, these activities were only educational* [...] *Seppilli was especially interested in the CSES, moving traditional hygiene toward new frontiers: health education, health promotion, epidemiology, environment, prevention, a particularly technical take on hygiene*. [Translation of the original: *Lui parlava tedesco, era nato sotto l'indirizzo austro-ungarico, aveva studiato tedesco per fare l'esame di fisiologia, era di cultura mitteleuropea e nella sua impostazione ordinaria era un austriaco, rigido negli orari, nel lavoro, nella forma. Era un liberale e diventò socialista quando tornò in Italia. Era un liberale anche nello spirito. Io gli sono stato molto vicino, abbiamo viaggiato insieme, siamo andati all'estero, lui era apertissimo ai problemi sociali, ma come formazione politica era più vicino ai liberali che non ai socialisti. Era un libertario, un liberale nel senso ottocentesco del termine, però aveva una grande apertura mentale rispetto alle opinioni degli altri. Era aristocratico e considerava poco gli ignoranti, non i poveri, ma la gente stupida, però tutti coloro che avevano cose importanti da dire, bisognava ascoltarli e questa era la ragione per la quale era aperto alle opinioni, al confronto.* [...] *Di antica tradizioni igienista, fa negli anni cinquanta una apertura di natura politica verso la parte sociale della medicina e dell'igiene, sotto la spinta delle innovazioni che venivano dal mondo internazionale della OMS dei movimenti di sinistra che agitavano la nazione dopo la guerra. Seppilli che intanto era sindaco di Perugia, socialista, recepisce questi elementi di tipo culturale e li inserisce sia dentro l'Istituto d'Igiene come forma de insegnamento per gli studenti sia come impresa parallela all'interno dell'Istituto d'Igiene per svolgere azioni di tipo educativo e anche di ricerca. Inizialmente solo di tipo educativo.* [...] *Seppilli dedicava la sua attenzione soprattutto al CSES, spostando l'igiene tradizionale verso nuove frontiere: educazione sanitaria, promozione della salute ed epidemiologia, ambiente, prevenzione, una igiene che era soprattutto tecnica.* (Briziarelli L, 2014, min. 29:00)]

Alessandro Seppilli, born in Trieste (Austro-Hungarian Empire) in 1902 and of Jewish origin, was a charismatic figure until his death in Perugia in 1995, due to his scientific, academic and political influence. He was married to anthropologist Anita Schwarzkopf, who also contributed to his interest in

> *... approaching the understanding of diversities, respectfully teaching about the exchange among the different professions, so that the others could understand that health care education involved establishing relationships with different people, given the level of closure that existed in Italy. There was a culture that was still very much tied to professional power*. [Translation of the original: *... cercava di avvicinarsi alla comprensione delle diversità, di educare con molta dolcezza i rapporti con diverse professioni, cercando di far*

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> *capire che l'educazione sanitaria comportava la relazione anche con persone diverse, c'era una tale chiusura in Italia. C'era una cultura ancora molto collegata al potere della professione.* (Ferrari A, 2014, min. 34:00)]

Alessandro Seppilli's attitude was built upon his academic expertise and his work as a hygiene specialist before his exile in Brazil, as well as upon the experience in human interaction that he gained during his exile as director of a pharmaceutical company. There is no doubt that once back in Italy and involved in the CSES project, his ability to manage a team of young people was one of the keys for the development of the institution. One of these young people speaks to this:

> *I arrived at Perugia in 1954, after earning my medical degree. I began to attend the hygiene course in my fifth and sixth year. I got in touch with professor Seppilli because of my thesis. After graduating, he told me that I could work in health education and I contacted the provincial doctor.* [...] *The WHO was to award a scholarship to go to London, which I won, so off I went to the Health Education Center of London, where I spent one year. One of the things that caught my attention was that group work was common practice. In 1957, I returned to Italy and we decided to promote the subject of health education among the health professionals, so we organized a summer course, because in London they always organized a summer course for health service professionals. A year later we launched the course and the WHO supported us by inviting my London tutor, John Burton, who spoke Italian because he was married to an Italian woman.* [Translation of the original: *Io venni a Perugia nel 1954, dopo che mi laureai in medicina. Cominciai a frequentare il corso d'igiene, quinto e sesto anno. Contattai il prof. Seppilli per una tesi. Una volta laureata, Seppilli mi disse che potevo occuparmi di educazione sanitaria e andai dal medico provinciale.* [...] L'OMS *aveva dato una borsa di studio per Londra, la presi io e andai a Londra, al* Health Education Center of London. *Feci un anno lì. La cosa che mi aveva colpito molto era che si lavorava molto in gruppo. Nel '57 io tornai e si decise di diffondere questa storia dell'educazione sanitaria tra operatori sanitari e scolastici e si decise di fare il corso estivo, perché a Londra facevano un corso estivo per personale dei servizi. L'anno dopo lanciammo il corso, la OMS ci aiutò mandandoci il mio tutor di Londra, John Burton, che parlava italiano perché aveva sposato una italiana.* (Modolo MA, 2014, min. 21:00)]

The combination between Burton's British pragmatism and the social commitment of the 1950 Italian left made it possible to incorporate

> *... a wide breadth of ideas and an attitude of openness toward a HE* [health education] *model, which was unknown here, except for what was being built in Perugia. Immediately, we started to interact with people, both because Seppilli encouraged us in that direction, and also because public health had begun to wage a battle against social diseases in the sixties, and interventions were implemented against tuberculosis, trachoma, rabies and actions were initiated for the prevention uterine and cervical cancer. We started to advertise our activities, something that was unusual for HE, because we used to go to the towns and show movies and then we explained what had to be done in order to detect cancer.* [Translation of the original: *... idee molto aperte e aprí tutto un modello di ES che non conoscevamo qui, salvo quello che si stava costruendo qui in Perugia. Cominciammo subito un'azione con la gente perché sia per Seppilli che spingeva in questa direzione sia perché negli anni '60 la sanità aveva avviato una lotta contro le malattie sociali, quindi c'erano interventi contro*

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*la tubercolosi, il tracoma, la rabbia e cominciavano gli interventi per la prevenzione dei tumori della cervice uterina. Cominciammo a fare propaganda che non era proprio ES, perché andavamo nei paesini, la sera proiettavamo una pellicola e dopo spiegavamo come si doveva fare per lo screening del cancro.* (Briziarelli L, 2014, min. 09:00)]

Undoubtedly, the Italian model – that readily incorporated the Marxist critical anthropology discourse and was reluctant to accept the structural-functionalism of the English-speaking world[46] – helped forge the identity of the CSES:

> *... we had a love-hate relationship with the Anglo-Saxon model, because we used to greatly nurture ourselvess from the overall European culture, particularly from the British Labor Party, but not so much from the USA. Therefore, we were always in contact with and got inspiration from the British scientists but much less from the US ones. Instead, we had a close intellectual relationship with the Canadians, who had advanced models that were similar to ours, as well as with some Dutch and German scientists that sympathized with the social democratic movements. Through the UISEP we adopted two types of attitudes. On the one hand, we developed an Italian model with social democratic characteristics, which made its way forward while the health reform was in full bloom and with the participation of the people, but whose cultural elements of health information and education were those coming from places such as the north of Europe. It was a love-hate relationship because we fought as militant leftists against the US and even the British influence, but the spirit of the cultural avant-gardes coming from England was similar to ours, we were together in this. The* Bundeszentrale für gesundheitliche Aufklärung *of Cologne was also close to us because it was run by scientists that supported the SPD, which was rare and difficult to find in the UIESP because nobody had ever mentioned health education regarding the workers' health problems, they left it all to the International Labor Organization (ILO) in Geneva.* [Translation of the original: *... avevamo con il modello anglosassone un rapporto di amore e odio perché noi recepivamo moltissimo dalla cultura che si formava a livello europeo, soprattutto dalla parte inglese laburista, non dalla parte americana. Quindi avemmo sempre un contatto e un'inspirazione da alcune parti degli scienziati inglesi, molto meno dagli americani e invece avemmo stretti rapporti intellettuali con i canadesi che avevano dei modelli avanzati vicino ai nostri e con quella parte di olandesi e tedeschi che erano tutti vicini ai movimenti socialdemocratici. Attraverso l'UISEP noi avevamo due tipi di atteggiamenti. Uno: sviluppavamo un modello italiano di tipo socialdemocratico avanzato sul pieno della riforma sanitaria e della partecipazione della gente, ma gli elementi culturali di informazione di educazione sanitaria erano quelli che venivano dalle punte avanzate di tipo Nord Europeo. Era una relazione di amore e odio perché noi combattevamo come militanti della sinistra l'influenza americana, ma anche quella del governo inglese, ma gli spiriti culturali delle avanguardie culturali che venivamo dall'Inghilterra erano anche le nostre, ci lavoravamo insieme. El* Bundeszentrale für gesundheitliche Aufklärung *di Köln era con noi vicino perché era diretto da scienziati vicini al SPD, che era una cosa assai rara e difficile nella UISEP perché mai aveva parlato di educazione sanitaria per i problemi sanitari dei lavoratori perché li lasciava tutti a la OIT di Ginevra.* (Briziarelli L, 2014, min. 48:30)]

The summer course of the CSES that was inaugurated in 1958[68] was, for many decades, a point of reference in Europe. Its

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annual gatherings not only accepted Italian students, but also a great number of students from other parts of the world, including Spaniards from the sixties onwards. The appeal of the course was that

> *... it was based on the Socratic method (that was implemented in London) – I see today that many groups are recovering the Socratic dialogue – and it was organized in ten days. We launched a call and a lot of people came, around 60 people. We worked in groups. There was an introductory class in the morning, and then two hours of group work to discuss what each person did individually in their own work and what was or was not applicable. In the afternoon, we worked on communication, we had to create something for publication (flyers, banners, films). The course focused on one topic, a specific problem (nutrition, mental health, among others).* [Translation of the original: *... il corso era fondato sul metodo socratico (che usavamo a Londra), sto vedendo che molti gruppi stanno rilanciando il dialogo socratico, organizzato in 10 giorni. Facemmo un bando e venne molta gente, circa 60 persone. Si lavora in gruppo, la mattina si faceva una lezione di inquadramento, poi due ore di lavoro di gruppo per discutere sulle cose che ognuno faceva nel proprio lavoro e se si potevano applicare o no. E il pomeriggio era sulla comunicazione, si doveva produrre un qualche cosa per pubblicare (flanellografie, manifesti, filmine). Il corso aveva un tema, un problema specifico (alimentazione, salute mentale etc.).* (Modolo MA, 2014, min. 31:00)]

However, the incorporation of the social sciences, especially medical anthropology, into the world of hygiene and classical public health, was a totally unprecedented event in Europe. The anthropological contribution to the formation of health professionals was indeed uncommon in the academic tradition of European public health.

> *People from all over Italy came to study about health education and what it was about. My father* [Alessandro Seppilli] *had the idea that it was necessary to be acquainted with anthropology to study health education. Thus, anthropology was included in health education curricula in 1956. Every summer I gave an extensive seminar, a debate on anthropology, to explain what it is and what its purpose is. A short time later, I published a work about the WHO, the first work addressing the contribution of cultural anthropology and health education; thereafter, a collaboration started, which has continued ever since.* [Translation of the original: *Venivano da tutta Italia delle persone a studiare cosa voleva dire l'educazione sanitaria e mio padre* [Alessandro Seppilli] *ebbe l'idea che per studiare l'educazione sanitaria bisogna conoscere l'antropologia e così l'antropologia entra nel 1956 nei programmi di educazione sanitaria e io facevo tutti gli anni, d'estate, una lunga lezione, un dibattito sull'antropologia, cos'è, a cosa serve e pubblicai poco dopo quell'altro lavoro su l'OMS, il primo lavoro sul contributo dell'antropologia culturale e l'educazione sanitaria e da lì cominciai una collaborazione che va avanti fino ad oggi.* (Seppilli T, 2014, min. 31:00, I)]

The course structure was similar to that of the participatory model developed by the British, and consisted of an introductory seminar and, above all, workshops, practical and participatory activities that were articulated in

> *... thematic clusters. An ordinary day included a class that was delivered by anyone of us (Paolo Bartoli, Riccardo Romizzi and me). Tullio Seppilli gave the inaugural class on medical anthropology and we took turns delivering classes on cultural models of health and disease, cultural learning and dissemination, data collection techniques in the community, and communication. Then,*

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*we conducted group work through workshops and especially through discussion of different experiences regarding specific topics. I coordinated the group about labor and birth, in which many Spaniards participated. We were totally immersed in group work (from 10 am to 6 or 7 pm). We worked a lot on medicalization processes, prevention in the health field and on the political significance of the work, which we believed was the main road to medicalization; the shift of medicine from disease to health and normality were the foundations of the power of social medicine, because by dealing with prevention we dealt with everyday life (eating, sexuality). Eventually, our approach became very critical, we invited the participants to think of their own models from a cultural point of view, including the scientific models*. [Translation of the original: *... lavori di gruppo tematici. Le giornate comprendevano una lezione frontale di qualcuno di noi (Paolo Bartoli, Riccardo Romizzi e io). Tullio Seppilli faceva la lezione inaugurale di antropologia medica e noi ci alternavamo su modelli culturali di salute e malattia, apprendimento e circolazione culturale, tecniche di rilevazione nella ricerca di comunità, il tema della comunicazione. Poi si entrava in gruppo, dove c'erano delle esercitazioni, ma soprattutto confronto tra esperienze intorno a certi temi. Io gestivo un gruppo sul parto e la nascita, erano presenti molti spagnoli. C'era un'immersione nel lavoro di gruppo tutto il giorno (dalle 10 alle 6-7 di sera). Lavoravamo molto sui processi di medicalizzazione, la prevenzione nel campo della salute anche il significato politico, ma da lì a poco noi la abbiamo considerata come la strada maestra della medicalizzazione, lo spostamento della medicina progressivo dalla malattia alla salute e alla normalità era la base del dominio della medicina nel sociale, perché occupandosi di prevenzione, ti occupavi della vita quotidiana (alimentazione, sessualità). Man mano che andava avanti nel tempo il nostro approccio era molto critico, noi invitavamo i partecipanti a considerare da un punto di vista culturale i loro stessi modelli anche quelli che loro consideravano scientifici*. (Falteri P, 2014, min. 05:54)]

Although anthropology always occupied a prominent place, which Tullio Seppilli always preserved, contradictions still emerged regarding the expectations of the anthropologists on the one hand, and of public health specialists on the other:

*We did not always agree with Tullio, who was more of a scientific doctor than we were. With the hygiene specialists, we had the feeling that our anthropological approach was a sort of ornament, that we were just chit-chatting and that the true and important matters were those addressed by the hygiene specialists. We never dared to venture into the field of the specialists in hygiene, but, while on the one hand, they did assign us a very important role, on the other hand, the impression was clear that a hygiene specialist could become a bit of an anthropologist. In this regard, Tullio was less sensitive, I don´t know if it was because he was the son of a hygiene specialist or because of his training. That was the reason why those working in this field felt a little like missionaries. There was this feeling of: "we arrived, we healed them and saved everybody"; on the one hand you promote health, on the other hand you medicalize society*. [Translation of the original: *In questo, spesso, non andavamo d'accordo con Tullio che era molto più medico scientifico di noi! Con gli igienisti avevi la sensazione che la prospettiva antropologica fosse un po'un ornamento, che tutto sommato noi facessimo delle chiacchiere perché poi le cose vere e importanti fossero i temi dell'igiene. Mentre noi non ci siamo mai azzardati ad entrare nel campo degli igienisti, loro sì, da una parte ci davano uno spazio notevole, ma dall'altra la*

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> *sensazione era molto netta che anche l'igienista può fare un po' l'antropologo, su questo Tullio era meno sensibile, non so se perché figlio di un igienista o per la sua formazione.* [Per questo] *coloro che lavoravano in questo ambito si sentivano un po' missionari, c'è un elemento: "arriviamo noi, vi salviamo e vi facciamo stare tutti in salute", da una parte promuovi la salute dall'altro medicalizzi la società.* (Bartoli P, 2014, min. 30:00)]

Bartoli, an anthropologist, highlights an important consequence of the anthropologists' doubts regarding a process that, finally led not so much to relativism but rather to the deepening of the medicalization process. Thus an intense debate about "medicalization" was generated, which has been increasingly present in the medical anthropology agenda since the end of the twentieth century[69] and that responded to the fear that the labour market of the anthropologists could be absorbed by the hygiene specialists.[70] However, the anthropologists that worked at the CSES

> *... introduced the concept of medicalization, but insisting that the meaning was neutral. We spoke in terms of cognitive models, of medical behaviors in the population; it was not necessarily negative, it was taking into account what was going on. Those were times when Paolo and I were doing field research near Lake Trasimeno about the coincidences and discrepancies between popular and official medicine, based on the first specialties that had widely emerged in the territory: obstetrics and pediatrics.* [Translation of the original: ... *presentare il concetto di medicalizzazione insistendo però che il significato era neutro, ne parlavamo nei termini di modelli cognitivi, di comportamenti medici della popolazione, non era necessariamente negativo, era aver presente quello che stava accadendo. Anni in cui io e Paolo facevamo ricerca sul campo vicino al lago Trasimeno a proposito dell'incontro scontro tra medicina popolare e ufficiale a partire dalle prime specializzazioni che si erano diffuse capillarmente nel territorio: ostetricia e pediatria.* (Falteri P, 2014, min. 31:47)]

This permitted them, even with the limitations that they observed, to set as their main goal that of changing the attitudes of health professionals, offering critical training regarding social and cultural variables. In Perugia:

> *We have always been convinced that medicine could not be truly social if physicians did not receive the important cultural contribution of the humanistic disciplines, which is not about teaching a little cultural anthropology, medical psychology and medical sociology, but about creating a space in the students' medical mind that enables them to consider the patient not as a person on a stretcher but as a social being. This was what we believed. We wanted the student to understand that there was a part within the human being that was not strictly clinical and that a physician should take that into account* [...] *Although, in fact we never succeeded in this respect, we could never change this objectively. With Modolo we worked both in medicine and in the training courses for the health professionals, introducing humanistic and social disciplines. And we introduced these courses mainly for the non-medical staff rather than for the physicians. In my course, we used to send students to study in a specific neighborhood, in factories or in a peripheral health service, so that they could understand, through this knowledge of the situation, many other things that they didn't know because they were always in the hospital. We could do it, but it was always very difficult.* [Translation of the original: ... *noi siamo sempre stati convinti che la medicina non poteva essere veramente sociale se i medici non avessero ricevuto una*

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> *importante aggiunta culturale da parte delle discipline umanistiche, che non era solo insegnare un po' di antropologia culturale, psicologia medica, sociologia medica, ma di creare nella testa dello studente medico uno spazio per considerare il paziente non un uomo sul letto da visita, ma un uomo sociale, questo era il nostro ragionamento, cercavamo di far capire allo studente che c'è una parte non strettamente clinica dell'uomo che deve essere considerato dal medico.* [...] *Questo in realtà non è stato mai raggiunto, non si è mai avuto un cambiamento oggettivo. Io e la Modolo abbiamo lavorato sia in medicina che nei corsi di formazioni del personale sanitario introducendo discipline umanistiche sociali, quindi abbiamo introdotto questi corsi più a livello di personale non medico che medico, nel mio corso gli studenti venivamo mandati a studiare un quartiere, una fabbrica, un servizio periferico in modo che preparassero, attraverso questa conoscenza del terreno, qualcosa che loro non sanno perché loro stanno solo in ospedale. Lo abbiamo fatto però sempre con grande fatica.* (Briziarelli L, 2014, min. 01:05:00)]

Despite this differential factor, that of the critical addition of the social sciences, the main training areas continued to be linked to

> *... the culture developed in the health education centers of London, Edinburgh and Ireland. It was the same culture that we brought into Italy that included scientific and technical elements that we introduced and to which we added political elements; at that time those foreign professionals worked very willingly with us, because we supported this political discourse through an international society on health policy; we were a scientific organization made up of public health and health culture scholars, all of us leftists, who supported a public health discourse in the socialist sense*. [Translation of the original: ... *la cultura sviluppata dal centro di educazione sanitaria di Londra, di Edimburgo e quella irlandese. Era la stessa che noi portavamo in Italia, erano elementi scientifici e tecnici, noi li introducevamo nei nostri e vi mettevamo elementi politici e quindi questi stranieri lavoravano con noi volentieri perché noi portavamo avanti questo discorso politico attraverso una società internazionale di politica sanitaria, era un'associazione sanitaria di scienziati studiosi di sanità pubblica e cultura sanitaria, tutti di sinistra, che portavano avanti un discorso di sanità pubblica nel senso socialista.* (Briziarelli L, 2014, min. 56:00)]

The difference came from the personal attitude and the political commitment of the hygiene specialists and anthropologists that collaborated in that task, as they understood that in Southern Europe "*the topic of prevention had a very strong political value*" (Bartoli P, 2014, min. 1:38) that implied

> *... collaboration with the movement of educational cooperation in the field of the school, teachers, and educators in the health services. The method was participatory and was related to group work. I was in charge of an anthropology group that was attended by teachers and educators from all over Italy and who formed territorial groups*. [Translation of the original: ... *collaborazione con il movimento di cooperazione educativa nel campo della scuola, degli insegnanti, degli educatori dei servizi. Il metodo era partecipativo, legato ai lavori di gruppo, io tenevo un gruppo di antropologia a cui venivano insegnanti, educatori da tutta Italia e formavano gruppi territoriali*. (Falteri P, 2014, min. 03:43)]

Unlike US culturalism, which undoubtedly gave rise to the initial impulse for the development of the anthropological discourse in Perugia, the Perusine discourse could have a critical perspective related, on the one hand, to Italian Marxist critical anthropology and,

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on the other hand, to the significance that the political commitment had in the emancipation of the subaltern classes. For that reason, social participation actions included:

> *... politics, local institutions, labor unions and workers. In the sixties we had already established a strong relationship with the union of metal-mechanic workers in Terni and Perugia, the union of ceramic workers in Perugia and the union of textile workers. Our ideas were sustained by this relationship and we could transmit the type of work that we conducted to the factory workers, which also helped us to improve our working models. We even organized health care training courses for the unions, which were truly health care actions for the factory committees and workers' councils. The CESS entered the social sphere, and in turn received important elements from the social sphere that helped us move forward with our discourse, which was difficult because it was not accepted by the official areas of medicine or hygiene. When we shared the results of our research, it was easy for us to speak with the workers and explain to them what was going on. We worked a lot with the ceramist workers of Deruta in trying to understand the level of damage caused by lead and helping them put their claims forward. It was a combination of, on the one hand, technical public health work and on the other hand, the political work of educating and helping the workers gain knowledge for carrying out their struggle against their employers.* [Translation of the original: *... la politica, le istituzioni locali, i sindacati e i lavoratori. Già negli anni 60 noi avevamo forti legami con il sindacato dei lavoratori metalmeccanici a Terni e a Perugia con i ceramisti, i lavoratori della Perugina, il tessile e in questo rapporto trovavamo sostegno alle nostre idee e portavamo il tipo di lavoro che facevamo con gli operai nelle fabbriche e ci serviva anche come affinamento dei nostri modelli di lavoro. Tanto è vero che organizzammo per i sindacati corsi di formazione sulla tutela della salute che erano vere e proprie azioni di educazione sanitaria nei confronti dei consigli di fabbrica e dei lavoratori. Il CESS entrò nel sociale, però recepiva anche dal sociale elementi e che ci aiutavano a tirar avanti il nostro tipo di discorso che era difficile perché non veniva accettato dalla medicina ufficiale né dalla igiene ufficiale. Era facile per noi quando consegnavamo i risultati delle nostre indagini, parlare con i lavoratori e spiegare cosa succedeva. Con i ceramisti di Deruta lavorammo molto per capire il grado di danno prodotto dal piombo e per portare avanti le loro rivendicazioni. Era un mescolamento di lavoro, tra lavoro tecnico d'igienista e politico di istruire e far sì che i lavoratori acquisissero conoscenze per supportare la loro lotta contro il padrone.* (Briziarelli L, 2014, min 19:23)]

The apparent political radicalism of the project was itself an obstacle. Despite the debates concerning health participation, commitment to the local posed problems for generalization, thus leading to

> *... the scant dissemination of our ideas. People came from all over Italy but the model did not spread. There were no other places where the same project was implemented. The greatest resistance came from the hygiene specialists, who not only did not accept the proposal but outright rejected it. They battled against both* [Alessandro] *Seppilli and his hygiene specialist students, they did not accept health education as a scientifically validated instrument. Science for them was numbers, tables and statistical significance, the opposite of qualitative discourse, which for them was ridiculous, when now we know it is essential. The situation was difficult, it was a fight, but we were fighters.* [Translation of the original: *... idee si irradiarono poco.*

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> *Venivano qui da tutte le parti d'Italia, però il modello non si propagava. Non si creavano altri punti in cui si faceva la stessa cosa. La resistenza più grossa fu quella degli igienisti perché non solo non accettarono le proposte, ma le rifiutarono, fecero guerra sia a* [Alessandro] *Seppilli che ai suoi allievi igienisti, non accettarono che l'educazione sanitaria fosse uno strumento scientificamente validato. La scienza per loro era quella dei numeri, delle tabelle, la significatività, invece il discorso di tipo qualitativo, oggi ormai siamo tutti d'accordo che sia indispensabile, era ridicolo. La situazione fu difficile, era una lotta, ma eravamo combattenti.* (Briziarelli L, 2014, min 18:00)]

A second obstacle was the quantitative radicalization of the health professions and the public health approach. The Perusine model was based on an ethnographic, qualitative and local perspective, which for the public health professionals implied a professional reformulation and a much more relativistic and respectful attitude towards the subjects of the intervention. Training in ethnographic techniques was much more complex and presented personal costs and educational difficulties. Despite the presence of the social sciences in the *summer courses*, the shortness of the interventions enabled acceptance of

> *... the qualitative dimension of the investigation* [...] *but they did not really understand it, they did not understand the importance of qualitative method. A questionnaire to be answered by 100 people was better for them than a semi-structured interview with a folk healer using the qualitative method. This was never explicitly said, but the feeling was that for them science was not done with qualitative data. We certainly accepted the importance of quantitative data, statistical data, but for us that was not enough, as not everything was reflected. I saw no conflict in this respect, but for many hygiene specialists this was hard to understand.* [Translation of the original: *... gli aspetti qualitativi della ricerca li accettavano ma non li capivano molto, non veniva colta l'importanza del metodo qualitativo. Era meglio un questionario somministrato a 100 persone che non una intervista semi-strutturata di tipo qualitativo fatta a un guaritore. Questo non ci è stato mai detto esplicitamente, però la sensazione era questa che la scienza non si fa con il dato qualitativo, naturalmente noi non negavamo l'importanza del dato quantitativo, del dato statistico, diciamo che non dice tutto, io non vedo nessun conflitto, però per molti igienisti questa cosa non era facile di capire.* (Bartoli P, 2014, min. 42:47)]

It was difficult for the academic anthropologists to adapt themselves to the needs of health education. In this sense, the CSES lost influence in the nineties:

> *We agreed because, as it was known, we had perceptions of health education that were very open. However, there was a strong dialectical tension that gave out in the end. We could not go any further, and little by little the experience of the experimental center came to an end. I was the director of the center for many years although I did not participate much in the course. The relationships remained but the course gradually lost its momentum.* [Translation of the original: *Andavamo d'accordo perché avevano concezioni, come è noto, di educazione sanitaria molto aperta, ma nel merito c'era una dialettica molto forte interna, alla fine si è esaurita, più in là di tanto non potevamo andare avanti e poi man mano si è spenta anche l'esperienza del centro sperimentale. Io sono stata molti anni nel direttivo del centro pur non partecipando più al corso, i rapporti sono rimasti, però il corso si stava a mano a mano spengendo.* (Falteri P, 2014, min. 48:00)]

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Undoubtedly, the crisis of the CSES model coincides with the ideological changes that occurred after the Ottawa and Jakarta conferences. The precepts of the latter conference led to a sort of pragmatic action that implied a lesser degree of social, personal and political commitment. For that reason, this section can be concluded with the dialogue between Paóla Falteri and Paolo Bartoli in Perugia in the spring of 2014:

> Bartoli: *I would like to know why the interest in anthropology has suddenly come to an end* [*Io vorrei capire perché all'improvviso l'interesse per l'antropologia è svanito.* (Bartoli P, 2014, min. 41:10)].
>
> Falteri: *Paolo, don't be silly, it's because our approach was critical, though in a constructive sense* [*Paolo sei un po'tonto, perché il nostro approccio era critico anche se in senso costruttivo.* (Falteri P, 2014, min.41:25)]

## HEALTH EDUCATION IN FRANCO'S SPAIN: FROM RURAL PROMOTERS TO ADOLFO MAILLO

The new Francoist state maintained several health and educational proposals of the Second Republic to help fight hunger, child mortality and infectious diseases. However, health education was never a priority because the authorities of the General Health Office (DGS) [*Dirección General de Sanidad*] were skeptical about its effectiveness.[71] They designed ads and promoted radio broadcasts[72,73,74] and, above all, they published two book collections. The first collection, called "*Al Servicio de España y del Niño Español*" (ASENE), [At the Service of Spain and Spanish Children] published 311 books between 1938 and 1964[75] and reflected a nationalist and pronatalist rhetoric. Its main goal was mortality reduction, professional training and propaganda. Several of these books mentioned health education.[76] The second collection was called "*Folletos para medicos*" [Brochures for physicians] which published 76 titles aimed at physicians between 1944 and 1964, under the seal of the General Health Office. Although several of these publications were aimed at the general population, their actual dissemination is unknown, and therefore, it is impossible to evaluate their impact on the health behavior of the population.[77]

The most interesting attempt in this respect during the 1941-1959 period was the program of *divulgadoras rurales* [rural female health promoters] of the *Sección Femenina* [Women's Section] of FET & JONS, along the lines of the so-called barefoot doctors. This project trained young women to work in rural communities in programs that included childcare, good eating habits and hygiene recommendations. Most of these women were recruited from the same communities where they lived, as the women coming from the cities were not easily inserted into these contexts.[77] Moreover, in contrast to these modest programs, there were actions to extend the coverage of the SOE [Compulsory Sickness Insurance], which was limited to providing medical and health care services to *those insured*.[33]

Spain did not join the *Union internationale pour l'Education sanitaire de la Population* – today de International Union for Health Promotion and Education (IUHPE) – until 1959. When it finally joined, the General Health Office (DGS) began to publish specific *Brochures* in their series about international organizations,[78] as well as about Claire E. Turner's work on health education in schools.[79] The main Spanish contribution to the IUSSP was the organization of its 6th Conference in Madrid in 1965, which was held in the headquarters of the *Organización Sindical Española* [Spanish Trade Union Organization], an emblematic institution of Francoist Spain. This event was considered an image strategy to give visibility to the regime. The international participation was important:

> *Seppilli had no relation with the Spanish but had a good relationship with the*

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> *Portuguese and Brazilian scientific world, because he had always written reviews and articles for a Brazilian journal that was also published in Portugal. In the 1966 conference held in Spain he met Bosch Marin, a pediatrician, who later became the president of the Unión Internacional de Educación Sanitaria* [*International Union for Health Education*]. *Marin was open-minded, he was not a Franco supporter although he had been introduced as a part of the Francoist structure. The Conference was held in the* Casa de Falange [House of the Phalanx] *and in the trade unions. There we met an enthusiastic and lively group of people from Argentina and Brazil, who brought a gust of fresh air into the conference to which the regime offered no opposition*. [Translation of the original: *Seppilli non aveva relazioni con gli spagnoli, però le aveva con il mondo scientifico portoghese e brasiliano perché per tutta la sua vita fece recensioni e articoli per una rivista brasiliana che c'era anche in Portogallo. In Spagna alla conferenza del '66 aveva legato con quello che diventò il presidente dell'Unione internazionale di Educazione alla Salute, Bosch Marin, che era un pediatra. Una persona aperta, non era franchista, anche se fu presentato come un uomo dell'apparato franquista. La conferenza si tenne nella Casa della Falange, nei sindacati. Noi andammo lì e trovammo un mondo molto vivace: argentini, brasiliani che portarono nella conferenza venti nuovi che il regime non impedì.* (Briziarelli L, 2014, min. 45:00)]

The conference had little impact on Spanish health policies. Coinciding with the event, a collective work on health education[80] was published, with the participation of pedagogue Adolfo Maíllo (1901-1995),[81] the mastermind behind the attempts to import the new model of "school health education" during the sixties.[82] Maíllo was then the director of the *Centro de Orientación y Documentación Didáctica de Enseñanza Primaria* (CEDODEP), [Center for Orientation and Didactic Documentation in Primary Education], a technical institution that was in charge of implementing the reform of Francoist primary education. In this reformist context, Maíllo was interested in the health education of school children.[83] He believed in an interdisciplinary health education approach and that such teachings could not be restricted to school curriculum contents, as he was influenced by the Perusine summer course[68] and by his readings of anglo-saxon anthropology and sociology.[84] Recent studies[85] consider that his attitude was the result of his wide field experience in rural communities, where he first worked as a teacher, and later within the sphere of literacy campaigns. He believed that peasants could be illiterate but not uncivilized and that it was necessary to first do work that included local dimensions in geographical, economic, sociological or cultural terms before launching any literacy programs. A previous knowledge of the local sphere could enable "community-based education." Maíllo was the ideologist behind the educational action related to the opening of public spaces for watching television in the rural communities (*Tele clubs*).[86] His ideas had little impact due to the contradictions that such model implied during Francoism and due to the arrival of a new generation of academic technocrats into Spain.

## Perugia during the Spanish transition to democracy

The limitations of Francoist health education, except for the nutrition education activities introduced in the sixties,[87,88] highlights the gap existing between Spain and the developments in other European countries. Franco's regime opted for Social Security, a disease-centred healthcare approach which was criticized[89] and yet upon which the regime constructed legitimacy. From the sixties onwards, this insurance engendered a debate that would end in the health reform of the democratic transition.[90] The new health

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organizational scheme did not fully break away from the curative healthcare proposed by the Francoist model,[91] despite the criticism regarding the role that primary health care and health education should play in it and which sought to align the Spanish reform with Alma Ata's guidelines.

Health education played a marginal role in the debates of the seventies, a situation which started to change with the creation of the Ministry of Health in 1977. At the beginning of the eighties, renewed ideas on health education emerged. During that decade a third of the CSES summer course attendees were Spaniards:

> *The participation of the Spaniards was stimulating; most of them were women who had lots of energy, and a desire to do and to change things that was much stronger than in Italy during those years of transition. Sometimes they were even more competent*. [Translation of the original: ... *era entusiasmante la partecipazione degli spagnoli, in gran parte donne, avevano un'energia, un desiderio di fare e di cambiare molto superiore agli italiani, in quegli anni di transizione, spesso erano anche più preparati*. (Falteri P, 2014, min. 15:00)]

> *They provided an element of action to the classes; sometimes students are a little passive, you speak and they just listen; but they were different, there was much more liveliness and participation with them around* [Translation of the original: ... *hanno aportato un elemento di attività, spesso gli allievi sono un po' passivi, tu parli e loro ascoltano, mentre con loro c'era molta più effervescenza*. (Bartoli P, 2014, min. 16:30)]

Some of them stayed for a longer time. Later, local entities in Madrid, Zaragoza and other cities organized local courses. The anthropology contents in those courses were a novelty to the Spanish professionals. For many of them the role played by the publication of some 65 articles on anthropological topics related to medicine or similar concerns in the journal *Jano: Medicina y Humanidades*, between 1985 and 1995, was indeed significant. The publication was distributed at no charge to physicians throughout the country.

The connection between these sectors and professional anthropology in Spain took a long time to be established due to the slow pace with which anthropology was institutionalized in the country.[92] Between 1988 and 1989, at the request of Lluis Salleras along with Ignasi de Juan Creix, the *Institut Català de la Salut* organized in Barcelona a course, in which public health specialists and medical anthropologists such as Paolo Bartoli,[93] Eduardo Menéndez, Oriol Romaní and Josep M. Comelles participated. This course continued to be delivered in different cities of Spain, while the medical anthropology of Italy sponsored the postgraduate training project of the *Universitat Rovira i Virgili* in Tarragona, in 1994.

The CSES was a remarkable teaching institution for an entire generation of specialists in public health and community nursing, with the most progressive of profiles. In the 1990s, the progressive Spanish public health specialists stated, in private, that the CSES model was a thing of the past. Nevertheless, two decades later many of them are still active in institutions such as the *Sistema de Asesoramiento y Recursos en Educación para la Salud* [*SARES*, System of Consultancy and Health Education Resources] of the Government of Aragón,[94] while local community health services keep this flame alive.

## CONCLUSIONS

> *In the eighties and nineties we traveled all throughout Italy to the USLs* [Unità Sanitaria Locale, from Italian, Local Health Units]*, which are currently called ASL o AUSL* [Azienda Unità Sanitaria Locale]*, but then they never called us again; in Italy there was a strong interest for prevention and health education but now this interest has waned* [Translation

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of the original: *Noi negli anni 80-90 giravamo in tutta Italia nelle USL ora si chiamano ASL o AUSL, ma poi non ci hanno chiamato più da nessuna parte, c'era nel paese un'attenzione molto forte ai temi della prevenzione e dell'educazione sanitaria, mi sembra che quest'attenzione sia venuta meno*. (Falteri P, 2014, min 01:01:20)]

The over four decades of perspective offered by Paola Falteri highlight a substantial change that intensified after the Jakarta Conference and which brings to the forefront the progressive, subaltern nature of the local participatory projects that were so important in the 1950s. It cannot be denied that in the foundational projects, the presence of physicians was extremely important, whereas community nursing has evidently gained ground in the last decades. In the initial CSES, medical anthropology was taught to fill a formative gap in social sciences. It was essential to compensate the growing biologicism in medicine, but above all to offer research tools based on ethnography that were very important to understanding local cultural diversity. In the years when the Perusine centre was launched, medical anthropology *stricto sensu* did not exist as such.[95] Applied anthropology from the United States and progressive pedagogy were imported critically to substantiate health education, which was innovative in Europe.

This scenario has changed greatly, especially due to the role assumed by community nursing in health education and health promotion, precisely as one of the effects of Alma Ata and of the goals outlined in the Ottawa and Jakarta Conferences. In the new community nursing and in public health manuals, the social sciences, both sociology and medical anthropology, occupy a central role in the conceptual definition and theoretical synthesis. From the instrumental point of view, other methods such as grounded theory have in part taken the place of ethnography. They include contents and techniques that are present in the academic curricula of general nursing study curricula, as three of the most important reformers, Henderson, Lenninger and Collière[96,97,98] earned their PhDs in anthropology. Today, it is not surprising to find Alessandro Seppilli's definition of health education, included in this article, in Spanish manuals and textbooks about medicine and community nursing.[99]

From a historical perspective, the CSES was a cutting-edge endeavor and a point of reference in a brilliant period in the history of public health in general and health education in particular. Between the San Francisco Conference and the Jakarta Conference in 1997, we may consider that the hegemony of social democratic and Christian social thinking, with wide demands for democratic radicalization, helped encourage collective civil action at the local scale, in contrast to individual empowerment.[62] The influence in the conceptualization of health education was clear.

From the perspective of applied social sciences in Europe, the CSES was an *avant-garde* and innovative experiment due to its explicit and critical incorporation of anthropology into its agenda. The paternal-filial relationship between Alessandro and Tullio Seppilli cannot be reduced to an accidental relationship. Alessandro Seppilli, whose wife was Anita Schwarzkopf, also an anthropologist, first approached anthropology with the aim of finding out the contribution that this social science could make to the understanding and diagnosis of local health concerns. Tullio Seppilli knew how to construct an organic narrative rooted in his mentor Ernesto de Martino, who went beyond the boundaries of the relativism that characterized US cultural anthropology. Furthermore, his followers, who were involved in the CSES project, had no objections to responding to the demands of applied anthropology made by health care professionals, in view of their political and social commitment.

Possibly, in Europe, only Italy had the right conditions to carry this innovative initiative forward. The rigid academicism of European medicine and anthropology of those days could only be broken with the renewed

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social commitment of professionals, both physicians and other health professionals as well as academic anthropologists. The impossibility of such commitment and participation account for the failure of health education in the late years of Francoism and its late success during the Spanish democratic transition.

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