LABORATORIO DEI DIRITTI FONDAMENTALI

HEALTH AS A FUNDAMENTAL RIGHT: A STUDY ON MIGRATION AND HEALTHCARE IN TURIN

LDF RESEARCH REPORTS > 01 2012

ISSN 2280-8884

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With the contribution of:
• *Eros Brunone Avena* (box 7, *Cultural mediators as essential players in intercultural healthcare: a socio-anthropological perspective*)
• *Serena Coppola* (para. 2.1.4. *The European Union*)
• *Elena Grasso* (para. 2.1.5. *The national level*)
• *Anna Odone* (*Appendix 2 Migrant health: health status of migrant populations in Italy*; para. 1.2.2., *Quantitative epidemiologic data*).

Statistical data by the Servizio Sovrazonale di Epidemiologia dell'Azienda Sanitaria Locale TO3 – presented in Chapter 4, *The health status of the migrant population in Turin*, have been processed by
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ISSN 2280-8884

The report is available at:
www.labdf.eu/pubblicazioni/rapporti

"It is my aspiration that health will finally be seen, not as a blessing to be wished for; but as a human right to be fought for."
Kofi Annan

"...the right to health is much more than a convenient phrase which health workers, non-governmental organisations, and civil-society groups can brandish about in the vague hope that it might change the world. The right to health is a legal instrument—a crucial and constructive tool for the health sector to provide the best care for patients and to hold national governments, and the international community, to account."
The Lancet (Editorial)

The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."
Paul Hunt

ACKNOWLEDGMENTS

We are grateful to *Giuseppe Costa*, for the precious advice he provided and for agreeing to share the data of the Servizio Sovrazonale di Epidemiologia dell'Azienda Sanitaria Locale TO3.

We are also grateful to *Luisa Mondo* for all her help, for assisting us with revising the text and for her endless patience.

We further wish to thank:
Matteo Bagatella, *Roberto Bertolino*, *Alberto Biglino*, *Margherita Busso*, *Alessandra Cipparrone, Serena Coppola, Oriana Elia, Franca Fronte, Elena Grasso, Valentina Grosso Gonçalves, Chiara Marinacci, Piergiuseppe Olmo, Stefania Orecchia, Valentina Porcellana, Tania Re, Piercarlo Rossi, Guido Savio, Teresa Spadea, Manuela Spadaro,* and *Cecilia Tibaldi*.

We would like to express our gratitude to all interviewees for the time they devoted to us and for sharing their unique experiences.

Finally, we wish to thank *Laura Ferrero* for her research assistance.

LDF's activities are funded by

FOREWORD

Vladimiro Zagrebelsky

The present report presents the results of a research project focused on access to healthcare by migrants in the Turin (Italy) area, carried out in 2011 and 2012 by the *Laboratorio Diritti Fondamentali* (LDF). According to LDF's philosophy, the study buries its roots in the law, tracing the contours of the right to health and its definition as articulated in international human rights law. At the same time, the study aims to provide an account of concrete phenomena relating to the right to health as they surfaced from a field investigation in the Turin area. To cite a phrase often found in rulings issued by the European Court of Human Rights, this study does not concern itself with rights "that are theoretical or illusory but rights that are practical and effective". Hence, considerable attention is devoted to the so-called social determinants of health and to the way social conditions impact on the effective, non-discriminatory enjoyment of the fundamental right to health by members of a particularly vulnerable segment of the population.

Aspects of the study that are grounded in legal principles are reconciled, in methodology and content, with a practical analysis of the social reality as observed 'on the ground'. The study is by nature interdisciplinary and this aspect clearly emerges in the dialogue and exchange that the authors of the study – jurists by training – have been able to establish with a public health specialist and a medical anthropologist.

The study area is geographically limited to the city of Turin. The methodology used, whereby a web of social relationships is constructed through interviews with a large number of health practitioners and professionals, would have been impossible to carry out on a regional or national scale. However, this does not constitute a weakness. Detailed, careful investigation of the phenomena studied, both in legal and social terms, is a distinguishing feature of the research presented in this document. Restricting the playing field to a relatively circumscribed area made the enterprise possible.

The study area and the employed methodology provided a unique experience for the authors, which I believe is worth highlighting. The actors they sought to interview were extremely responsive and demonstrated a genuine willingness to contribute to the researchers' efforts. This readiness extended well beyond natural courtesy, to a demonstration of authentic interest (and perhaps excessive trust) towards legal discourses rooted in human rights.

This, in my view, is of great significance: it reveals what occurs when jurists direct their attention to the concrete ramifications and 'real life' circumstances that are usually confined to the realm of theory and abstraction. The openness encountered by the researchers also reflects a need, expressed by people who work in extremely challenging physical and social contexts, to exchange and compare views and experiences. Responding to this need from a different standpoint, namely a different professional background, provided an opportunity to show recognition and respect for the role these professionals perform.

It is difficult to summarize and evaluate the results of the present research in a handful of words. While highlighting possible and necessary improvements that need to be implemented in the sphere of access to health care and migration, the study also discloses the existence of a unique system, developed in the Turin area, that often succeeds in providing solutions to the numerous problems experienced by migrants. Such a conclusion, however, should be verified by comparing the findings of the study with the views of migrants. Their voice was not heard during the course of the present research, as this would have required further resources and additional time.

However, investigating the direct experience of migrants will constitute a promising trajectory for future research.

Overall, the information gathered throughout the study suggests that, despite some room for improvement in coordination efforts, public health facilities often work in synergy with the non-profit and voluntary sector. The latter forms of collaboration not only make up for shortcomings in the public sector, but also provide services that, because of their very nature, the public sector would experience difficulties in providing. Thus, when combined, the public and voluntary sectors constitute the core of a system that responds to the criterion of subsidiarity, notwithstanding its roots in a 19th century religious tradition which is unique to Turin. This system may be interesting not merely within the scope of the present study, but also as a future model.

Comparison with different scenarios characterizing other European countries is an important facet of LDF's work. Now that a number of obstacles to the effective realization of the right to health have been identified and some satisfactory solutions have been found in the Turin area, it would be promising and useful to perform comparative assessments.

To the young researchers and authors of the report, to those who have worked on the project with them or have provided advice, it remains for me to express my thanks and appreciation.

LIST OF ACRONYMS

A&E	Accident and Emergency
AIDS	Acquired Immune Deficiency Syndrome
ASL	Azienda Sanitaria Locale (Local Health Service Authority)
CEDAW	Committee on the Elimination of Discrimination against Women
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CIE	Centri di Identificazione e Espulsione (Identification and Repatriation Centres)
COA	Centro Operativo AIDS (AIDS Operative Centre)
CRC	Committee on the Rights of the Child
CSDH	Commission on Social Determinants of Health
ECHR	European Convention on Human Rights
ESC	European Social Charter
EU	European Union
FGM	Female Genital Mutilation
HDD	Hospital Discharge Documentation
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
INAIL	Istituto Nazionale per l'Assicurazione Contro gli Infortuni sul Lavoro (National Occupational Safety Agency)
INPS	Istituto Nazionale della Previdenza Sociale (National Social Insurance Agency)
ISI	Informazione Salute Immigrati (Immigrant Health Information)
ISTAT	Istituto Nazionale di Statistica (Institute for National Statistics)
LDF	Laboratorio dei Diritti Fondamentali (Fundamental Rights Laboratory)
LEA	Livelli Essenziali di Assistenza (Essential Levels of Care)
MDC	More Developed Country
NGO	Non-Governmental Organization
OHCHR	High Commissioner for Human Rights
OR	Odds Ratio
SeRT	Servizio TossicoAlcoldipendenze (Drug and Alcohol Dependency Service)
SMPC	Strong Migratory Pressure Country
SPRAR	Sistema di Protezione per Richiedenti Asilo e Rifugiati (System of Protection for Asylum Seekers and Refugees)
SSN	Sistema Sanitario Nazionale (National Health System)
SSR	Servizio Sanitario Regionale (Regional Health Service)
STD	Sexually Transmitted Disease
STP	Straniero Temporaneamente Presente (Temporarily Present Migrants)
TB	Tubercle Bacillus
TFEU	Treaty on the Functioning of the European Union
TOP	Termination of Pregnancy
TUI	Testo Unico sull'Immigrazione (Single Text on Immigration)
UN	United Nations
URP	Ufficio per le Relazioni con il Pubblico (Public Relations Office)
WHO	World Health Organization

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CHAPTER 1.
INTRODUCTION

1. INTRODUCTION

The present report is the result of the first year of the "Right to Health and Migration" project, developed by the *Laboratorio Diritti Fondamentali* (LDF). The main purpose of this publication is, first of all, to give visibility to the wide range of problems affecting access and utilization of healthcare services by the migrant population in the city of Torino (Italy). Secondly, but of equal importance, the report seeks to frame the concerns which emerge within a human rights framework, specifically through the lens of the normative content of the right to health as it is articulated in international human rights law. In tune with LDF's philosophy, the intended final result is to provide a snapshot of our local reality by transcending theoretical inquiries and abstract discussions on human rights and focus on the way in which the right to health is given effect and enjoyed 'on the ground'. Finally, this study seeks to prompt additional reflection on the importance of integrating a human rights perspective when addressing healthcare policies, strategies and legislative action in our country, and in this sense stimulate the debate on Italy's responsibilities to comply with international human rights obligations.

1.1 DESCRIPTION AND AIMS

Our study rests on the premise that not all users of the health system can fully exercise their right to health and that certain vulnerabilities make access to and use of health services difficult. Considering health as a fundamental right requires directing attention to certain segments of the population, particularly those who live in vulnerable, marginalised or otherwise disadvantaged situations.[1] Our project's focus is on migrants as one of such groups.

The definition of migrant adopted in this study is the United Nations definition: "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country".[2] The migrant category itself also includes sometimes overlapping sub-categories, such as migrant workers and their families, long-term and short-term migrants, asylum seekers, undocumented migrants and human trafficking victims. In order to obtain as full a picture of reality as possible, no distinction is made between documented and undocumented migrants; however, migrants in detention or those held in Italy's Identification and Repatriation Centres (*Centri di identificazione e espulsione* or CIEs) fall outside the scope of the investigation.

Although migration in itself does not constitute a health risk,[3] the migration process may lead to greater vulnerability to physical, mental and social health problems, which will vary according to the different conditions experienced by individuals.[4] Migration may also have negative repercussions on the health of some vulnerable sub-groups, such as trafficking victims, asylum seekers, undocumented migrants, and unaccompanied minors.[5] The United Nations General Assembly has expressed concern as to "the situation of vulnerability in which migrants frequently find themselves, owing, *inter alia*, to their absence from their states of origin and to the difficulties they encounter because of different language, customs and culture, as well as the economic and social difficulties and obstacles to return to their states of origin suffered by migrants who are non-documented or in an irregular situation."[6] Although situations and experiences vary from one migrant to another, many will face similar obstacles to realizing their human rights, including their right to health.

Against this backdrop, the present research seeks to unearth the broad

1 Office of the United Nations High Commissioner for Human Rights (OHCHR) and World Health Organization (WHO) (2008a). *Fact Sheet 31: The Right to Health*.

2 UNESCO; the International Organization for Migration's definition of 'migration' is "a process of moving, either across an international border and within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition or causes". International Organization for Migration (2004). *Glossary on Migration, International Migration Law Series*.

3 See Chapter 5 and Appendix II.

4 International Organization for Migration (2007). *Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments.*

5 World Health Organization (2008). World Health Assembly. *World Health Assembly resolution WHA61.17 on the health of migrants*.

6 United Nations (2007). General Assembly Resolution. *Human rights of migrants*, UN Doc. A/RES/57/218.

spectrum of challenges faced by migrants, irrespective of their legal status, as recipients of health services in the city of Torino.

The aim of the present study is to assess the obstacles (whether legal, social, cultural, or institutional) that prevent migrants from accessing and using to the fullest extent health services in the city of Torino, Italy.

Our study includes both qualitative and quantitative data and was carried out by an interdisciplinary research team. While the authors are jurists, the team included a specialist in public health and preventive medicine[7] and a medical anthropologist.[8] Qualitative data is gathered through a field investigation based on semi-structured, in-depth interviews with key actors at the local level, including staff of public hospitals, patient administration, emergency wards, social services, cultural mediators, local and regional government representatives and staff, local and national NGOs, volunteer and community organizations, and other experts in our field of interest. The quantitative data relating to the key health concerns of the migrant population were provided by LDF's research partner, the Regional Epidemiology Unit in Turin's Administrative Area 3 (*Servizio Sovrazonale di Epidemiologia ASL To3)*. The methodology is described in greater detail in Chapter 1.2.

The intersection between migration and healthcare has been the subject of numerous international[9] and national[10] studies, which have inspired and guided our study. However, what emerges from a review of available Italian literature on the topic is the absence of a human rights analysis of the numerous issues which are identified as causes for concern. This may be in part attributable to a generally limited attention afforded to international human rights standards and corresponding state obligations in Italian political and public discourse, as well as in the realm of policymaking at the national, regional, and local level.

In aiming to cover new ground in relation to previous research and to introduce new elements into the debate on migration and health, our study carries out research based on human rights in general and the right to health in particular.

The selected conceptual container, or the lens through which we assess the information gathered in the course of our investigation, is the normative content of the right to health as defined in international human rights law. We therefore analyse the right to health in terms of availability, accessibility, acceptability and quality, and in terms of the underlying determinants of health, or the factors and conditions which influence the right to health beyond health services, goods and facilities.[11] In this regard, we also take into consideration other integral components of the right to health, such as, inter alia, adequate nutrition and housing, healthy working and environmental conditions, education and information accessibility.

The right to health is used as a yardstick against which the findings of our research are measured, in order to ultimately assess the degree of realization of the right under scrutiny in the research area.

7 Author of Appendix 2, *Migrant health: health status of migrant populations in Italy*.

8 Author of Box 7, *Cultural mediators as essential players in intercultural healthcare.*

9 See, *inter alia*, Rechel, B., Mladovsky P, et. al. (ed.) (2011). *Migration and health in the European Union, European Observatory on Health Systems and Policies Series,* Maidenhead: Open University Press; World Health Organization (2010). *How health systems can address health inequities linked to migration and ethnicity*, Copenhagen: WHO Regional Office for Europe; World Health Organization (2010). *Health of migrants: the way forward - report of a global consultation*, Geneva: WHO; Nygren-Krug, H. (2003). *International migration, health and human rights*, Geneva: World Health Organization; International Organization for Migration (2010). *Migration Health Report of Activities 2010*, Geneva: IOM; International Organization for Migration (2005). *Health and Migration: Bridging the Gap*, Geneva: IOM; Ingleby, D. (2009). *European research on migration and health. Background paper for AMAC project*. Brussels: IOM; European Union Agency for Fundamental Rights (2011). *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, Vienna: FRA; Stanciole, A., Huber, M. (2009). *Access to health care for migrants, ethnic minorities, and asylum seekers in Europe: policy brief*. Vienna: European Centre for Social Welfare Policy and Research; Peiro, M.J., Benedict, R. (2009). *Migration health: better health for all in Europe: final report*. Brussels: International Organization for Migration; European Observatory on Access to Health Care, Doctors of the World, (2007) *European survey on undocumented migrants' access to health care*.

10 See, *inter alia*, Osservatorio nazionale sulla salute nelle regioni italiane (2011). *Rapporto Osservasalute 2011*, available on www.osservasalute.it; Ministero della salute/Centro nazionale per la prevenzione e il controllo delle malattie (CCM) – Regione Marche (2009). *La salute della popolazione immigrata: metodologia di analisi*; Istituto Nazionale di Statistica (2008). *Salute e ricorso ai servizi sanitari della popolazione straniera residente in Italia, Anno 2005*, available on www3.istat.it; CARITAS/MIGRANTES (2011). *Dossier Statistico Immigrazione 2011, 21° rapporto*, Roma: Edizioni Idos; Geraci, S., Maisano, B., Mazzetti, M. (2005). *Migrazione e Salute. Un lessico per capire*, Roma: Centro Studi Emigrazione; Geraci, S., Martinelli, B. (2002). *Il diritto alla salute degli immigrati. Scenario nazionale e politiche sociali* Roma: Anterem; Il nostro pianeta (2010). *Indagine*

The study also aims to highlight the benefit of an approach based on human rights in general and on the right to health in particular. Because such an approach places the well-being of individuals, communities, and populations at the very core of the health system, the right to health can help to ensure that a health system is "neither technocratic nor removed from those it is meant to serve".[12] This objective has also been identified by the World Health Organization (WHO), in its statement that "healthcare systems and services are mainly focused on disease rather than on the whole person, whose body and mind are linked and who needs to be treated with dignity and respect"[13] and that to overcome this limit "healthcare services and systems must embrace a more holistic, people-centred approach."[14]

Moreover, reframing something as a right emphasizes its fundamental importance in terms of social or public goals, and it hinges on the idea that the dignity of each person must be central in all aspects of healthcare. A rights-based approach offers a strong "normative vocabulary" that allows for both the identification of entitlements by rights-holders and the duties to provide such entitlements, not to society in general, but to each individual.[15]

Against this backdrop, our work seeks to add a small stepping stone towards the promotion of a stronger human rights culture in Italy by using human rights as a lens with which to view the intersection between health and migration. The underlying aspiration is to see a shift for human rights away from the mere rhetorical level towards a true commitment to rights-oriented action when developing health policies and programs.

The integration of a human rights perspective in ongoing health and migration discourse in Italy, both at the national and local level, provides a solid normative framework anchored on concrete entitlements and corresponding responsibilities.

1.2 THE STUDY

A combination of qualitative and quantitative methods was used to collect the data in our project.

1.2.1 QUANTITATIVE EPIDEMIOLOGIC DATA[16]

A quantitative analysis was used to describe the health status of migrant populations in the Piemonte Region. In particular, the analysis focused on the health-related issues raised through the interviews.

All hospital discharge records from 2009 were retrospectively analyzed. The study population included the total resident population of the Piemonte Region. Data was provided by the Regional Epidemiology Unit in Turin's Local Healthcare Centre 3 (*Servizio Sovrazonale di Epidemiologia ASL To3)* and analyzed in collaboration with its staff.

Diseases were classified according to the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10). Descriptive analyses were carried out and data on hospitalization were presented by cause, gender, age bands and whether patients were Italian, foreign residents, or illegal immigrants. Absolute frequencies and rates (per 1000 residents) were calculated and are presented in tables and graphs.

Age bands were defined as specified in the introduction (<1 year, 1-4, 5-17,

sui percorsi di salute dei migranti a Torino, IRES Piemonte; NAGA (2012). *Comunitari Senza Copertura Sanitaria, Indagine sul difficile accesso alle cure per i cittadini rumeni e bulgari a Milano e in Lombardia: quando essere comunitari è uno svantaggio*, Milano, available on www.naga.it; Gruppo Abele (2008). *Rapporto donne migranti e salute* Torino: EGA Edizioni.

11 OHCHR (2008) supra note 1, at p. 10.

12 Hunt, P. and Backman, G. (2009). "Health systems and the right to the highest attainable standard of health", in Clapham, A., and Robinson, M., *Realizing the Right to Health*, Swiss Human Rights Book Vol. III. Bern: Ruffe & Rub.

13 World Health Organization (2007). *People at the Centre of Health Care, Harmonizing mind and body, people and systems*, Geneva.

14 *Ibid.*

15 Leary, V. (1994). "The Right to Health in International Human Rights", *Health and Human Rights*, Vol. 1(1), p. 24-56.

16 Author: Anna Odone.

18-34, 35-49, 50-64 and >64 years). The population was split in the following subgroups for comparative analyses: Italian residents, foreign residents and undocumented migrants. Study participants were categorized based upon 'citizenship' as listed in medical records. Undocumented migrants were identified through the categories 'foreign citizenship,' 'foreign residence' or 'irregular status.'

To calculate risks, data on the total population were obtained from the Regional Demography database. The population total from the 1st January 2009 was used. Data on the total Italian resident population were obtained by subtracting the foreign resident population from the total resident population. As no data were available on irregular immigrant populations, hospitalization risks for this subgroup of the population could not be calculated.

1.2.2 QUALITATIVE DATA

Data concerning the obstacles encountered by migrants wishing to access and use health services in Turin was primarily gathered through a series of interviews with key actors involved at local level in the field of health and migration, complemented by desk research.

The interviewees included people with responsibility for public healthcare services, other healthcare practitioners and professionals, non-profit association personnel, public administration personnel, and specialists in the areas studied. A total of 96 interviews were carried out. Of these, 26 were with non-profit sector personnel, 30 with physicians from various fields (Emergency Medicine, infectious diseases, paediatrics, epidemiology, general practice, surgery, gynaecology and obstetrics), 13 with non-physician healthcare practitioners (trained nurses, social and health care practitioners, midwives), 11 with cultural mediators, 12 with personnel employed in local institutions and bodies (Police; Prefecture; Regional Healthcare Services Agency; Turin City Council and its Office for Foreigners, Office for Foreign Minors and Office for Adults in Difficulty), 8 with psychologists, 3 with university research staff, 2 with social workers, and 1 with an educator. In some cases, interviewees belonged to more than one category, for example in interviews with physicians working in the non-profit sector.

The interviews were conducted following the interview guidelines in Appendix 3, and they were targeted at investigating the migrant population's difficulties and needs in terms of health, as well as the solutions provided and the problems experienced by existing healthcare services. It must be stressed that, although interviews were not conducted with migrants, this will be an area for future research.

The study also drew on previous research on migration and health in Turin, as well as two conferences organized by LDF, during which information and opinions were sought from sector specialists.

1.3 REPORT STRUCTURE

The first part of the document (Chapter 2) will be devoted to outlining our conceptual framework. We will begin by exploring the legal recognition of the right to health at the international, regional and national level. We will then analyse the components which make up the right to health - its so called 'normative content' - and explain what obligations arise for states.

In Section 3 we will fence off the playing field by describing the migration phenomenon in the city of Torino and by providing an overview of the key actors and health services in our study area. Chapter 4 provides an overview of the health status of the migrant population in the city of Torino. Section 5 will present and analyse our results and findings against the backdrop of our theoretical framework. Reflecting the normative content of the right to health, it will be split into two subsections, the first focusing on the right to health care and services in terms of their availability, accessibility, acceptability and quality, and the second will concentrate on the underlying determinants of health. Section 6 will be devoted to conclusions.

As a concluding remark it must be stressed that the present work intends to serve as a 'baseline report' whose key objective is to "chart the territory" and hopefully provide a solid basis for further, more detailed investigations on specific issues which emerged.

CHAPTER 2.
THE RIGHT TO HEALTH

2. THE RIGHT TO HEALTH

Following a description of our investigation and its objectives, the conceptual underpinnings of the study, which provide the theoretical foundations for our analysis, must be explored. The aim of this section is to explain what is meant by the expression "right to health" and provide an overview of how the right to health is recognized and articulated in international human rights instruments and in other internationally accepted standards and norms. We will then move to the core of our theoretical overview and analyse the components which make up the right to health or its so called 'normative content' and identify what obligations arise for states.

2.1. DEFINING THE RIGHT TO HEALTH

During the course of our research what has emerged, as far as the definition of the right to health is concerned, is a degree of conceptual confusion surrounding the term. The expression is used in different ways and different contexts, but seldom reflects its meaning and content as defined in international human rights law. To quote the editorial of the special issue of the medical journal *The Lancet* devoted to the sixtieth anniversary of the Universal Declaration of Human Rights, "[t]he right to health is much more than a convenient phrase which health workers, non-governmental organisations, and civil-society groups can brandish about in the vague hope that it might change the world. The right to health is a legal instrument—a crucial and constructive tool for the health sector to provide the best care for patients and to hold national governments, and the international community, to account".[1] This is why this first part is devoted to pinning down the meaning of the right to health as articulated in international law and in other internationally accepted standards.

First of all, the expression 'right to health' is the shorthand version for the *right to the highest attainable standard of physical and mental health*. The right to health has been recognized as a fundamental human right which is indispensable for the enjoyment of many other human rights, and vital in order to live a life in dignity.[2] However, the right to health does not equate a right to be *healthy*. The right to health is composed by both freedoms and entitlements. The freedoms include the right to control one's health and body and the right to be free from interference (such as the right to be free from torture, non-consensual medical treatment and experimentation) while the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the *highest attainable level of health*.[3] The right to the highest attainable standard of health is concerned with both processes and outcomes. It is interested in not only what a health system does (for example, providing access to essential medicines and safe drinking water), but, as we will see shortly, also how it does it: for example, transparently, in a participatory manner, and without discrimination.[4] As outlined in the present chapter, the right to health has been endorsed by a wide array of international and regional human rights instruments.

2.1.1. THE RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

The right to health is relevant to all virtually all States, as every State in the world has ratified at least one international human rights treaty recognizing the right to health.[5] In this regard, it must be underlined

1 Lancet (2008) "Editorial: The right to health: from rhetoric to reality" *The Lancet*, Volume 372, Issue 9655, p. 2001.

2 Riedel, E. (2009) "The Human Right to Health: Conceptual Foundations", in Clapham, A., and Robinson, M., *Realizing the Right to Health*, Swiss Human Rights Book Vol. III. Bern: Ruffe & Rub, p. 36.

3 Committee on Economic, Social and Cultural Rights (CESCR) (2000). General Comment No. 14, UN Doc. E/C.12/2000/4.

4 Hunt P. and Backman G., (2009) "Health systems and the right to the highest attainable standard of health", in Clapham, A., and Robinson, M., *Realizing the Right to Health*, op. cit. p. 83.

5 Office of the United Nations High Commissioner for Human Rights and World Health Organization (2008) *Fact Sheet 31: The Right to Health*.

that Italy has ratified the major human rights treaties dealt with under this section, with the exception of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990).

The 1948 Universal Declaration of Human Rights[6] includes health as part of the right to an adequate standard of living (art. 25).[7] The Declaration affirms:

> *(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*
> *(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.*

While the Universal Declaration of Human Rights is not strictly legally binding, it is almost universally acknowledged by legal scholars that many of its provisions constitute customary international law.

The right to health is explicitly recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR).[8] Article 12, states that:

> *1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

An authoritative interpretation of the substantive content of the right to health is provided by the United Nations Committee on Economic, Social and Cultural Rights in General Comment 14.[9] The content of the General Comment will be addressed in greater detail, *infra*, in section 2.2.

Additionally, the right to health is recognized in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965,[10] which states that States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law in the enjoyment of right to public health, medical care, social security and social services. The Right to Health is also contained in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979.[11] Article 12 states that:

> *1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.*
> *2. Notwithstanding the provisions of paragraph I of this article, States Parties*

6 Universal Declaration of Human Rights, UN General Assembly Resolution 217 A (III). A/810 at 71 (1948).

7 Pillay, N. (2008) Right to health and the Universal Declaration of Human Rights, *Lancet*, Vol 372 December 13, 2008.

8 Ratified by Law n. 881, October 25, 1977.

9 See Committee on Economic, Social and Cultural Rights - General Comments, www2.ohchr.org/english/bodies/cescr/comments.htm. Also see Alston, P. (2001) "The historical origins of the concept of 'general comments' in human rights law", in Boisson de Chazournes, L. and Gowlland-Debbas, V. (eds.), *The International Legal System in Quest of Equity and Universality*, Leiden: Martinus Nijhoff.

10 Ratified by Law n. 654, October 13, 1975.

11 Ratified by Law n. 132, March 14, 1985.

shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

A number of aspects of the right to health are contained within the Convention on the Rights of the Child[12] both implicitly, in the obligation imposed on States Parties by Article 6 to ensure, to the maximum extent, possible the survival and development of the child and explicitly in Articles 24 and 25. Article 24 sets out that States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall take appropriate measures:

(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.

The Convention on the Rights of Persons with Disabilities[13] is also quite detailed when it comes to defining the right to health, as it recognizes, at art. 25, that:

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:
a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
c. Provide these health services as close as possible to people's own communities, including in rural areas;
d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
e. Prohibit discrimination against persons with disabilities in the provision

12 Ratified by Law n. 176, May 27, 1991.

13 Ratified by Law n. 18, March 3, 2009.

of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
f. Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Even though, as we mentioned in the introduction, Italy has not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families it must be highlighted that the document contains provisions relating to the right to health. In particular, article 43, which specifically obliges States to ensure equal access to health care by regular migrant workers and their family members, and article 28 which guarantees the right of migrants and their families to receive any medical care that is urgently required for the preservation of their life or for the avoidance of irreparable harm to their health, regardless of their irregularity with regard to stay or employment. Work-related issues of health have also taken been addressed by the International Labour Organization (ILO). Conventions No. 155 on Occupational Safety and Health (1981), and No. 161 on Occupational Health Services (1985).

Box 1. The key human rights treaties containing the right to health

- Convention on the Elimination of All Forms of Racial Discrimination (1965): article 5 (*e*) (iv).
- International Covenant on Economic, Social and Cultural Rights (1966): article 12.
- Convention on the Elimination of All Forms of Discrimination against Women (1979): articles 11 (1) (*f*), 12 e 14 (2) (*b*)
- Convention on the Rights of the Child (1989): articles 24 e 25.
- Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990): articles 28, 43 (*e*) e 45 (*c*).
- Convention on the Rights of Persons with Disabilities (2006) article 25.

2.1.2. THE UNITED NATIONS HUMAN RIGHTS MECHANISMS

Over the last decade, increasing attention has been paid to the right to the highest attainable standard of health at the United Nations level, for instance by human rights treaty monitoring bodies and by the Commission on Human Rights - now replaced by the Human Rights Council - which in 2002 created the mandate of Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health.[14] Since the creation of this mandate, the Special Rapporteur has submitted annual thematic reports and reports on country missions to the Human Rights Council (and the former Commission). Examples of reports which focus on specific themes include reports on a human rights-based approach to health indicators; the rights to sexual and reproductive health; water, sanitation and the right to the highest attainable standard of health; right to health in the context of access to medicines and intellectual property rights; mental disability and the right to health right to health and criminalization of same-sex conduct and sexual orientation, sex-work and HIV transmission; right to health and development; right to health and informed consent; and the right to health and the reduction of maternal mortality.[15]

The Human Rights Council[16] and its predecessor, the Commission, have also adopted a number of resolutions on the right to health. In

14 Commission on Human Rights resolution 2002/31. See *Fact Sheet N° 27: Seventeen Frequently Asked Questions about United Nations Special Rapporteurs*. Hunt, P. (2001) "The right to health: from the margins to the mainstream" *Lancet* Vol 360 December 7, 2002. An overview on special procedures can be found in Golay, C., Mahon, C. and Cismas, I. (2011) "The Impact of the UN Special Procedures on the Development and Implementation of Economic, Social and Cultural Rights", in *International Journal of Human Rights* Vol. 15, No. 2.

15 Reports are available at www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx

16 The Human Rights Council is an intergovernmental body within the United Nations system responsible for strengthening the promotion and protection of human rights and for addressing situations of human rights violations and make recommendations on them. www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx.

2010 the Human Rights Council adopted a general resolution Right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[17] Other Council resolutions include ones focusing on the right to health in the context of development and access to medicines, on preventable maternal mortality and morbidity, right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the context of development.[18]

Attention to the right to health has also been paid by the United Nations Treaty Bodies.[19] The Committee on Economic, Social and Cultural Rights (CESCR), which is the body entrusted with monitoring the Covenant, has adopted General Comment 14 on the "right to the highest attainable standard of health", in the year 2000, which expands upon Article 12 of the ICESCR, as mentioned above.[20] General Comment 14 is considered to be the most comprehensive interpretation of the international right to health, and corresponding state obligations. In Chapter 5 we will draw on some elements contained in this document in order to provide the framework for our analysis.

As to examples from other bodies, the Committee on the Elimination of Discrimination against Women (CEDAW) has adopted "General Recommendation 24 on "Women and health"[21] and the Committee on the Rights of the Child (CRC) has adopted "General Comment 4 on Adolescent health and development in the context of the Convention on the Rights of the Child" and "General Comment 3 on HIV/AIDS and the rights of the child".[22] Finally, the Committee on the Elimination of Racial Discrimination adopted "General Recommendation No. 30: Discrimination Against Non Citizens", which is particularly relevant for our focus on migrants. The document states that States parties must "remove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the areas of education, housing, employment and health" and "respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services".[23]

2.1.3. THE WORK OF THE WORLD HEALTH ORGANIZATION

The WHO, like most specialized agencies of the UN system, places great emphasis in its work on formulating policies, strategies and programmes of action, rather than laws.[24] Yet, internationally, as a normative standard, the right to health was articulated for the very first time in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[25] The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The WHO definition is, generally speaking, the accepted starting point for subsequent elaboration of the right to health in international, regional and national instruments. This definition focuses on the coexistence of two elements: a 'negative' element that refers to absence of disease or infirmity and one 'positive' element which entails the promotion of human well-being. Such an articulation suggests that the right to health was conceived in broad terms that included the right to an adequate standard of living, thus reflecting and reinforcing the public health principle that a person's health status "is influenced by a number of socio-economic factors that are generally

17 *Human Rights Council resolution* 15/22 of 30 September 2010.

18 Resolutions are available at www2.ohchr.org/english/bodies/hrcouncil/15session/resolutions.htm.

19 Whose tasks, in a nutshell, involve the assessment of the extent to which States parties are complying with the obligations imposed by treaties to which they are parties. This includes the examination of actual or potential violations and evaluation of information given by governments and relevant interested parties, such as NGOs, and make suggestions and recommendations for future follow-up of the implementation of the treaty within the country concerned.

20 Committee on Economic, Social and Cultural Rights. *General Comment 14, The right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4.

21 Committee on the Elimination of Discrimination Against Women (1991). *General Recommendation 24, Women and Health*, UN Doc. A/54/38/Rev.1. also see *General Recommendation No. 14 (Ninth Session). Female circumcision*. UN Doc. A/45/38 e General Recommendation No. 15 (Ninth Session), *Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, UN Doc. A/45/38.

22 Committee on the Rights of the Child, *General Comment No. 3, HIV/AIDS and the rights of the child*, UN Doc. CRC/GC/2003/1.

23 Committee on the Elimination of Racial Discrimination, *General Recommendation no. 30, Discrimination against Non-Citizens*, UN Doc. CERD/C/64/Misc.11/rev.3

24 Riedel, E. (2009) op. cit.

25 World Health Organization (1946). Constitution of the World Health Organization, adopted by the International Health Conference, New York, 19 June–22 July 1946, and signed on 22 July 1946 by the representatives of 61 States.

accepted as falling outside the confines of clinical curative medicine".[26]

The right to health has subsequently been introduced in a number of WHO declarations, such as the 1978 Alma-Ata Declaration on Primary Health Care, which "strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".[27] The Declaration calls on states to ensure the availability of the essentials of primary health care, which include education concerning health problems and the methods for preventing and controlling them, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning; immunization against major infectious diseases, prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries and provision of essential drugs. In 1998, the World Health Assembly reaffirmed the commitment of nations to achieve such goals in the World Health Declaration, which demonstrates a willingness "to promote health by addressing the basic determinants and prerequisites for health" and the priority "to pay the greatest attention to those most in need, burdened by ill health, receiving inadequate services for health or affected by poverty".[28]

2.1.4. THE COUNCIL OF EUROPE AND THE EUROPEAN UNION

The two most prominent European supranational organizations, the Council of Europe and the European Union, also recognize the right to health.

THE COUNCIL OF EUROPE

The European Social Charter (ESC) complements the European Convention on Human Rights in the field of economic and social rights. The Charter has several provisions which guarantee, expressly or implicitly, the right to health. Article 11 covers numerous issues relating to health. It states that:

> *With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:*
> *1. to remove as far as possible the causes of ill-health;*
> *2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
> *3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.*

The health and wellbeing of children and young persons are protected by Articles 7 and 17. The health of pregnant women is covered by Articles 8 and 17 and the health of elderly persons is dealt with in Article 23.[29] The European Social Charter is overseen by the European Committee of Social Rights, which makes assessments on the conformity of national situations with the European Social Charter and adopts conclusions in the framework of the reporting procedure.

Under the European Social Charter states must ensure compliance with

26 Judith Asher (2004) *The Right to Health: A Resource Manual for NGOs* p. 19.

27 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

28 World Health Organization (1998). World Health Assembly Resolution on the World Health Declaration, WHA51/5 adopted by the fifty-first World Health Assembly, Geneva, 1998.

29 For further information Council of Europe (2009) *The Right To Health and the European Social Charter*, Information document prepared by the secretariat of the ESC.

a number of elements connected to the right to health. These are, first, a health care system including public health arrangements providing for generally available 'medical and para-medical practitioners and adequate equipment consistent with meeting its main health problems ensuring a proper medical care for the whole population'. Second, it requires the provision of special measures safeguarding health and health care access for vulnerable groups. Third, public health protection measures, preventing air and water pollution, noise abatement, food control and environmental hygiene, must be provided. Fourth, there is a requirement to provide health education. Fifth, in order to prevent epidemics, measures providing vaccination, disinfection and control of epidemics are required.[30]

The Council of Europe Convention on Human Rights and Biomedicine of 4 April 1997 aims "to ensure equitable access to health care of appropriate quality in accordance with the person's medical needs" and imposes an obligation on States to use their best endeavours to reach it. Article 3 of the Convention states that "[p]arties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality".[31]

The European Convention on Human Rights and its protocols do not explicitly recognise the right to health, but offer indirect protection through the expansive judicial interpretation of other, health-related rights.[32] These include the right to life (Article 2),[33] the prohibition on torture, inhuman, or degrading treatment or punishment (Article 3) [34] and the right to respect for privacy and family life (Article 8).[35]

THE EUROPEAN UNION[36]

Within the EU legal system, the lack of fundamental rights provisions in the original Treaties, related to the strong economic focus that characterized the EU at the outset, entailed only a gradual development of the protection of such rights. To this day, the protection of fundamental rights in the EU displays unique characteristics.

In the EU legal system, the protection of the right to health, and of other economic and social rights, is limited. Such protection is mainly grounded on a series of secondary laws which regulate certain aspects of the right to health in various sectors.

Although the Charter of Fundamental Rights of the European Union recognises health as a fundamental right (Art. 35), the Union still lacks exclusive authority in this area (TFEU Art. 4 and Art. 6). It can intervene only by complementing and promoting cooperation between member states (TFEU Art. 168), and has no power to define a common health policy. Thus most measures adopted by the EU in such a field are primarily aimed at coordinating national systems in three areas: protection of workers in the workplace,[37] access to cross-border healthcare services,[38] and consumer protection.[39]

Health protection is one of the objectives pursued by the EU, as shown by Health Strategy 2008-2013 - which is part of the wider framework for growth, Europe 2020, - as well as by legislation on food and pharmaceutical products. However, it does not constitute, *strictu senso*, a fundamental right. Health is moreover taken into account when developing solutions to an ageing population, when addressing protection of the workplace, in order to increase employment and the quality of work, as well as to guarantee a single market of healthcare services.

30 McHale, J. (2010) Fundamental rights and health care in *Health Systems Governance in Europe: The Role of European Union Law and Policy*, Edited by Elias Mossialos.

31 Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.

32 See Chenal, R. (2010) "Il diritto alla salute e la Convenzione europea dei diritti dell'uomo" in Cavallo Perin, R. *et. al.* (eds.) *I diritti sociali come diritti della personalità*, Napoli: Edizioni Scientifiche Italiane.

33 See, *inter alia*, *Association X v. UK* (1978), *L.C.B. v. UK* (1998), *Karchen et al. v. France* (2008), *G.N. et al. v. Italy* (2009).

34 See, *inter alia*, *D. v. UK* (1997), *Keenan v. UK* (2001), *Mouisel v. France* (2002).

35 See, *inter alia*, *Lopez Ostra v. Spain* (1994), *Storck v. Germany* (2005), *X v. Austria*, no 8278/78 (1979), *Taskin and others v. Turkey* (2004), *Tatar v. Romania* (2009).

36 Author: Serena Coppola.

37 Law on the protection of the health of workers in the workplace is very extensive and tends to be sectorial: for example, protection of maritime workers, workers on secondment, pregnant workers, etc. Below are some of the most important rulings in the area of application of the two main laws governing the protection of workers in general, namely Directive 89/391 (on implementation of measures aimed at promoting improvement in health and safety of workers during work) and subsequent modifications, and Directive 2003/88 (on some aspects of organisation of working hours) : Court of Justice Case C-173/99 *BECTU*, [2001] ECR I-04881; joined cases from C397/01 to C403/01, *Pfeiffer et al*., ECR I8835; Case C14/04, *Dellas et al*., ECR I10253, Case C484/04, *Commission/United Kingdom*, ECR I7471; Case C-243/09 *Fuß* not yet reported.

38 The obligation for member states to reimburse medical expenses paid by their citizens in another member state has been gradually confirmed by the Court of Justice through the following rulings: *Decker* Case C- 120/95, [1998] ECR I-01831; *Koholl* Case C-158/96, [1998] ECR I-01931; *Peerbooms* Case C-157/99, [200] ECR I-05473; *Vaenbraekel* Case C-368/98, [2001] ECR I-05363; *Mullür-Frauré* Case C-385/99, [2003] ECR I-04509.

39 Legislation on consumer health protection consists of an enormous number of regulations and action

2.1.5. THE NATIONAL LEVEL[40]

In the Italian legal system, the right to health entails a 'positive' component, namely the right to receive services, i.e. health care and medical treatment, and a 'negative' component, i.e. the right not to suffer damage caused by others. Article 32 section 1 of the Italian Constitution identifies health as a fundamental right, but guarantees free health care only for those with low or no income. Although the realization of the right is subject to available resources,[41] essential healthcare services must be provided to all individuals, with no discrimination as to citizenship or income.[42] Moreover, resource considerations and public finance requirements cannot, under Italian law, impinge on the 'minimum core' of the right to health, which is protected by the Constitution as an inviolable facet of human dignity.[43] Since the seventies, the Court of Cassation and the Constitutional Court have considered the right to health as a right for which, in case of infringement, compensation may be claimed,[44] thus associating it with the rights provided for under Article 2 of the Constitution. The right to health constitutes a guiding principle for the enactment of legislation but can also be invoked in relations between private citizens:[45] every individual's relationship with health goods and services does not only involve the expectation that healthcare services and treatment will be provided, but also that no action that may harm a person's health can be taken. The protection of the right provided for by Article 32 of the Italian Constitution, therefore, encompasses both public and private interests and relationships.[46]

Ordinary civil courts have the jurisdiction to rule on disputes regarding certain aspects of the right to health.[47] For example, a community wishing to bring a claim to assess the need to protect its health - possibly endangered, for example, by a government decision to build a nuclear power station in the area - will have its case heard in the ordinary civil courts, as established by the Court of Cassation.

The right to receive compensation for the harm caused to his/her health, understood as harm to the psycho-physical wellbeing of the interested party, regardless of whether or not it is the consequence of an offence, was recognised in ruling 184 of 14th July 1986. The ruling linked compensation for "biological harm" to Article 2043 of the Civil Code and Article 32 of the Constitution, and recognised the right to health as an autonomous personal right which may also apply in relations between private individuals.[48] According to Court of Cassation rulings 8827/2003 and 8828/2003, compensation can be awarded for material or 'biological' damage for pain and losses suffered and compensation for moral damage, as long as the damage suffered is the consequence of harm to a constitutionally protected interest".[49] Non-economic damages are further provided under article 2059 of the Italian Civil Code. This has also been upheld by the Constitutional Court, which in 2003 provided an interpretation of Article 2059 of the Civil Code, specifying further categories of non-economic harm deriving from harm to constitutionally guaranteed interests, and clarifying that damages may be awarded regardless of whether or not an offence can be identified.[50]

It must be further noted that the obligation to compensate both in the case of unintentional or intentional harm also applies to public bodies, as specified in Ruling 307 of the Constitutional Court of 22 June 1990. In the latter case, the Court confirmed that compensation could be awarded for harm to health caused by insufficient provision of information by public authorities on the precautions required to reduce risk of infection. In this case, a mother had initiated legal action against the Ministry of Health in

plans in various areas where the Union has authority. See, *inter alia*: Food and animal feed safety; Scientific committees in the consumer safety, public health and environment sectors; Food and animal feed (GMOs); Restricted use of genetically modified microorganisms (GMMs); Medical Devices; Active implantable medical devices; In vitro diagnostic medical devices.

40 Author: Elena Grasso.

41 The right to health entails decision-making regarding instruments, times and methods of implementation, which are defined in legislation (Ruling no.139, 27 July 1982) and may have to take account of both organizational aspects of healthcare services and of other interests also requiring protection (Ruling no. 175, 10 November 1982).

42 Constitutional Court Ruling no. 423, 2 December 2005.

43 See Ruling 309, 16 July 1999.

44Constitutional Court, 26 July 1979, no. 88.

45 The Court had to establish whether damage to health, in this case resulting from a firearm injury, was eligible to be compensated as impairment of the asset of health *res ipsa*, since remedy could not be limited to the consequences of reduced ability to produce income. The court ruled that compensation was due in the same measure as for non-economic damage under article 2059, with the same offence occurring.

46 Art. 32 Const., in Bartole, S. and Bin, R. (eds.) (2008). *Commentario breve alla Costituzione*, Padova, p. 320 – 332.

47 Perlingeri, P. (1982). "Il diritto alla salute quale diritto della personalità", in *Rass. Dir. civ.,* p. 1020. See also Ordinanza Trib. di Trani, 28 marzo 2008, n. R.G. 10087/08.

48 See also civil cassation rulings: 29 December 1990, n. 12218, in Rep. Foro it., 1991, Sanità pubblica, no.191; 3 October 1996, no. 8661, id., 1996, I 3331.

49 Civil Cassation, sect. III, ruling n° 8827, 31.05.2003.

50 Constitutional Court ruling n° 233, 11 July 2003.

relation to damage suffered from poliomyelitis (including permanent spinal paralysis), which she had contracted from her son because inadequate information had been provided about the risks of contracting the disease.

Individuals also have the right to receive adequate information in relation to the nature and possible developments of the treatment they may be given, as well as any possible alternative treatments. This information must be as exhaustive as possible, in order to guarantee free and informed choices to be taken by individuals. In this regard, informed consent "must be considered a fundamental principle in the protection of health, a principle whose configuration is the responsibility of national legislation".[51]

The right to free or affordable healthcare, as set out in Article 32 of the Constitutions, have often been interpreted as a 'programmatic objective', and the Constitutional Court has always attempted to strike a balance between the principles of the Constitution, the independence of parliament and budgetary requirements.

The right of citizens to the provision of health services from the State is covered by Law 833/1978, which established the Italian national health service (*Servizio Sanitario Nazionale, SSN*) in tune with the criteria of equity and universality. The objectives of the *SSN*, operating through Local Healthcare Units which subsequently became Local Healthcare Enterprises under Legislative Decree 502/1992, extended beyond the requirements of the Constitution: access to healthcare services and the right to health are guaranteed for all citizens, and the service is free of charge for categories of individuals beyond those with no or low income.

Ruling 455 of 16 October 1990 seeks to strike a balance between the right to public provision of health care and the availability of sufficient financial resources, and identifies criteria of 'reasonableness' against which to assess the provision of healthcare against other "values and interests of equal importance".[52] The latter interests cannot be ignored by constitutional judges in their interventions.[53] Nevertheless it is only in more recent times that human right-based interpretations have influenced the Constitutional court in its balancing exercises between economic considerations. The Court identified within the right to health an "irreducible core protected by the Constitution as an inviolable component of human dignity"[54] that must be afforded more weight than the need to reduce public spending.

However, the definition of what constitutes the essential content of the right to health comes under the authority of the State, which is entrusted with the task of defining "essential levels of healthcare services that must be guaranteed throughout the country."[55] The Constitutional Court held that the legislature must enact the necessary rules to ensure that everyone, throughout the country, can access and utilize health care services and that regional legislation cannot impose limitations on the enjoyment of such services.[56] Finally, a combined reading of Articles 3, 32.1, and 117.2.m of the Constitution leads to an understanding of the notion of an essential level of health care,[57] as the level needed to ensure a free and dignified existence to anyone in need of treatment and to their family.[58] This interpretation, linked to the dignity of individuals, goes beyond guaranteeing mere 'survival rights'.[59]

2.2 THE NORMATIVE CONTENT OF THE RIGHT TO HEALTH

The substantive aspects of the right to health may be broken down into two main categories: the right to health care or health services (which is generally understood as the provision of preventative, curative and rehabilitative medical services) and the right to the underlying

51 Constitutional Court ruling no. 43823, December 2008.

52 Chieffi, L. (2003), in Chieffi (ed.), *Il diritto alla salute alle soglie del terzo millennio Profili di ordine etico, giuridico ed economico*, from conference held in Belvedere di San Leucio (Caserta) 23 and 24 March 2001, Torino: Giappichelli.

53 Luciani, M. (1993). "Art. 81 della Costituzione e decisioni della Corte costituzionale", in VV. AA., *Le sentenze della Corte costituzionale e l'art. 81, u.c., della Costituzione*, from conference held in Rome 8-9 November 1991, Milano, pp. 53-62.

54 Constitutional Court rulings: no. 509, 20 September 2000; no. 309, 16 July 1999; no. 267, 17 July 1998; no. 2473, June 1992.

55 See Art. 117.2.m.

56 See Constitutional Court ruling no. 282, 26 June 2002, Tucciarelli, C. (2002). *La sentenza 282 della Corte Costituzionale: prime interpretazioni delle disposizioni costituzionali sull'esercizio del potere legislativo delle Regioni*, on www2.unife.it/forumcostituzionale. Molaschi, V. (2002). "Dei livelli essenziali delle prestazioni", in *REGIUSAN*, pp. 31.

57 For ruling on definition of essential level of health care, see Constitutional Court rulings: no. 162, 8 May 2007, and no. 134, 31 March 2006.

58 Art.32, in Bartole, S. and Bin, R. *Commentario breve alla Costituzione, cit.*

59 Balduzzi, R., "Salute (diritto alla) (voce)", in *Diz.D. Pubbl.,* VI, 5379.

preconditions for health. It is important to acknowledge and emphasize the existence of both categories, as the right to health is very often associated uniquely with the right to *healthcare*. Such an interpretation, as explained by the UN Special Rapporteur on the right to health, would appear to be in contrast with international human rights law: the right to health should be interpreted as an inclusive right, which extends not only to timely and adequate health assistance but also to the determinants of health. Among the determinants of health that are of primary relevance from a human rights perspective include, but are not limited to, access to safe drinking water and sanitation, the right to food and adequate nutrition, adequate housing and living condition, and a safe work environment.[60] As stated before, the right to health is closely related to and dependent upon the realisation of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. Although for the purposes of the present document the main focus will be on the right to health care and health services, the related rights but the underlying preconditions for the right to health, cited above, will also be touched upon.

In 2000 the United Nations Committee on Economic, Social and Cultural Rights (CESCR) adopted General Comment No. 14, which outlines in great detail the various dimensions of the right to health. The framework within which we will analyse the issues addressed in our report is drawn primarily from this document.

2.2.1. AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY

In order to clarify the implications of adopting a health and human rights approach, the CESCR has stated that there are four underlying standards, or criteria, with which states must comply in order to realize the right to health. They are *availability, accessibility, acceptability, and quality*.

The following definition of the components have been defined as follows by the CESCR's General Comment 14:

Availability means that public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.

Accessibility means that health facilities, goods and services have to be accessible to everyone without discrimination and is made up of four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility:
– *Non-discrimination*: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections

60 United Nations (2007) *Report of the UN Special Rapporteur on the right to the highest attainable standard of health to the United Nations General Assembly*, UN Doc. A/62/214.

of the population, in law and in fact, without discrimination on any of the prohibited grounds.

– *Physical accessibility*: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

– *Economic accessibility* (also referred to as "affordability"): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

– *Information accessibility*: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

Acceptability means that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality means that health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. [61]

2.2.2. NON-DISCRIMINATION

In the text of the General Comment, the Committee highlights that states are prohibited from exercising any discrimination in access to health care and underlying determinants of health, as well as to the means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[62] It further states that "the obligation to ensure non-discrimination is closely linked to the principle of equity, which implies that states must pay attention to all sectors of the population: this does not mean that everyone should be treated in exactly the same way, but

61 Committee on Economic, Social and Cultural Rights (CESCR) (2000). General Comment No. 14, UN Doc. E/C.12/2000/4.

62 *Ibid.*

rather that health systems must recognise, and provide for, the differences and specific needs of groups within the population, such as migrants, who experience a disproportionate level of mortality, morbidity and disability".[63]

2.2.3. THE RIGHT TO PARTICIPATION

The Committee highlights another essential point on the right to health which involves the right to participation. It is highlighted that the effective and sustainable provision of health-related services can only be achieved if people participate in the design of policies, programmes and strategies that are meant for their protection and benefit. The involvement of communities in setting priorities, and in designing, implementing and evaluating government programmes, policies, budgets, legislation and other activities relevant to the right to health is not only a human right, but has been shown to increase the likelihood that the needs of the community will be met more effectively. Community action and involvement is the key to the empowerment that is essential to understanding and claiming human rights, including the right to health.[64]

2.2.4. STATE OBLIGATIONS

Governments are responsible not only for not directly violating rights, but also for ensuring the conditions which enable individuals to realize their rights to the fullest possible extent. This is referred to as reflecting obligations to *respect*, *protect* and *fulfil* rights, and governments are legally responsible for complying with this range of obligations for every right in every human rights document they have ratified.[65] As far as the right to health is concerned, the definitions included in this section are once again based on General Comment 14, which states as follows:

Respecting the right to health applies mainly to government laws and policies and requires that states refrain from undertaking actions that inhibit or interfere (directly or indirectly) with people's ability to enjoy the right to health, such as by introducing actions, programmes, policies or laws that are likely to result in bodily harm, unnecessary morbidity, and preventable mortality. It also requires states to refrain from taking retrogressive measures as part of its health-related laws and policies.

Protecting the right to health applies mainly to obligations of governments to make efforts to minimise risks to health and to take all necessary measures to safeguard the population from infringements of the right to health by third parties. States are *not responsible* for the acts or omissions of non-governmental enterprises such as the private sector (for example, multinational corporations, including pharmaceutical companies, health insurance companies, biomedical research institutions, private care providers, and health management organizations); but they *are responsible* for taking measures aimed at ensuring that such bodies refrain from violating the rights of individuals and communities.

Fulfilling the right to health applies to positive measures that governments are required to take, such as by providing relevant services, to enable individuals and communities to enjoy the right to health in practice. It requires that all necessary steps be taken to ensure that the

63 Asher, J. (2004) *op. cit.*

64 Committee on Economic, Social and Cultural Rights (CESCR) (2000). General Comment No. 14, UN Doc. E/C.12/2000/4.

65 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22-26, 1997. Also see Eide, A. (1995) "Economic, Social and Cultural Rights as Human Rights", in Eide, A., Krause, C., Rosas, A. (eds.) *Economic, Social and Cultural Rights. A textbook*, Dordrecht: Martinus Nifhoff.

benefits covered by the right to health are provided and that appropriate legislative, administrative, budgetary, judicial, promotional and other relevant measures are adopted to ensure its full realization. It also requires that special measures be taken to prioritise the health needs of the poor and otherwise vulnerable and disadvantaged groups in society.

The obligation to fulfil the right to health is commonly divided into the associated obligations to *facilitate, provide* and *promote* the right to health. This reflects the different types of responsibility that governments incur to take positive measures to implement the right to health.

– *Facilitating the right to health* requires states to take positive measures that enable and assist individuals and communities to enjoy the right to health.

– *Providing the right to health* requires states to intervene when individuals or groups are unable, for reasons beyond their control, to realize the right to health themselves through the means at their disposal.

– *Promoting the right to health* requires states to undertake actions that create, maintain and restore the health of the population. Health promotion is an important component of the measures necessary to fulfil the right to health. It points to the close link between good health and information and education — a link that is intrinsic to public health. In order to enjoy the right to health, individuals and communities must have adequate and appropriate health-related information.

2.2.5. PROGRESSIVE REALIZATION

The Committee states that the right to the highest attainable standard of health is subject to progressive realization and resource availability. In other words, it does not imply that a comprehensive, integrated health system that ensures access to all can be put into existence immediately but, rather, that states must take effective measures to progressively work toward its development. P. Hunt and G. Backman identify three key implications arising from the concept of progressive realization.[66] The first implication is that states must have a comprehensive, national plan for the development of its health system, which covers both the public and private sectors. This highlights the essential role played by health planning, as underlined in health literature as well as in the Declaration of Alma-Ata and General Comment No. 14. Another implication of progressive realization is that, in order to be effective, a health system "must include appropriate indicators and benchmarks so as to assess whether or not the state is improving its health system and progressively realizing the right to the health".[67] Moreover, Hunt and Backman stress that indicators must be disaggregated on grounds such as sex, socio-economic status, rural/urban location and age, so that the state knows whether or not its programs for disadvantaged individuals and communities are working.[68] In this regard, in a report devoted to indicators, drafted in his capacity of Special Rapporteur, Hunt highlights that, although indicators and benchmarks are already commonplace features of many health systems, they rarely have all the elements that are important from a human rights perspective, such as disaggregation on appropriate grounds.[69] The final implication arising from progressive realization is what is commonly referred to as the principle of non-retrogression. This means that at least the current level of enjoyment of the right to health must be maintained and measures lowering such enjoyment of the right to health are not permitted.[70]

Some scholars have expressed concern over the obligation of progressive

66 Hunt, P. and Backman, G. (2009) *op. cit.*

67 see Riedel, E. (2009) *op. cit.*, p. 36.

68 Hunt, P. and Backman, G. (2009) *op. cit.*; United Nations (2003) *Interim report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health*, UN Doc. A/58/427. See also Gruskin S. and Tarantola, D. (2002) "Health and Human Rights" in Detels R., McEwan, J., Beaglehole, R., and Tanaka, H. (eds.) *The Oxford Textbook of Public Health*, 4th edition, Oxford University Press, pp. 19-20.

69 United Nations (2003) *Interim report of the Special Rapporteur cit.*; see Gruskin, S. and Tarantola, D., *op. cit.*, pp. 19-20.

70 Hunt, P. and Backman, G. (2009) *op. cit.*

realization by stating that it allows for a "loophole" for states not to fully comply with their obligations.[71] However, as General Comment 3 on the nature of Sates Parties Obligations of the Committee points out, progressive realization must be understood as an obligation on States parties to move "as expeditiously and effectively as possible towards the full realization of the right in question".[72] In other words, progressive realization does not mean that a state is free to choose whatever measures it wishes to take so long there is some degree of progress but, rather, that a state has a duty to adopt those measures that are most effective, taking into account resource availability and other human rights considerations.

2.2.6. IMMEDIATE OBLIGATIONS

In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, *minimum essential levels* of each of the rights contained in the Covenant. In other words, the fact that economic conditions may make it impossible for a government to fulfil its core obligations immediately does not mean that it is entitled to do nothing about them. The state still has the obligation to take immediate, deliberate, concrete and targeted steps towards fully realizing the right to health, and must start immediately to create the conditions necessary to fulfil its core obligations.[73]

The committee draws on other instruments, such as the Programme of Action of the International Conference on Population and Development and the Alma-Ata Declaration, cited above, in order to provide an overview of what the core obligations arising from article 12 are.

Box 2: Core obligations

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- To ensure equitable distribution of all health facilities, goods and services;
- To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

71 Asher, J. (2004) *op. cit.*

72 Committee on Economic, Social and Cultural Rights (1991) *General Comment No. 3, The nature of States parties obligations*, UN Doc. E/1991/23.

73 Para 43.

Box 3: Priority obligations

The Committee also lists obligations which must be afforded priority, and these include

- To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- To provide immunization against the major infectious diseases occurring in the community;
- To take measures to prevent, treat and control epidemic and endemic diseases;
- To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- To provide appropriate training for health personnel, including education on health and human rights.

2.3. MIGRANTS AND VULNERABILITY

Some groups or individuals face specific hurdles in relation to the right to health. These can result from biological or socio-economic factors, discrimination and stigma, or, as it more often occurs, a combination of these. Considering health as a human right requires specific attention to different individuals and groups of individuals in society, in particular those living in vulnerable situations.[74] It is almost universally acknowledged that migrants can been identified as one of such groups experiencing particular vulnerabilities. When we use the term vulnerability, we refer to the social, cultural, economic and political environment of individuals, families, communities and societies, and occurs in situations where people are limited in their ability to make free and informed decisions.[75] With the disclaimer that this is just a broad, generalized overview, a number of the factors which increase vulnerability of migrants to health issues include separation from spouses, families and familiar social and cultural norms, language barriers, poverty, inadequate living conditions, and exploitative working conditions, including sexual violence. A number of United Nations General Assembly Resolutions acknowledge "the situation of vulnerability in which migrants frequently find themselves, owing, inter alia, to their absence from their states of origin and to the difficulties they encounter because of differences of language, custom and culture, as well as the economic and social difficulties and obstacles for the return to their states of origin of migrants who are non-documented or in an irregular situation."[76] Moreover, if we consider the correlation between low socio-economic status and poor health, which we will explore in detail in Chapter 5.2,[77] we see that, while it affects both nationals and non-nationals, migrants may be further disadvantaged and discriminated against in relation to the "underlying determinants of health". A number of studies at the international European, and national level show that socioeconomic conditions affect migrants' physical, mental and social situation in the new country and they may experience more health problems than the "average" person,[78] a consideration that also emerges from the data presented in our report.

2.4. CONCLUSIONS

Our conceptual container, which follows the contours of the normative content of the right to health, provides a method of analysis and a framework for action, which can then be used to help shape specific interventions

74 OHCHR/WHO (2008) *op. cit.*

75 Brummer, D. (2002) *Labour Migration and HIV/AIDS in Southern Africa*, IOM Regional Office for Southern Africa, International Organization for Migration.

76 United Nations General Assembly (2000) *Resolution on Protection of migrants*, UN Doc. A/RES/54/166 at para. 5.

77 Chapter 5.2., *The right to the underlying preconditions of health*.

78 Chetail, V. and Giacca, G. (2009) "Who Cares? The Right to Health of Migrants", in Clapham, A. and Robinson, M., *op. cit.*

aimed at improving the health situation of the population, in our case with a specific focus on the migrant population. This approach requires working with the international human rights documents as outlined above, in order to help identify the specific applicable rights, and then considering how and to what extent morbidity, mortality, and vulnerability are caused or exacerbated by the insufficient realization of human rights.[79] The analysis which unfolds in the following sections follows such an approach.

79 Gruskin, S. and Tarantola, D. (2002) *op. cit.*, p. 26.

CHAPTER 3.
THE TURIN CONTEXT

3. THE TURIN CONTEXT

The aim of the present chapter is to set the stage for our discussion by outlining the key features of the context studied. The first part of the chapter identifies the local authorities and institutions responsible for the provision of healthcare services at the local level. The second part of the chapter traces the contours of the migration context in quantitative terms by providing key data and statistics. Finally, a brief overview of the main healthcare services dedicated to migrants will be provided, addressing both services provided by the national health system and those offered by the non-profit healthcare sector.

3.1. HEALTH PLAYERS

The main institutional player in the field of healthcare regulation is the *Regione Piemonte* (Piedmont Regional Authority). Following the reform of the health system (*SSN, Sistema Sanitario Nazionale*) in the 1990s and the amendment of Title V of the Italian Constitution, regional authorities began to play a more central role in health planning and in organisation of the healthcare system. The State is still responsible for defining Essential Levels of Care (*LEA, Livelli Essenziali di Assistenza*), while regional authorities are now responsible for implementation in their regions.

Regional authorities have primary responsibility for legislative and administrative functions related to health care and hospital care in line with the principles established by national legislation.[1] The regional authorities further have the responsibility of defining principles underlying the organisation of healthcare services and actions as well as criteria for funding for local health units and hospitals, for technical action, and for the promotion and support of local health units and hospitals, also in terms of management control and evaluation of quality of care.[2]

The department responsible for healthcare in the *Regione Piemonte* is the Department of Health and Healthcare and Social and Family Policy (*Assessorato alla Tutela della Salute e Sanità, Edilizia Sanitaria e Aress, Politiche Sociali e Politiche per la Famiglia*). In addition to health, the Department also has direct responsibilities in the area of immigration. The Department also heads the Management Sectors (*Direzioni*), the Regional Agency for Healthcare Services (*Agenzia Regionale per i Servizi Sanitari, Aress*), local healthcare units and hospitals, and the Regional Healthcare and Welfare Council (*Coresa*).

The regional law which is most relevant to our study is Law 18, of 6 August 2007, which redefines regulations for the planning and structure of the Regional Health Service (*SSR, Servizio Sanitario Regionale*). The *Regione Piemonte*, under this law, not only defines health as an objective to pursue through health and healthcare policies, but places it as a priority objective, to be taken account in every other area of decision-making.[3]

The law lists the principles on which social and health planning is grounded, including:

– the protection and promotion of health as a common good, an inalienable right of citizens, and an area of collective interest
– the importance of prevention and of health promotion activities
– the primary role of those involved in identifying priority needs
– involvement of local government bodies, of citizens and of health sector professionals in defining programmes
– ensuring uniform quality of service to citizens in all parts of the region
– appropriateness, quality and continuity of services

Regional social and health planning is largely addressed by the Regional

1 Legislative Decree 502/1992, art. 2.1.

2 *Ibid*, art. 2.2.

3 Source: www.dors.it

Social and Health Plan. This is the "planning instrument" which the *Regione*, within the parameters of the regional development plan and relative economic and financial policy, uses to define regional health and healthcare policy objectives, and adapts the organisation of social and health services to the care requirements of the population (...), also with reference to suitable indicators of the population's state of health".[4]

It is important to note that the *Consiglio Regionale* (Regional Council) has recently approved the 2012-2015 Social and Health Care Plan. The changes introduced include the establishment of six federations, or consortia, which will be responsible for organising areas of activity such as purchasing, stocking, distribution, and management control, with the aim of generating large savings through economies of scale. Until now, these activities have been carried out by the individual local health units. Another important change is a reorganisation of the hospital network according to levels of complexity. Hospital facilities will be reorganised within various areas into specialisation hospitals (Referral Centers), cornerstone hospitals, and area hospitals.[5]

Another important instrument available in healthcare planning is the Zone Plan; this is an instrument through which municipal councils together with local health units define an integrated system of actions and of social services for a particular area.[6] The Zone Plan is the primary instrument for implementing social service networks; through social and health care integration, it aims to achieve health for people, and continued improvement of quality of services as well as social promotion, also by setting up ways to observe issues as they emerge at the various levels of population affected.[7]

The social services zone plan fits into the more general framework provided by other related regional policies, including obviously healthcare.[8] The role of the *Provincia* (Provincial Authority) should not be forgotten: it defines and implements Zone Plans as the intermediate, decentralised planning body for regional policy and area coordination, as established by Article 5 of Regional Law 1/2004.

For the purpose of the present study, it should also be recalled that under Regional Law 18/2007, alongside the regional Social and Health Care Plan, local social and health care planning also makes use of Profiles and Health Plans (*Profili e Piani di Salute, PePS*); these provide the necessary information base for developing the Zone Plan, and shaping many other planning decisions included in or connected with the Social Regulatory Plan (PRS).

Article 14 of the Regional Law defines the *PePS* as an "instrument through which the local community, at district level, describes its health profile, identifies health objectives and produces guidelines that will shape the area's policies". Hence it is a new district planning instrument, under the direct responsibility of the mayor and drawn up in close contact with the community: citizens, social bodies, economic bodies, institutions, those working in services, and so on.

Through this instrument, health objectives will be shared and will apply across various areas of life, reshaping local policy in all sectors: local communities, represented by their mayors, will be key players in decision-making, and the healthcare system will be the means of implementing policy, and no longer a separate, independent system.[9] In line with information provided by these instruments, local implementation plans,[10] used by local health units to plan their activity, and hospital implementation plans,[11] used by hospitals to plan their activity, will also be developed.

A further planning instrument is the Permanent Conference for Social

4 Law no. 18, 6 August 2007, art. 11.

5 Social and Health Care Plan, p. 107.

6 Regional Law, 8 January 2004, n. 1, art. 17.

7 *Ibid*, art. 17.4.

8 *Ibid*, art. 17.5.

9 Source: www.dors.it

10 Law no. 18, 6 August 2007, art. 15.

11 *Ibid*, art. 16.

and Health Care Planning,[12] a body through which local government entities work together to define and evaluate regional health and social care policy. It is important, and of particular interest for this study, that the President of the Regional Council, the Mayor of Turin, the Presidents of the *Province* (provincial authorities) surrounding Turin, and one non-profit sector representative participate in this body.

Finally, given that the population studied is the migrant population, mention should also be made of measures taken by the *Regione* regarding health care, and deriving from its responsibilities in terms of immigration. Regional Law 64, of 8 November 1989, titled "Regional measures in favour of non-EU immigrants resident in Piedmont", provides for various types of measure that can be implemented by the *Regione*, including promoting social welfare for immigrants in need,[13] as well as initiatives aimed at realising the right to health care and to social services available to citizens, especially with regard to social inclusion for migrant women and to maternal healthcare.[14]

3.2. MIGRATION: SOME DATA

Migration to Turin is considerable: the city has the third greatest number of migrant inhabitants after Rome and Milan.[15] As Table 1 shows, the number of migrants resident on 31st December 2010 was 131,856, out of a total of 908,568 inhabitants.[16]

Table 1. Number of migrants in Turin, 2010[17]

	Total	Males	Females	< 18
EU Citizens	57.638	21.360	25.349	10.929
Non EU Citizens	74.218	28.284	28.333	17.601
Total	131.856	49.644	53.682	28.530

As the table clearly shows, the majority of migrants are non-EU migrants, and are female. There are clearly fewer migrants from within the EU, despite the fact that Romania has become an EU member state, and clearly more female than male European migrants.

In terms of country of origin, the migrant population includes over 130 different nationalities. The most numerous non-EU migrants are Moroccans, and the most numerous EU migrants are Romanians, as shown by the tables below, from the Turin City Council Statistics Office (*Ufficio di Statistica del Comune di Torino*).

Table 2. The 5 most numerous non-EU nationalities resident in Turin[18]

Country	Males		Males, Total	Females		Females, Total	Total
	< 18	> 18		< 18	> 18		
Morocco	2.668	8.306	10.974	2.335	6.271	8.606	19.580
Peru	794	2.850	3.664	848	4.501	5.349	8.993
China, Rep. of	833	2.188	3.021	782	2.110	2.892	5.913
Albania	678	2.348	3.026	603	2.152	2.755	5.781
Moldova	455	1.231	1.686	455	2.370	2.825	4.511

12 *Ibid*, art. 6.

13 Regional Law no. 64, 8 November 1989, Regional measures in favour of non-EU immigrants resident in Piedmont, B.U. 15 November 1989, n. 46, art. 10.1, H.

14 *Ibid*, art. 10.1, I.

15 Istat, retrieved from demo.istat.it

16 Data presented relate to the documented migrant population.

17 Ufficio Statistica Comune di Torino, www.comune.torino.it/stranieri-nomadi/stranieri/torino/dati.htm, 5 July 2012. Table modified and translated by Anthony Olmo, Irene Biglino.

18 Ufficio Statistica Comune di Torino, 3 October 2011, retrieved from www.comune.torino.it/stranieri-nomadi/stranieri/torino/dati.htm, 5 July 2012. Table modified and translated by Anthony Olmo, Irene Biglino.

Table 3. The 5 most numerous EU nationalities resident in Turin[19]

Country	Males		Males, Total	Females		Females, Total	Total
	< 18	> 18		< 18	> 18		
Romania	5.430	19.640	25.070	5.128	22.742	27.870	52.940
France	53	463	516	54	556	610	1.126
Poland	24	108	132	28	402	430	562
Germany	24	191	215	18	214	232	447
UK	11	219	230	6	193	199	429

Table 4 and Table 5 show, respectively, the number of migrant residents in the various neighbourhoods of Turin and in the various city districts.[20] The *Barriera di Milano* and *Aurora* neighbourhoods, and city districts such as districts 5, 6 and 7 have the largest migrant populations.

Table 4. Composition of the Turin migrant population by gender and neighbourhood, 2009[21]

Neighbourhood	Males	Females	Total
Centro	2.264	2.290	4.554
San Salvario	3.502	3.283	6.785
Crocetta	1.625	1.972	3.597
San Paolo	2.260	2.619	4.879
Cenisia	2.667	2.880	5.547
San Donato	4.310	4.238	8.548
Aurora	7.271	6.066	13.337
Vanchiglia	1.746	1.827	3.573
Nizza millefonti	2.689	2.722	5.411
Mercati generali	2.408	2.686	5.094
Santa Rita	2.287	2.758	5.045
Mirafiori Nord	1.291	1.643	2.934
Pozzo Strada	2.544	2.901	5.445
Parella	2.673	2.998	5.671
Le Vallette	1.774	1.954	3.728
Madonna di Campagna	3.047	3.146	6.193
Borgata Vittoria	3.549	3.397	6.946
Barriera di Milano	7.642	6.672	14.314
Falchera	1.498	1.563	3.061
Regio Parco	1.487	1.559	3.046
Madonna del Pilone	577	702	1.279
Borgo Po e Cavoretto	756	1.064	1.820
Mirafiori Sud	1.647	1.746	3.393
Total	61.514	62.686	124.200

Table 5. Composition of the Turin migrant population by gender and city district, 2008[22]

City District	Males	Females	Total
1	3.988	4.243	8.231
2	3.373	4.140	7.513
3	6.999	7.581	14.580
4	6.549	6.635	13.184
5	7.577	7.705	15.282
6	9.834	8.790	18.624
7	9.178	7.941	17.119
8	4.161	4.247	8.408
9	4.493	4.718	9.211
10	1.814	1.843	3.657
Total	57.966	57.843	115.809

19 Ufficio Statistica Comune di Torino, 3 October 2011, retrieved from www.comune.torino.it/stranieri-nomadi/stranieri/torino/dati.htm, 5 July 2012. Table modified and translated by Anthony Olmo, Irene Biglino.

20 See Appendix 4 for a map of city districts and suburbs of Turin.

21 Ufficio Statistica Comune di Torino, 31 December 2009, retrieved from www.comune.torino.it/statistica/, 5 July 2012. Table modified and translated by Anthony Olmo, Irene Biglino.

22 Ufficio Statistica Comune di Torino, 31 December 2008, retrieved from www.comune.torino.it/statistica/, 5 July 2011. Table modified and translated by Anthony Olmo, Irene Biglino.

Migrant population data for Turin reflect regional data. At the beginning of 2011, there were 398,910 migrants resident (208,243 women and 190,667 men),[23] with the most numerous nationalities being Romanians (34.4% of the migrant population), Moroccans (16.1%), and Albanians (11.5%). It is interesting to note how the migrant population resident in Piedmont has grown. In 2002 there were 127,563 migrants resident and today migrants account for around 8.9% of the total population of Piedmont.[24] This percentage exceeds the national figure of 7% of migrants for the total population of 60,340,328, on 1 January 2010.[25] It should also be remembered that between 5% and 10% must be added to take into account undocumented migrants, who will not have completed the census.

3.3. HEALTH SERVICES

To conclude this chapter, we provide a brief overview of the main healthcare services for the migrant population, in both the public and the non-profit sectors. The *Laboratorio Diritti Fondamentali* updated the Migrant Healthcare Services Guide (*Guida ai servizi sanitari per immigrati*), initially published in 2008 by the *Regione Piemonte*,[26] and this can be consulted for a complete, detailed account of all health services available to migrants in Turin, as well as other useful services such as canteens and dormitories. In our survey of key services we will concentrate on services for undocumented migrants, as documented migrants can in most cases enrol in the *SSN* and make use of services as Italian citizens. Further details can be obtained by consulting Appendix I.[27]

It must be emphasised that generally, and also in comparative terms,[28] a good level of care is provided to undocumented migrants. The key service is provided by the Immigrant Health Information Centres (*Centri di Informazione Salute Immigrati*) or *ISI* Centres. These were established as an experiment in the mid 1990s,[29] became a permanent part of the system in 2004,[30] and today are the main providers of public healthcare for undocumented migrants.[31] The Centres issue a regional *STP* (*straniero temporaneamente presente*) code which is required for undocumented migrants to access healthcare services.[32] Just like Italian or documented migrant citizens enrolled in the *SSN*, undocumented migrants who go to *ISI* Centres can receive health care from the physician on duty: medical consultation and advice, prescriptions for diagnostic tests and feedback on results, drug prescriptions, and referrals for specialist appointments or for hospital admissions.[33]

Some good practices in health care for undocumented migrants in Piedmont: In view of the increasing numbers of undocumented migrants suffering from chronic and debilitating illnesses and the large number of those accessing the *ISI* Centres, the *Regione Piemonte* Department of Health and Health Care issued a circular dated 3/8/2004 with instructions confirming the same procedure to obtain exemption from paying health care charges for undocumented migrants and for Italians. Physicians at the *ISI*, where complete patient healthcare records are held, may file application procedures for exemption from charges.[34]

Under Regional Deliberation 6-3264 of 27June 2006, the Piedmont Regional Authority also recognised the right of undocumented migrants to receive necessary supplementary services and prosthetic assistance: the *ISI* Centre physician refers the patient to the relevant *SSN* specialist, with full case records and a presentation letter. The specialist provides any

23 Regione Piemonte, Settore Statistica e Studi, Piemonte Statistica, retrieved from www.ruparpiemonte.it/infostat

24 Istat (2011), retrieved from noi-italia.istat.it

25 *Ibid*.

26 Regione Piemonte, Assessorato Regionale alla Tutela della Salute e Sanità (2008). *Guida ai servizi sanitari per immigrati.* The 2012 version is available on www.labdf.eu

27 For further information, see Appendix 1, *Healthcare and the legal status of migrants*.

28 Platform for International Cooperation on Undocumented Migrants (PICUM) (2007). *Access to Health Care for Undocumented Migrants in Europe*, Brussels: PICUM.

29 Regional Council Deliberation no. 56-10571, 15/7/1996.

30 DGR 43-1493, 20 December 2004. At the same time guidelines for the activation and functioning of the ISI Centres were also approved. Under DGR 20-9847, 20 October 2008 guidelines for start-up and management of the *ISI* Centres were approved.

31 This role is also defined in the 2007-2010 Social and Health Care Plan of the *Regione Piemonte*, approved under DCR 24 October 2007, section. 4, par. 4.5.3.6.

32 For further information, see Appendix 1, *Healthcare and the legal status of migrants*.

33 Regione Piemonte - Assessorato alla tutela della Salute e Sanità, *Guida op. cit.*, p. 68.

34 *Ibid*.

necessary prescriptions. These are then forwarded to the relevant district or area services according to where the patient is domiciled, and the patient will then be directly provided with what is needed, or with an authorisation to present to an authorised supplier of prosthetics.[35]

Since February 2012, undocumented female migrants have been able to undergo Pap tests for the prevention of cervical cancer.

The non-profit sector: As previously mentioned, one feature which characterizes the city of Turin is its vibrant non-profit sector. Particularly in the area of migration and health, several associations, NGOs and other entities provide a wide range of health services to migrants, for the most part to undocumented migrants who cannot register with the *SSN*. Among the most important non-profit healthcare centres are the *Sermig* centre,[36] the *Camminare Insieme* centre,[37] and the Red Cross medical centres. Mental healthcare services are also provided by many non-profit associations, such as *Frantz Fanon,*[38] *Mamre*,[39] and the *Marco Cavallo Centre*[40], to both documented and undocumented migrants.

Most public and non-profit initiatives are connected through the Piedmont Immigration and Health Groups (*Gruppi immigrazione e salute, GrIS*), which provide a network in order to optimise and optimize the work of the individual professionals, volunteers, NGOs and associations working in the field of immigration and healthcare.

As mentioned above, the Immigrant Healthcare Services Guide can be referred to for a complete list of services available for the migrant population.[41]

35 *Ibid*, p.69.

36 www.sermig.org

37 www.camminare-insieme.it

38 www.associazionefanon.org

39 www.mamreonlus.org

40 www.docvadis.it/cmmc-centro-migranti-marco-caval

41 www.labdf.eu/pubblicazioni/altre

CHAPTER 4.
THE HEALTH STATUS OF THE MIGRANT POPULATION IN TURIN

4. THE HEALTH STATUS OF THE MIGRANT POPULATION IN TURIN[1]

The present chapter seeks to provide a description of the health status of the migrant population in Turin. The data used in this section is provided primarily by *LDF*'s scientific partner, the Regional Epidemiology Unit,[2] although other sources are used to complement such data with regard to specific issues. The latter sources include but are not limited to:

– *ISTAT* surveys (e.g. state of health and use of healthcare services)
– hospital admissions (hospital discharge documentation, HDD)
– *ISTAT* data on miscarriage and termination of pregnancy (TOP), admissions of psychiatric patients to care institutions, *ISTAT* data on deaths
– labour and delivery records
– infectious disease notification documents

It should be noted, however, that such data is generated only when the demand for health assistance and the provision of healthcare meet. Clearly, unexpressed needs are not reflected in the data. Similarly, forms of health assistance which are not provided by the National Health Service (*SSN*) but for example, by the voluntary sector, or health needs that are resolved within the migrant communities are not included in the data. Finally, cases concerning migrants who return to their country of origin in order to receive assistance will not be accounted for in the statistics. The foregoing points reveal that the picture sketched on the health status of the migrant population may not be completely accurate, as it may suggest a healthier population than what it is in reality.

Most of the cited data derives from hospital discharge forms for the whole Piedmont area. Although this study, as previously explained, focuses on the city of Turin, trends identified at regional level in all likelihood reflected the reality at the municipal level as well: of 398,910 migrants resident in the Region of Piedmont (on 1 January 2011),[3] as many as 127,717 were resident in the city or municipal area of Turin,[4] and 207,488 were resident in the Province of Turin.[5]

A more general overview on the health status of migrants at the national level is provided in Appendix 2.

Table 6. Resident migrant population, Piedmont Region, 2009[6]

Resident Migrant Population						
	Males		Females		Total	
Age	n.	%	n.	%	n.	%
<1	3581	2,0	3490	1,8	7071	1,9
1-4	12890	7,1	12043	6,2	24933	6,6
5-17	27459	15,1	25712	13,2	53171	14,1
18-34	64551	35,4	70391	36,1	134942	35,8
35-49	55990	30,7	57733	29,6	113723	30,1
50-64	14518	8,0	20568	10,6	35086	9,3
>64	3349	1,8	4966	2,5	8315	2,2
TOT	182338	100	194903	100	377241	100

1 Chapter drafted in collaboration with Luisa Mondo, *Servizio Sovrazonale di Epidemiologia ASL TO3 (*Regional Epidemiology Unit).

2 For further information on methodology, see Chapter 1.2.2, *Quantitative epidemiologic data*.

3 *Istat*, see demo.istat.it

4 *Ibid.*

5 *Ibid*.

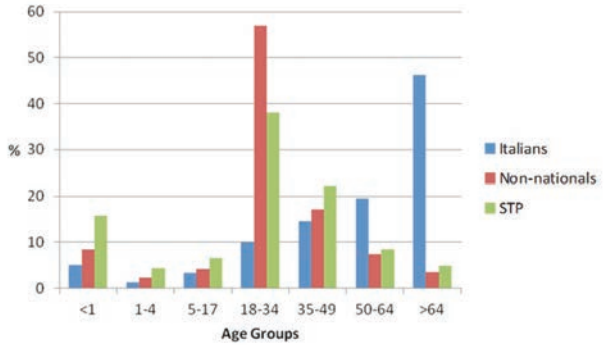
6 *Regione Piemonte, Settore Statistica e Studi, Piemonte Statistica*, database available on www.ruparpiemonte.it/infostat

4.1. HOSPITAL ADMISSIONS

In 2009, there were 782,692 hospital admissions in Piedmont; of these, 93.55% were Italians, 0.5% were documented migrants, and 5.95% were undocumented migrants or, to use the Italian terminology, 'temporarily present migrants', or *STPs* (*Stranieri Temporaneamente Presenti*).

As Figure 1 shows, most migrants admitted to hospital belong to younger age groups, particularly between 18 and 34 years of age. The rate of admissions decreases significantly in those aged over 50.

Figure 1. Percentage distribution of hospital admissions by age group, resident Italian population, resident migrants and undocumented migrants, Piedmont Region, HDD, 2009[7]



Figures 2 and 3 show total admissions according to age group for males and for females: they reveal that the admissions rate in the migrant population is higher than in the Italian population, for males aged between 1 and 4, and for females aged between 1 and 49.

Figure 2. Total hospital admissions by age group, males, Piedmont Region, HDD, 2009[8]

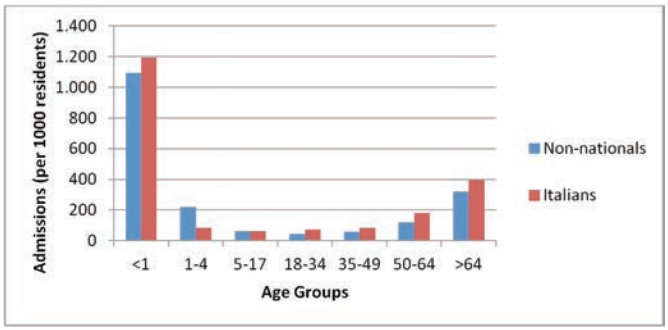
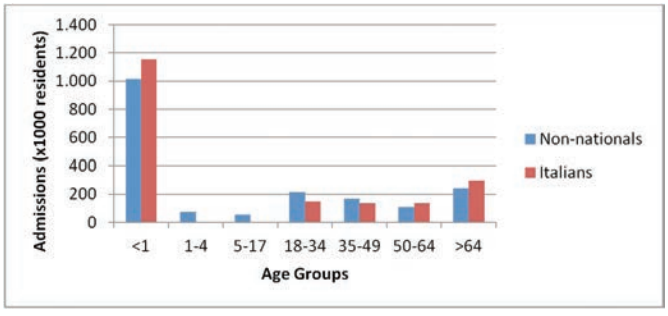


Figure 3. Total hospital admissions by age group, females, Piedmont Region, HDD, 2009[9]



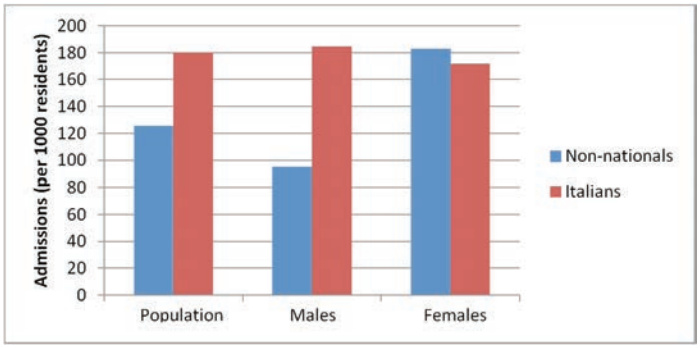
7 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

8 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

9 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

As the figures above show, and as Figure 4 further demonstrates, the majority of migrants admitted are women, although they account for only around half of the total migrant population. In 2009, there were 35,615 admissions for migrant women, against 17,333 for migrant men.

Figure 4. Total hospital admissions by gender, Piedmont Region, HDD, 2009[10]



4.2. REASONS FOR ADMISSION OF MEN

The main reason for admission to hospital of males is injury and poisoning, at about twice the rate of the Italian population. Digestive system illnesses (no difference with the Italian population), and respiratory tract illnesses are also important.

Injury and poisoning

The most important point emerging from the injury and poisoning data is the issue of work-related injuries. Information gathered from the interviews also appeared to indicate this as a serious problem for the migrant population, especially for males, as described in Chapter 5.2. Our data confirm this and show a generally high level of injuries in the migrant population in Piedmont (Table 7 and Figure 5).

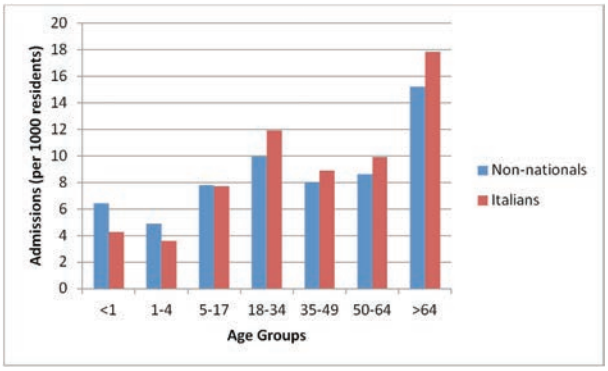
Table 7. Hospital admissions for injury and poisoning, males, Piedmont Region, HDD, 2009[11]

Age Group	Population	n.	Rate
<1	ita	70	4,28
	non ita	23	6,42
1-4	ita	242	3,59
	stp	2	
	non ita	63	4,89
5-17	ita	1710	7,71
	stp	6	
	non ita	214	7,79
18-34	ita	4076	11,91
	stp	91	
	non ita	643	9,96
35-49	ita	4277	8,92
	stp	40	
	non ita	449	8,02
50-64	ita	4181	9,93
	stp	13	
	non ita	125	8,61
>64	ita	7565	17,84
	stp	4	
	non ita	51	15,23

10 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

11 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

Figure. 5. Hospital admissions for injury and poisoning, Italian and migrant population, by age group. Males, Piedmont Region, HDD, 2009[12]



This category also includes domestic accidents, sports injuries, or injuries occurring in a variety of circumstances. However, we were informed by specialists in this area that it would be extremely difficult, if not impossible, to obtain more precise estimates of work-related injuries only from this data, for two reasons.

Firstly, the space where the nature and cause of injury needs to be inserted on the Hospital Discharge Documentation forms is sometimes not completed. In addition, migrants sometimes do not state that the injury occurred at the workplace, for fear of the consequences this may entail. This is certainly the case for undocumented migrants who are working in the informal employment sector; but it is also true for documented migrants who, for fear of losing their jobs, often prefer to remain silent about the cause of accidents.

Recent data produced by *INAIL* reveal that the national injury rate in the migrant population is 45 for every 1,000 people employed[13] The rate is 39.2 for the host population.[14] Moreover, for Italian workers, injuries have decreased by 1.9% overall, while for migrants there has been an increase of three quarters of a percentage point. In 2009, there were 119,240 injuries against 120,135 in 2010.[15]

However, some factors that have a significant effect on how this data is interpreted should be recalled. Firstly, the number of migrants who are residents in Italy has increased in recent years. Secondly, migrants are on average more active than Italians in terms of work; and thirdly, they often carry out more dangerous jobs.

In addition, there are some further variables that may influence interpretation of the data above. A study was carried out by the Regional Epidemiology Unit on a sample of the population enrolled in the INPS between 2000 and 2005. It reveals how some factors clearly differentiate the More Developed Country (MDC) population, in this case obviously mostly Italians, from the so called Strong Migratory Pressure Country (SMPC) population, in Italy: gender (14% of SMPC workers are women against 32% of MDC workers; age (the average age of SMPC workers is 35 against 37 for MDC workers); and duration of employment contracts (60% of MDC workers have contracts lasting more than 3 years, against 27% of SMPC workers).

In addition, the different distribution of MDC workers and SMPC workers in some sectors of the economy should be noted. Table 8 shows that 20% of workers from SMPC countries are employed in the construction industry against 13.2% of MDC workers. Conversely, 12.4% of MDC workers are employed in the wholesale and retail sectors against 5.7% of SMPC workers.

12 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

13 *Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro* (2011). *Rapporto Annuale 2010 con analisi dell'andamento infortunistico*, p. 172.

14 *Ibid*.

15 *Ibid*, p.171.

Table 8. Classification of economic activities[16]

Economic Activities	MDC	SMPC
Mining	0,4	0,3
Food products, beverages and tobacco	4,3	3,2
Textile and clothing	6,6	5,0
Chemicals, chemical products and man-made fibres	4,4	4,1
Basic metals and fabricated metal products	23,9	21,9
Leather, wood, paper, coke industries	12,5	12,0
Electricity, gas and water	0,8	0,0
Construction	13,2	20,0
Wholesale and retail sale	12,4	5,7
Accommodation and food service activities	6,2	8,8
Transportation, storage and communication	6,9	6,7
Financial and real estate activities	8,4	12,2

To sum up, when the above variables are included in quantification of risk of injury at work, the study concluded that SMPC workers are exposed to 1.40 times the risk that MDC workers are exposed to, per 1000 people per year (Table 9).

Table 9. Controlled relative risk[17]

	Crude Risk	Gender	Age	Professional Level	Economic Activity	Duration of contract	Year	All variables
SMPC vs. MDC	2.24*	1.97*	2.23*	1.55*	2.06*	2.03*	2.30*	1.40*

* $p < 0,01$

Digestive system illnesses

Such health problems are often related to stress, inadequate or inappropriate nutrition, poor dentition, or alcohol abuse. There are frequent cases of gastritis and iatrogenic ulcers caused by anti-inflammatory drugs supplied by a chemist or passed from one patient to another, and taken, without gastric protection drugs, in order to alleviate toothaches or aching joints. The extent of this type of problem does not appear very different in the migrant and Italian populations.

Respiratory system illnesses

Illnesses related to the respiratory system are also fairly common in the male migrant population, although at a lower rate and to a lesser degree than the Italian population. This phenomenon may, at least to a certain extent, be connected to high exposure to tobacco smoke, to toxic substances in the work environment, to air and domestic pollution, and to unhealthy living conditions, such as over-crowding and unheated accommodation in winter.

4.3. REASONS FOR ADMISSION OF WOMEN

Admissions to hospital for migrant women seem largely related to maternal, neonatal and child health problems, such as complications in pregnancy, labour and delivery, or in puerperium) and, to a lesser extent to digestive tract illnesses and genito-urinary system illnesses.

Maternal, neonatal and child health

An important international study reviewed previous research on

16 Compiled by Giraudo M., Bena A., Leombruni R. Presented at conference "Facts Beyond Figures – Communi-Care for Migrants and Ethnic Minorities", Milan 21-23 June 2012. Title of Paper: *Temporary employment and migrant workers: an analysis of injury risk by job characteristics and job tenure*. Table modified and translated by Anthony Olmo, Irene Biglino.

17 *Ibid*. Table modified and translated by Anthony Olmo, Irene Biglino.

mother and child health and compared data on pregnancy outcomes in migrant women and host-country women in 12 European countries (for a total of 18 million pregnancies).[18] The study revealed that migrant women showed a clear disadvantage for all the health outcomes considered, with a greater risk of newborns weighing less than 2,500 grams, of pre-term births, of perinatal deaths, and of congenital anomalies. The same study also examined the same data in relation to integration policies; risks associated to the analysed health outcomes were clearly and significantly reduced in countries with a strong integration policy. (Table 10).

Table 10. OR of main pregnancy outcomes according to maternal receiving country[19]

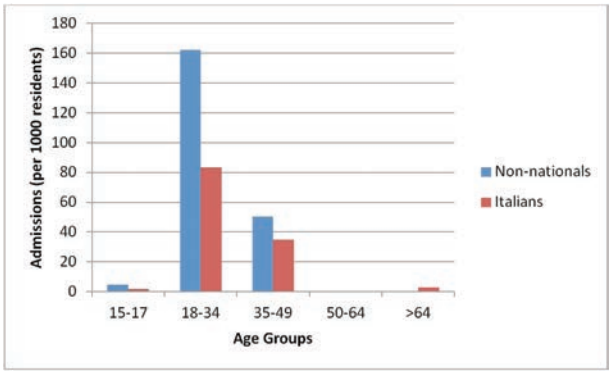
	Low Integration Countries: Austria, France, Germany, Italy, UK, Spain and Switzerland	**High Integration Countries:** Belgium, Denmark, Norway, Netherlands and Sweden
Low Weight	1,77	1,08
Preterm Births	2,88	1,18
Perinatal Mortality	1,45	1,25
Malformations	1,20	0,87

The number of hospital admissions for migrant women because of complications relating to pregnancy, labour and delivery, and puerperium, is considerably higher than the number for Italian women of the same age. As Table 11 shows, the rate of admissions for 15- to 17-year-old migrant women and for 18- to 34- year-old migrant women is almost double the rate for Italian women, and is considerably higher in later age groups as well.

Table 11. Pregnancy-related Admissions, Piedmont Region, HDD, 2009[20]

Age Group	Population	n.	Rate
15-17	ita	365	1,74
	stp	26	
	non ita	120	4,67
18-34	ita	27046	83,37
	stp	1533	
	non ita	11430	162,38
35-49	ita	16385	34,83
	stp	204	
	non ita	2909	50,39
50-64	ita	16	0,03
	non ita	1	0,05
>64	ita	14	2,82

Figure 6. Hospital admission rates for pregnancy, Italian and resident migrant population, by age group, Piedmont Region, HDD, 2009[21]



18 Bollini P, Pampallona S, Wanner P, Kupelnick B. (2009). "Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature" *Social Science & Medicine*, Vol. 68, p. 452.

19 *Ibid*. Table modified and translated by Anthony Olmo, Irene Biglino.

20 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

21 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epideniology Unit).

The data can be partly explained, on the one hand, by the higher pregnancy rates of migrant women; However, migrant women may also experience a higher number of problems related to pregnancy, as well as labour and delivery, because they are disadvantaged in comparison to their Italian peers.

Obstetric history: analysis of data from labour and delivery records compiled in Piedmont in 2008[22] reveals cause for concern with regard to the obstetric history of migrant women. Table 12 shows that, despite having exactly the same entitlements, a dramatically lower number of documented and undocumented migrant women attend prenatal courses, take folic acid and undergo diagnostic tests, during pregnancy, in comparison to Italian women.

Table 12. Obstetric history, female, Labour and Delivery Records, 2008[23]

Obstetric History	Italians, Residents	Non Italians, Residents	Non Italians, Non Residents
Childbirths:	**29.026**	**8.300**	**328**
Childbirth classes	28,5%	6,4%	4,0%
Folic acid during pregnancy	70,6%	53,7%	37,0%
Folic acid before pregnancy	6,6%	3,2%	2,0%
Blood group unknown	5,2%	6,6%	10,3%
Toxoplasmosis non screened	2,0%	3,6%	10,1%
HBsAg non screened	7,9%	10,2%	15,4%
Streptococcus non screened	16,7%	25,3%	41,3%
HIV non screened	19,9%	18,5%	27,9%
VDRL non screened	27,0%	27,2%	39,0%

Neonatal data

Significant differences also emerge in neonatal data for children of Italian women and of migrant women. Table 13 shows that migrant women, particularly if they are undocumented, tend to have more premature and underweight babies, and more babies born with visible anomalies, as well as a higher rate of neonatal mortality. Table 14 and Figure 7 show the high rate of admissions for perinatal conditions.

Table 13. Neonatal data, Labour and Delivery Records, 2008[24]

Neonatal Data	Italians, Residents	Non Italians, Residents	Non Italians, Non Residents
Childbirth:	**29.026**	**8.300**	**328**
Preterm < 37 weeks	7,0%	7,6%	11,9%
Preterm < 28 weeks	0,3%	0,4%	1,8%
Preterm 28-31 weeks	0.6%	0,9%	1,8%
Preterm 32-34 weeks	1,8%	1,9%	2,4%
Preterm 35-36 weeks	4,3%	4,3%	6,4%
Weight < 1500g	1,1%	1,0%	3,0%
Weight 1500-2499	6,3%	4,9%	4,2%
Stillborns	0,3%	0,3%	0,9%
Malformations	1,1%	1,0%	1,5%

22 Compiled by Paola Ghiotti, *Area materno infantile*, presented at conference: *"Una rete in costruzione per la salute dei migranti"*, organised by Gruppo Immigrazione e Salute - Piemonte, Turin, 23 March 2010.

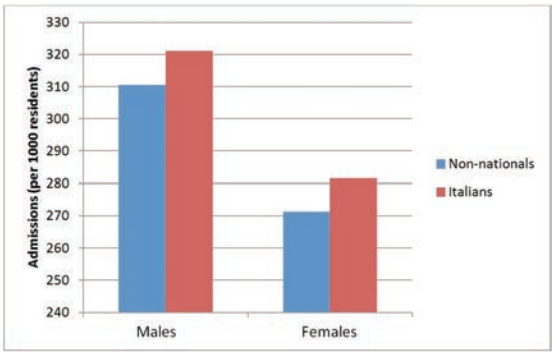
23 *Ibid*. Table modified and translated by Anthony Olmo, Irene Biglino.

24 *Ibid*. Table modified and translated by Anthony Olmo, Irene Biglino.

Table 14. Admissions for perinatal conditions, by gender, Piedmont Region, HDD, 2009[25]

Population	Male		Female	
	n.	Rate	n.	Rate
Ita	5267	321,14	4344	281,51
Stp	66		47	
Non Ita	1112	310,53	947	271,35

Figure 7. Hospital Admission Rates for perinatal conditions, Italian and migrant population, by gender, Piedmont Region, HDD, 2009[26]



Termination of Pregnancy (TOP): one of the most serious mother and child health problems in the migrant population is the large number of pregnancy terminations. Terminations by migrant women in Piedmont account for over 40% of termination procedures carried out between 1995 and 2009 (see Table 15).

Table 15. Percentage of TOPs in non-nationals and percentage of non-national women resident in Italy by region, 2009[27]

Regions	TOPs – Non Italian women	Resident Non Italian Women
Piedmont	40,63	7,85
Aosta Valley	27,65	6,20
Lombardy	43,70	8,71
Bolzano	42,38	7,35
Trento	34,69	8,09
Veneto	45,53	8,84
Friuli Venezia Giulia	34,86	7,32
Liguria	39,42	6,53
Emilia-Romagna	43,85	9,43
Tuscany	42,42	8,29
Umbria	43,82	9,89
Marche	44,56	8,24
Lazio	36,55	8,18
Abruzzo	26,40	5,35
Molise	6,01	2,52
Campania	15,90	2,56
Apulia	14,87	1,84
Basilicata	17,74	2,14
Calabria	19,90	3,16
Sicily	15,54	2,31
Sardinia	13,00	1,89
Italy	33,81	6,39

Our data also confirm a trend, noted in previous years, towards a decrease in TOPs by Italian women and an increase by migrant women, partly due to the increase in the female migrant population (Figure 8). This trend can also be seen at the national level (Figure 9).

25 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

26 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

27 Istat (2011) *Indagine sulle interruzioni volontarie della gravidanza - Rilevazione sulla Popolazione residente straniera per genere ed anno di nascita*. In Loghi, M., D'Errico, A., Spinelli, A. (2011) "Abortività volontaria delle donne straniere", Osservatorio nazionale sulla salute nelle regioni italiane, *Rapporto Osservasalute 2011 – Stato di salute e qualità dell'assistenza nelle regioni italiane*, p. 231. Table modified and translated by Anthony Olmo, Irene Biglino.

Figure 8. TOP Admissions Trend, Italian women and migrant women, HDD, 2000-2009[28]

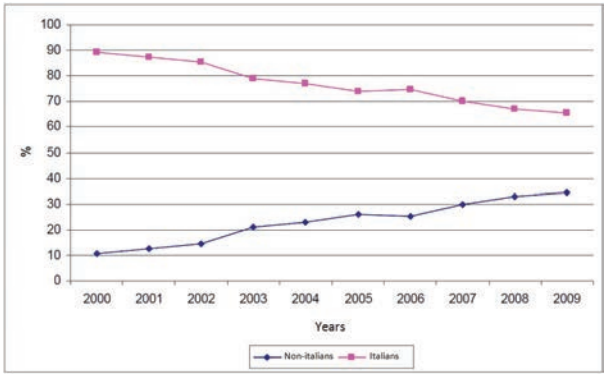
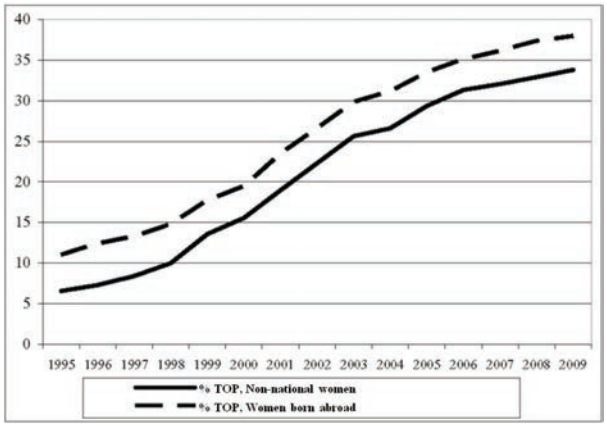


Figure 9. Percentage of TOPs in non-national women and in women born abroad, 1995-2009[29]



Romanian, Moroccan, Albanian and Nigerian women, the most numerous migrant nationalities in the Piedmont Region, undergo the highest numbers of terminations. Analysis of the data shows that migrants resident in the Province of Turin carry out the most terminations, followed by those resident in Alessandria and Novara, and this as well is in line with population distribution.[30] Migrant women terminate pregnancies at a younger age than Italian women; they are also more likely to have already undergone terminations and borne children.[31] This is particularly significant because it means that many of these women have already come into contact with the *SSN* but have nevertheless not been able to use contraceptives effectively or correctly.[32]

4.4. INFECTIOUS DISEASES

Every year in Piedmont, as reported in the 2012-2015 Piedmont Social and Health Care Plan, "around 10,000 cases of infectious diseases are reported through the various systems of epidemiological surveillance; around 30,000 admissions are specifically for reasons of infection or for reasons that can be linked to infection; the crude death rate in 2006 was 14.6 per 100,000 inhabitants."[33] According to the Plan, the most reported infectious diseases are "non typhoid salmonella, infectious diarrhea,

28 Data and figures by Regione Piemonte, Assessorato alla sanità, Coffano M. E., Del Savio M., Mondo L. (eds.) (2009). "Stranieri e salute", Città di Torino, Direzione servizi civici, Settore Statistica e Toponomastica, Ufficio Pubblicazioni, *Osservatorio Interistituzionale sugli Stranieri in Provincia di Torino, Rapporto 2009*, p. 312. Figure modified and translated by Anthony Olmo, Irene Biglino.

29 Istat (2011) *Indagine sulle interruzioni volontarie della gravidanza*. Figure by Loghi, M., D'Errico, A., Spinelli, A. (2011) *op. cit.*, p. 230. Figure modified and translated by Anthony Olmo, Irene Biglino.

30 Regione Piemonte, Assessorato alla sanità, edited by Coffano M. E., Dal Savio M., Mondo L. (2009) *op. cit.*, p. 312.

31 *Ibid.*

32 See Chapter 5.2. *The right to the underlying preconditions of health* and Chapter 5.1.3., Section iii) *The role of information*.

33 *Regione Piemonte, Piano socio-sanitario 2012-2015* (Piedmont Regional Authority, 2012-2015 Social and Health Care Plan), p. 85.

pulmonary tuberculosis, hepatitis A and syphilis."[34]

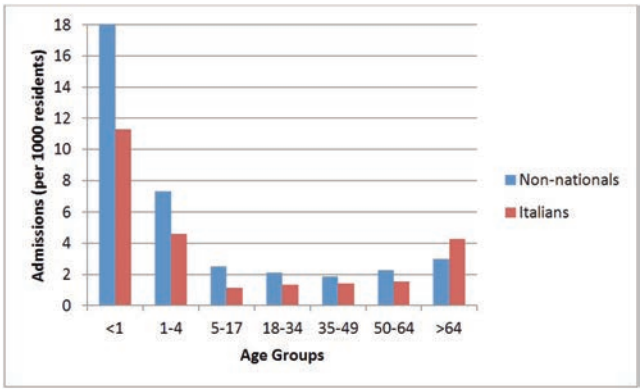
Table 16 shows admissions for infectious and parasitic diseases in the male population in Piedmont in 2009, according to age group and population (Italian, migrant, and "temporarily present" or undocumented migrants).

Table 16. Admissions for infectious and parasitic diseases, males, Piedmont Region, HDD, 2009[35]

Age Group	Population	n.	Rate
<1	ita	185	11,30
	stp	4	-
	non ita	67	18,71
1-4	ita	311	4,62
	stp	3	-
	non ita	94	7,29
5-17	ita	251	1,13
	stp	4	-
	non ita	69	2,51
18-34	ita	464	1,36
	stp	27	-
	non ita	135	2,09
35-49	ita	691	1,44
	stp	20	-
	non ita	104	1,86
50-64	ita	657	1,56
	stp	10	-
	non ita	33	2,27
>64	ita	1812	4,27
	non ita	10	2,99

Figure 10 shows clearly that in all age groups, with the exception of those aged over 64, the rate of infectious and parasitic diseases is noticeably higher in the migrant population. The data for children aged under one is particularly significant: this is very probably due to late access to medical care when the illness can no longer be treated in an outpatient medical centre.

Figure 10. Hospital Admission Rates for infectious and parasitic diseases, Italian and migrant resident population, by age group. Males, Piedmont Region, HDD, 2009[36]



34 *Ibid.*

35 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

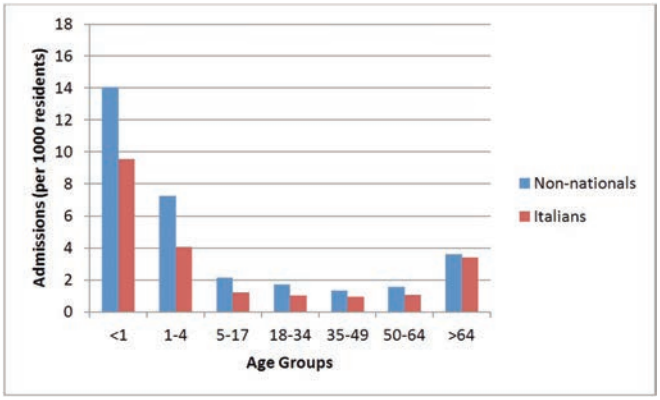
36 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

The female population's situation is not very different. Table 17 and especially Figure 11, giving hospital admission rates for infectious and parasitic disease in the resident female population, clearly show again that the rates for the migrant population are higher than those for the receiving country population. It should be noted that here the rate is higher for females aged over 64. Moreover, the rate for migrants aged under one year is again significantly higher than the rate for receiving country children of this age.

Table 17. Admissions for infectious and parasitic diseases, females, Piedmont Region, HDD, 2009[37]

Age Group	Population	n.	Rate
<1	ita	147	9,53
	stp	3	-
	non ita	49	14,04
1-4	ita	260	4,08
	stp	5	-
	non ita	87	7,22
5-17	ita	252	1,20
	stp	1	-
	non ita	55	2,14
18-34	ita	334	1,03
	stp	33	-
	non ita	120	1,70
35-49	ita	440	0,94
	stp	16	-
	non ita	76	1,32
50-64	ita	450	1,05
	stp	3	-
	non ita	32	1,56
>64	ita	1982	3,40
	non ita	18	3,62

Figure 11. Hospital Admission Rates for infectious and parasitic diseases, Italian and migrant resident population, by age group. Females, Piedmont Region, HDD, 2009[38]



Tuberculosis

Figure 12 shows that total reported cases of pulmonary tuberculosis are fairly stable in comparison to previous years, with a decrease in the receiving country population and an increase in the migrant population.

37 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

38 *Servizio Sovrazonale di Epidemiologia ASL TO3* (Regional Epidemiology Unit).

This reflects the national situation where there has been a gradual reduction in tuberculosis in the Italian population at the same time as an increase in the migrant population. Tuberculosis is considered one of the greatest problem areas for migrant health.

Figure 12. Rates of pulmonary tuberculosis[39]

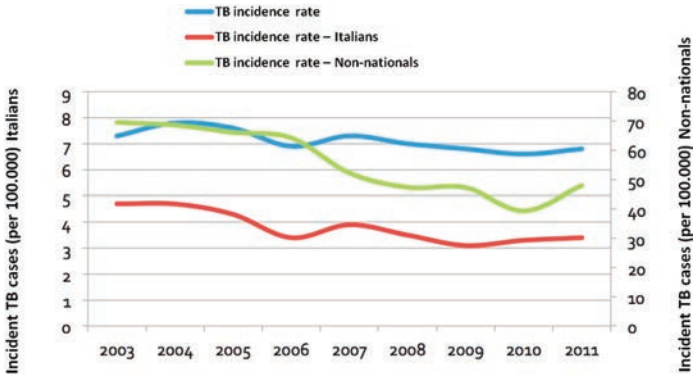


Table 18 shows that Romanian migrants are most affected by tuberculosis. This can partly be explained by the high proportion of Romanians resident in Piedmont.

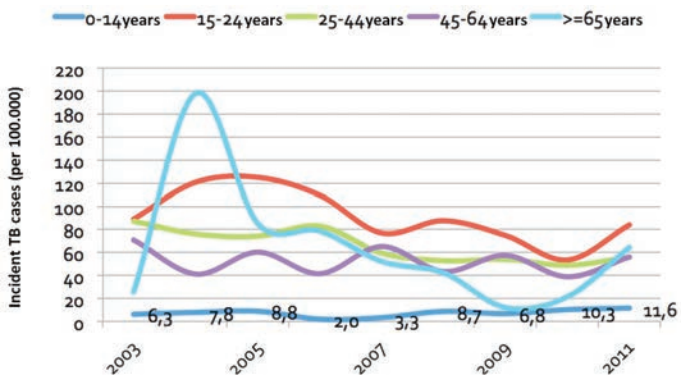
Table 18. TB cases by country of origin[40]

Origin	n.	%
Central Europe	98	39,0
North Africa	50	19,9
Sub-Saharan Africa	49	19,5
South America	22	8,8
Asia	21	8,4
Eastern Europe	5	2,0
Central America	3	1,2
Oceania	2	0,8
Western Europe	1	0,4
Total	251	100,00

Country of Birth	n.
Romania	87
Morocco	43
Senegal	16
Somalia	12
Peru	9
Nigeria	7
Brazil	7
China, Rep. of	6
Albania	6
India	5
Philippines	5

Finally, Figure 13, which illustrates rates of occurrence of TB according to age group, shows that the disease is most widespread in migrants aged between 15 and 24.

Figure 13. Rates of pulmonary TB by age group in migrants[41]



39 Data and figures from Servizio di riferimento Regionale di Epidemiologia per la sorveglianza, la prevenzione e il controllo delle Malattie Infettive (SeREMI) ASL AL - Alessandria (2012), *Bollettino Tubercolosi Piemonte – Andamento e caratteristiche della diffusione della tubercolosi in Piemonte*, Pasqualini, C., Bugiani, M., Demicheli, V. and Raso, R. (eds.); available on www.aslal.it/Sezione.jsp?idSezione=2296. Figure modified and translated by Anthony Olmo, Irene Biglino.

40 SeREMI ASL AL (2012) *op. cit.* Table modified and translated by Anthony Olmo, Irene Biglino.

41 Data and figures from SeREMI ASL AL (2012) *op. cit*. Figure modified and translated by Anthony Olmo, Irene Biglino.

HIV/AIDS

After a system for registering new cases of HIV infection was set up in 2008, 45,707 new cases of HIV infection were reported up to the end of 2009 in the 17 Regions or Provinces that joined the system (some of which had been reporting cases since 1985), with an annual rate of 4.6 cases per 100,000 residents. The proportion of migrants diagnosed with HIV increased from 11% in 1992 to 32.9% in 2006, and then decreased to 27.2% in 2009, with an annual rate of 22.5 cases per 100,000 inhabitants (Figures 14 and 15, and Table 19). The most frequent means of transmission of the disease is through heterosexual contact, with a noticeable increase (from 24.6% in 1992 to 70% in 2009).

Approximately one third of newly diagnosed HIV-positive individuals are at an advanced stage of the illness (late presenters), with their immune systems already heavily compromised and in many cases already suffering from AIDS. This was also confirmed in interviews with health sector specialists in this area. Such delays in starting antiretroviral treatment, which are partly explained by a lack of information and with consequent lack of knowledge about risky behavior, can often lead to a lower life expectancy in comparison to HIV-positive patients who start their treatment earlier. The significant factors (multivariate analysis of variance) associated with advanced illness at the time of diagnosis of infection were: age over 40 (OR = 3.0; 95% IC 2.3-3.9); foreign nationality (OR = 1.6; 95% IC 1.2-2.2); male-to-male versus heterosexual contact (HET vs MSM, OR = 2.1; 95% IC 1.5-2.9).

Figure 14. Percentage distribution of new diagnoses of HIV infection by nationality and year[42]

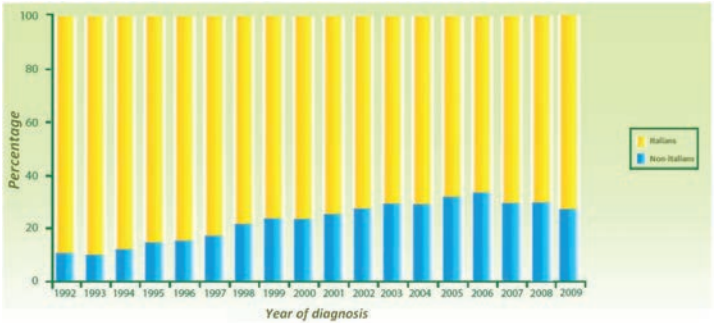


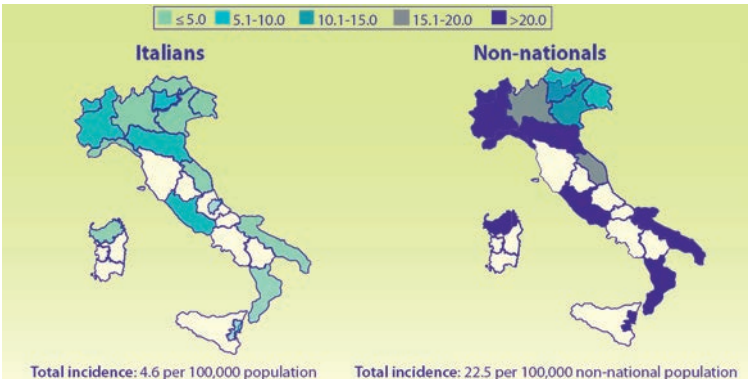
Table 19. Percentage distribution of cumulative cases of AIDS by registered nationality[43]

Geographical Area	<1995	1995-96	1997-98	1999-2000	2001-02	2003-04	2005-06	2007-08	2009-10	Tot.
Italy	96,7	94,9	91,2	86,9	85,0	83,5	78,4	77,5	73,3	91,5
Africa	1,1	2,1	4,1	6,3	9,1	9,1	11,8	11,1	13,2	4,1
Asia	0,1	0,2	0,3	0,5	0,6	0,8	1,3	1,2	2,2	0,4
Western Europe	0,5	0,9	0,8	0,5	0,3	0,4	0,3	0,3	1,0	0,6
Eastern Europe	0,1	0,2	0,4	0,7	0,8	1,6	1,9	3,5	3,5	0,6
North America	0,2	0,1	0,1	0,2	0,0	0,1	0,1	-	0,1	0,1
South America	1,1	1,5	2,6	3,2	3,0	4,1	4,3	4,6	5,9	2,1
Unknown	0,2	0,2	0,6	1,8	1,1	0,4	1,9	1,8	0,9	0,6

42 Data and figures from Istituto Superiore di Sanità (2011). *Notiziario dell'Istituto Superiore di Sanità 2011*, Volume 24, Number 5, Supplement 1 (Aggiornamento delle nuove diagnosi di infezione da HIV al 31 dicembre 2009 e dei casi di AIDS in Italia al 31 dicembre 2010), available on www.epicentro.iss.it/problemi/aids/datiCoa2011.asp. Figure modified and translated by Anthony Olmo, Irene Biglino.

43 *Ibid*. Table modified and translated by Anthony Olmo, Irene Biglino.

Figure 15. Incidence of new diagnoses of HIV infection in Italy (per 100,000 persons), 2009[44]



In Piedmont, 3,686 new cases of infection were reported between 1999 and the end of 2010, when 290 new cases of infection were reported, 6.8 cases per 100,000 residents, similar to previous years (Table 20).

Table 20. New cases of HIV/AIDS infection in Piedmont; prevalence and incidence rates[45]

Year	Female				Male				Total			
	n.	%	Rate	IC 95%	n.	%	Rate	IC 95%	n.	%	Rate	IC 95%
1999	107	33,6%	4,8	3,9 – 5,7	211	66,4%	10,1	8,7 – 11,5	318	100,0	7,4	6,6 – 8,2
2000	96	32,1%	4,3	3,4 – 5,2	203	67,9%	9,8	8,4 – 11,0	299	100,0	7,0	6,1 – 7,7
2001	105	32,1%	4,8	3,8 – 5,7	222	67,9%	10,9	9,4 – 12,3	327	100,0	7,8	6,9 – 8,6
2002	85	27,9%	3,9	3,0 – 4,7	220	72,1%	10,8	9,3 – 12,1	305	100,0	7,2	6,3 – 8,0
2003	110	33,8%	5,0	4,0 – 5,9	215	66,2%	10,4	9,0 – 11,7	325	100,0	7,6	6,7 – 8,4
2004	72	26,1%	3,2	2,4 – 3,9	204	73,9%	9,7	8,3 – 11,0	276	100,0	6,4	5,6 – 7,1
2005	77	26,1%	3,4	2,6 – 4,2	218	73,9%	10,4	8,9 – 11,7	295	100,0	6,8	6,0 – 7,5
2006	86	30,2%	3,8	3,0 – 4,6	199	69,8%	9,4	8,1 – 10,7	285	100,0	6,5	5,7 – 7,3
2007	87	27,0%	3,8	3,0 – 4,6	235	73,0%	11,0	9,6 – 12,4	322	100,0	7,3	6,5 – 8,1
2008	87	26,0%	3,8	3,0 – 4,6	247	74,0%	11,5	10 – 12,9	334	100,0	7,5	6,7 – 8,3
2009	93	30,0%	4,1	3,2 – 4,8	217	70,0%	10,1	8,7 – 11,4	310	100,0	7,0	6,1 – 7,7
2010	73	25,2%	3,2	2,4 – 3,9	217	74,8%	10,1	8,7 – 11,4	290	100,0	6,5	5,7 – 7,2

Of new cases of HIV infection in 2010, 28% were migrants and 58% of these were women, more than double the rate for Italians, where 16% of those infected were women. Thirty-eight percent of new cases of HIV infection in Piedmont were late presenters: 40% of these were migrants and 33% Italians. Table 21 shows geographic area of origin of new cases of infection.

Table 21. Geographical area of origin of new cases of HIV/AIDS infection, 2006 - 2010[46]

Nationality	n.	%
Sub-Saharan Africa	238	54,2%
Eastern Europe	72	16,4%
South America	57	13,0%
North Africa	34	7,7%
Asia	15	3,4%
Western Europe	9	2,1%
Central America	8	1,8%
Central Europe	4	0,9%
Sub-Saharan Africa	1	0,2%
North America	1	0,2%
Total	439	100,0%

44 Data and figures from Istituto Superiore di Sanità (2011) *op. cit.* Figure modified and translated by Anthony Olmo, Irene Biglino.

45 SeREMI ASL AL (2012) *op. cit.* Table modified and translated by Anthony Olmo, Irene Biglino.

46 SeREMI ASL AL (2011). *Bollettino HIV/AIDS, Anno 2010 (edizione 2011)*, Pasqualini, C. and Demicheli, V. (eds.), Table modified and translated by Anthony Olmo, Irene Biglino.

AIDS CASES

In terms of cumulative cases of AIDS reported to the *COA* (*Centro Operativo AIDS*, AIDS Operative Centre) since the start of the epidemic (in total 62,616 until the end of 2010, around 40,000 of these deceased), the Piedmont Region ranks fourth in Italy with 4,093 cases. Of these, 2,967 relate to the first 17 years, up to 1999 when 140 cases were reported; 1,126 cases were reported in the 11 following years until December 2010, when 22 cases were reported. Data from *SeREMI* (the Regional Service for Infectious Disease Epidemiology) report 4,252 cases of AIDS registered in Piedmont since the epidemic started, of which 74 cases were registered in 2010.

4.5. MENTAL HEALTH

It is widely acknowledged that worldwide, and particularly in Europe, illnesses such as depression, schizophrenia and alcohol abuse have the greatest impact on global burden of disease in terms of years of suffering.[47] Estimates by the WHO show depression to be one of the main causes of disability in adults and in the elderly. The extent and the seriousness of these conditions have resulted in mental health and dependency diseases being included in the 2012-2015 Social and Health Care Plan, among the 11 health problems considered as being of primary importance, under Article 12.1.a of Regional Law 18/2007.[48]

Despite this, there are still some considerable gaps in knowledge about the impact of such problems on public health at regional and local level. Indeed, only patients who have been diagnosed as suffering from one of the major psychiatric illnesses are treated by mental health services. For the other cases, it is difficult to establish to what extent management of these disorders is entrusted to other bodies, what care they receive and how many sufferers receive no care.[49]

In the migrant population in particular, the isolation brought about by separation from family and social networks, by job insecurity, by difficult living conditions and by exploitation can certainly have negative effects on mental health.[50] International studies have shown that migrants suffer from stress, anxiety and depression to a greater extent than host-country populations.[51] Mental health problems can also be the direct consequence of the process of migration, a process that is often particularly difficult and is frequently associated with trauma such as war, exploitation, slavery, physical and sexual violence, and having to live in situations of illegality.[52] According to WHO data, exposure to the risks associated with migration increases vulnerability to psycho-social disorders, substance abuse, alcoholism and violence.[53]

Nevertheless, although it would be logical to suppose that trends identified elsewhere may well also exist in Piedmont and Turin, there is no quantitative data to support this. Hence it is difficult to quantify the extent of such health problems in the local migrant population. This is of particular concern because of the great difficulties, further discussed in Chapter 5.1.2,[54] encountered by Departments of Mental Health in providing regular care to migrants, whether documented or undocumented.

47 *Regione Piemonte, Piano socio-sanitario,* (Piedmont Regional Authority, 2012-2015 Social and Health Care Plan) p.83.

48 *Ibid*, p. 116.

49 *Ibid*, p. 86.

50 United Nations (2009). United Nations Development Programme, *Human Development Report 2009 – Overcoming Barriers: Human Mobility and Development*, New York: UNDP, p. 56. Available on hdr.undp.org/en/reports/global/hdr2009/

51 *Ibid*.

52 United Nations (2010). *Report of the UN Special Rapporteur on the human rights of migrants, Jorge Bustamante*, UN Doc. A/HRC/14/30, par. 25.

53 World Health Organization (2008). World Health Assembly WHO. *Health of migrants. Report of the Secretariat*, UN Doc. A61/12, par. 17.

54 Chapter 5.1.2., *Cultural acceptability*.

CHAPTER 5.
THE RIGHT TO HEALTH PERSPECTIVE

This chapter seeks to probe into some of the reasons why the migrant population may experience a disproportionate burden in health terms, by addressing the difficulties encountered by migrants in accessing and using health services in particular those related to the *availability* and *quality* of services. For the most part, problems are connected with lack of resources in the health service, a situation which clearly affects not only the migrant population but the entire population. However, the vulnerability of migrants places them in a more unstable predicament, and exposes them to even the smallest of changes.

I. LACK OF RESOURCES: HOW TO ENSURE AVAILABILITY AND QUALITY OF SERVICES IN TIMES OF ECONOMIC CRISIS

Most interviewees highlighted scarcity of resources and their continuing decrease as one of the paramount obstacles to the effective functioning, and perhaps sometimes even to the present and future survival, of health services.

The economic crisis which has been a feature of the last few years has obviously had negative consequences on the resources available to public administration bodies in general, and on funding available for health services in particular. Clearly, such a situation has an impact on social welfare, which depends exclusively on public expenditure, and affects the entire population. Everyone tends to be affected, although to differing extents, by shrinking public services due to ever-increasing cuts in available resources. The tendency to cut back on projects and social services in times of crisis requires monitoring of public authorities to verify that they respect economic, social and cultural rights.

At the same time, social disruption, of which economic crisis is certainly a part, generally tends to have a more severe impact on the more vulnerable and marginalised sections of the population, including migrants. They already experience precarious social conditions as a result of restricted economic means, of lack of networks of family or friends, and of low working and living conditions. Any further reduction in public services, and especially the public health service, can only have further negative repercussions on their situation and their health.

Any cutbacks in public healthcare may make it impossible for such groups to deal with health problems, and clearly may have a negative impact on the possibility to realise their right to health. Furthermore, precarious health, as analysed below, tends to negatively affect many other spheres of the life of migrants, especially work, thus increasing the likelihood of further social descent.[1]

Concrete consequences of cuts in resources: As several interviews suggest, the problem of inadequate resources appears to affect all types of healthcare services without distinction, both in the public sector and in the non-profit sector. Some services are at risk of no longer being able to operate, or at least no longer being able to provide acceptable services in terms of both quality and quantity. Mental Health Departments and Centres, the branches of the *SSN (Sistema Sanitario Nazionale,* the Italian national health service) responsible for preventing, diagnosing and treating mental health problems, appear to be particularly affected in this regard. Several interviewees were critical when describing the situation of most of these facilities in Turin. Most health sector practitioners and professionals interviewed expressed the view that many Mental Health Departments

1 See Chapter 5.2., *The right to the underlying preconditions of health.*

and Centres are struggling to survive and have insufficient resources to meet the demand for mental health. With regard to migrants, the situation is even more critical: as explained below in Chapter 5.1.2,[2] Mental Health Departments and Centres are ill-equipped to deal with migrants' mental health, and do not adopt a sufficiently multicultural approach in their services.

As emerged from the interviews, one of the effects of under-resourcing is reflected in concrete terms in insufficient staff and hours of work, which clearly has a strong negative impact on the quality of services provided. One of the interviewees, a physician in a key Accident and Emergency department, described how she had had to work at times for 20 hours consecutively because of understaffing. On another occasion, we were told about a different type of problem: lack of staff means that sometimes physicians have to examine patients without a nurse being present. This has potential legal ramifications, since a nurse is required to be present not only to assist the doctor but also to witness that the doctor respects procedures during patient examinations. Another consequence of understaffing concerns cultural mediators. As will be described in Chapter 5.1.2.,[3] the number of cultural mediators used by health services is often insufficient. Often, some areas of origin are not covered by services, or the hours worked by mediators are insufficient in relation to demand.

In addition, lack of resources is often exacerbated by inefficient use of those few resources that are available. This problem is acknowledged by the 2012-2015 Regional Social and Health Care Plan, which states "inefficient use of available resources compromises, or runs the risk of compromising, the possibility for all citizens to use the *SSR (Servizio Sanitario Regionale,* Regional Health Service).[4] One example of inefficient use of resources that emerged during our study relates again to problems connected with cultural mediation. Most cultural mediators employed by the health services work standard office hours during the day, whereas it was reported by interviewees that the greatest demand for health services by migrants generally occurs in the evening and during the weekend. Consequently, organising cultural mediators' work schedules to take account of this would improve use of this resource, and would ensure greater respect for the cultural acceptability of the health service which, as seen in chapter 2.2,[5] is one of the founding pillars of the right to health.

The risk of an under-resourced public healthcare services

A large number of initiatives, both public and private, risk disappearing because of lack of resources. A particular cause for concern is the increasing difficulty fared by the public sector in supplying quantitatively and qualitatively acceptable health assistance. It is a particular cause for concern that the public sector finds it increasingly difficult to provide an adequate health service in terms of quantity and quality. Although it is true that very successful forms of interaction between the public sector and the non-profit sector can occur, as discussed below, it must be stressed that realisation of the right to health for everyone is primarily the responsibility of public institutions. If this situation should persist and if the resources available in the public sector should continue to decrease, the quality of the service can only deteriorate; in some cases, some health services may even cease to be available. As mentioned above, the first element of the normative content of the right to health is availability, that is to say, the existence in sufficient quantity of services, facilities, equipment, and goods. Removing or drastically decreasing some existing services may well mean that Turin's health service becomes inadequate, in terms of

2 Chapter 5.1.2., *Cultural acceptability.*

3 Chapter 5.1.2.,*Cultural acceptability.*

4 *Regione Piemonte, Piano Socio-Sanitario Regionale 2012-2015*, p.19.

5 Chapter 2.2., *The normative content of the right to health*.

availability. As previously mentioned, this situation may have particularly serious repercussion on the more vulnerable or marginalized groups in the population, such as migrants. It could also lead to breaches of the non-retrogression principle. As explained in Chapter 2.2,[6] this principle constitutes one of the hallmarks of the realisation of economic, social and cultural rights. It should be remembered that, according to this principle, states are required to maintain at least existing levels of realisation of rights and lowering the level of protection already achieved would generally amount to an infringement of this right.

It was reported that no noticeable decreases can be detected in funding for services specifically dedicated to migrants, such as the *ISI* Centres. As previously stated, cutbacks appear to be largely cross-cutting, thus affecting all services. However, this could result in indirect discrimination: cutting a service aimed at a vulnerable group like migrants could have proportionately greater negative consequences than cuts to other services, precisely because of the greater difficulties encountered by migrants, especially undocumented migrants, in finding adequate alternative treatment.

Finally, it is worth highlighting how this situation is in a state of constant flux. The Regional Council of the *Regione Piemonte* (Piedmont Regional Authority) recently approved the new 2012-2015 Social and Health Care Plan, which provides for significant changes in the organisation of the regional health system. These important changes include the establishment of Federations or consortia (whose aim will be to centralise activities such as purchasing, stocking, distribution, and asset management control) and hospital network programming. However, these changes will not be discussed as an analysis of the new Social and Health Care Plan lies outside the scope of this study.

Health needs and resource reduction

A serious issue pointed out in particular by public health specialists during interviews concerns the ability of the authorities to accurately evaluate the needs of the population, the areas which should be prioritised, and, as a result, how to respond in an appropriate manner when reducing expenditure. According to a number of specialists, public administration bodies often have inadequate knowledge about the scope of public sector actions, no information about the wellbeing produced by these actions, and thus no appropriate criteria with which to identify which cutbacks should be introduced.

Policy analysis is a common practice in other countries: it enables expectations and outcomes to be evaluated both before and after any action. However, it was referred that it is rarely carried out in Piedmont, or more generally in Italy. In health policy, health equity audits are very rare. Their purpose is to identify how equitable distribution of services and resources is, according to the specific health needs of various groups and areas, so as to be able to decide how to distribute resources according to real needs. Clearly, without appropriate measuring instruments, it is difficult for public administration bodies to be able to know precisely which services and projects can or cannot be cut. In accordance with the views of the Committee on Economic, Social and Cultural rights in General Comment 14,[7] Paul Hunt, the former UN Special Rapporteur on the right to health, gave considerable space during his mandate to promoting the use of indicators and benchmarks.[8] These instruments are crucial in guiding public administrations to use available resources in the best possible way and, more generally, to guarantee people's right to health.

6 Chapter 2.2., *The normative content of the right to health*.

7 United Nations (2000). Committee on Economic, Social and Cultural Rights. *General Comment No. 14 - The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, par. 57 and 58. For further analysis of General Comment 14, see Chapter 2.2., *The normative content of the right to health.*

8 See for example United Nations (2003). *Interim report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. A/58/427; see also Hunt, P. (1998). "State Obligations, Indicators, Benchmarks, and the Right to Education", in *Human Rights Law and Practice*, vol.4(2), p. 109.

It must be acknowledged that the realisation of the right to health right requires both economic resources and time. In this regard, it should be recalled that progressive realisation and maximum use of available resources are principles governing the fulfilment of states' obligations regarding economic, social and cultural rights. Indicators and benchmarks play a particularly important role in defining the obligations of states based on these principles.[9] The former Special Rapporteur rightly emphasises that without indicators and reference standards it is difficult to know how to monitor compliance with these principles, whose provisions are rather elusive.[10] Finally, the Rapporteur also stresses the importance of producing disaggregate data that clearly reveal discrimination[11] as well as the true extent of the realisation of economic, social and cultural rights, of all individuals in general and of migrants in particular.[12]

Overall, it would be mistaken to assert that it is enough to increase resources in order to achieve full realisation of the right to health. As the Special Rapporteur suggests, prioritising provides the key to optimising use of resources, in order to achieve gradual realisation of the right to health, particularly when resources are scarce. Hence, the way resources are used, spending priorities, and, in today's economic climate, priorities to protect in times of crisis and cuts, all play a fundamental role. The instruments mentioned above, such as indicators and benchmarks, are fundamental in providing public administration bodies with the means they need to interpret reality. The next important step consists in defining priorities, based on the outcomes of analysis of the situation. In terms of human rights, identification of priorities by public administration bodies must take particular account of the situation of populations, communities or individuals living in particularly difficult conditions, as many migrants do. In other words, vulnerabilities and disadvantages need to become the objective criteria according to which priorities can be established and attention must be given to both direct and indirect discrimination.[13] As the Rapporteur himself notes, in practical terms the definition of priorities often does not take sufficient account of the health needs and demands of categories such as women, people affected by disabilities, and other vulnerable groups.[14] Priorities identified by public administration bodies that reflect or even reinforce pre-existing situations of exclusion can seriously jeopardise the realization of the right to health.[15]

Once again, it is important to remember how inequities and social determinants of health affect realisation of the right to health. The priorities identified by public administration bodies in a large number of sectors, not only the health sector, will have a profound impact on the right to health. Therefore, it is absolutely essential to promote synergies in the various sectors affecting social determinants, such as housing and social security, in order to ensure full realisation of this right.[16] Finally, it must be emphasised that adopting a human rights based approach also requires procedural guarantees. The process of prioritisation must be as widely participated and as transparent as possible, and also requires accountability.[17] This is particularly important at this particular time, when, as mentioned above, the new Social and Health Care Plan of the *Regione Piemonte* is in the early stages of implementation (June 2012). Although the Plan provides for significant innovation in the regional health system, aimed at introducing considerable changes to the way citizens use services, the process of developing the Plan was not informed by effective consultation and participation.

9 Riedel, E. (2007). "Measuring Human Rights Compliance. The IBSA Procedure as a Tool of Monitoring", in Auer A., Flückiger A., Hottelier M. (eds.), *Etudes en l'honneur du Professeur Giorgio Malinverni, Les droits de l'homme et la constitution*, Geneva/Zurich/Basel: Schulthess, p. 64.

10 Hunt, P. (1998) *op.cit.*, p. 115.

11 Hunt, P. (2003) *op.cit.*, par. 12.

12 United Nations (2010) *Report of the UN Special Rapporteur on the human rights of migrants, Jorge Bustamante*, UN Doc. A/HRC/14/30, par. 17.

13 United Nations (2007). *Report of the UN Special Rapporteur on the right to the highest attainable standard of health to the United Nations General Assembly*, Paul Hunt, UN Doc. A/62/214., par. 26.

14 *Ibid*, par. 12.

15 *Ibid*.

16 *Ibid*, par. 22.

17 *Ibid*, par. 20 and 25.

Box 4. The Mamma+ Project

The *Mamma+* project is one example encountered during the study that reflects the difficulties in ensuring the survival of projects that have an important impact on the health of migrants, in this particular case the health of HIV-positive migrant women.

The project was set up by the *Azienda Sanitaria Ospedaliera OIRM-S.Anna* (Sant'Anna-Regina Margherita Children's Hospital) in partnership with the University of Turin and the non-profit organisation *Gruppo Abele* (Abele Group) with funding by the *Regione Piemonte* Department of Health and Healthcare. The project stemmed from the awareness that, to a large extent, health outcomes are largely dictated by the social conditions which people live.[18] The primary aim of the project was to establish a support network for HIV-positive mothers in order to ensure that they are able to access appropriate health care, and at the same time to strive to remove the social and cultural obstacles undermining the possibility of ensuring wellbeing to mother and child. Mothers with HIV often experience greater vulnerabilities in personal or family terms. Some of the women who accessed the program were single mothers and drug users. A large portion of the women were migrant women, often undocumented, mostly from African countries. Thus, in addition to a serious health condition, these women also faced problems caused by extreme relational and social difficulties. These causes of vulnerability as well as other reasons for their marginalisation, such as cultural barriers or stigma associated to the disease, tend to place such women on the margins of society and to make treatment even more difficult. The project also buried its roots in the recognition that dealing with a person's health – in this case, an HIV-positive woman with a child – also requires dealing with various everyday problems, such as paying rent or utility bills.

There are three different levels of care, according to the type of relationship established with each woman:

1) health care: essential for the woman and her child to be part of the treatment process; a health educator accompanies the woman to doctor and day hospital appointments, and regular home visits are planned, made by a paediatrician together with a health educator

2) health and social care: this includes the previous level of care as well as social care based on clearly-defined objectives.

3) Full care; when a good relationship has been established between the woman and social and health care professionals, wider-ranging care can be provided, including psychological and relational support, possibly also requiring resources and professionals from outside the work group.

As the project developed, the network of specialists was extended, according to need, to include specialists in ethno-psychiatry, lawyers specialised in immigration, or labour consultants specialised in contracts. Funding for the *Mamma+* project was almost halved in 2012. However, despite the drastic cuts that could have signified the end of the project, it has survived because of surplus funds. Fortunately, despite this imposed cutback and thanks to efforts made by those supporting it, it will regain funding in 2013.

It is clear that when priorities are being defined, it is important to defend and to promote a project such as this, which addresses infectious diseases, vulnerable groups, inequalities and social determinants of health. Furthermore, a project like this enables the

18 See also Chapter 2.2, *The normative content of the right to health*, and Chapter 5.2., *The right to the underlying preconditions of health.*

health system to save many resources, by helping patients to follow their treatment protocols properly and contributing enormously to reducing the risk of children of HIV-positive mothers becoming infected. Thus we welcome the decision of providing funding for the project again in 2013 and in the years to come.

II. A STRONG NETWORK IN TURIN: THE NON-PROFIT SECTOR COMPLEMENTS THE PUBLIC SECTOR

The research results, together with reflections prompted by the current economic crisis, lead to the conclusion that the only way to guarantee the right to health of marginalised groups in general, and migrants in particular, seems to lie in creating and strengthening a network of cooperation between players in the public arena and those in the non-profit or voluntary sector. The study reveals that the city of Turin is a setting where cooperative networking is already a consolidated practice, and is often productive and efficient. The existence of networks linking non-profit actors was described by many interviewees as a defining feature of the city, rooted in a strong sense of awareness and solidarity that has consolidated over the years.

From as early as the 1800s various non-profit sector initiatives gradually consolidated a tradition of charitable assistance that continues to the present day. A wide range of associations are involved specifically in the field of health and migration, often working together in an efficient manner. The important role played by Turin's banking foundations should be mentioned: they support the work of many of those in the non-profit sector and help to keep the network alive and active. The non-profit sector's ability to consistently provide a quality service to migrants may well be instrumental in enabling this part of the population to receive an adequate level of assistance. There is no quantitative data on this, and the area requires further research. However, it is widely recognised that the public sector alone would encounter difficulties covering the health needs of migrants, especially undocumented migrants who do not meet legal requirements regarding entry and residence in Italy, and migrants who for various reasons cannot register with the public health service.

Another significant aspect concerns the integration between the public sector and the private sector. A promising approach suggested by many interviewees is one whereby the public healthcare sector recognises and exploits the flexibility and positive features of initiatives in the non-profit sector. Given the public sector's struggle to deliver sufficient levels of care, for example in the area of mental health and migration, greater synergies between public services and non-profit initiatives would be very welcome. Against the backdrop of the current economic climate, the only solution may be to combine forces and opportunities, even at the cost of giving up some autonomy. This type of interaction may be, in some cases, an effective way to keep the public sector involved in sensitive and important areas, even in the face of financial difficulties.

Various cases, some of which are outlined in the box below, show how the public sector can find ways of not retreating from some of its responsibilities; indeed, by recognising the value of networking, where non-profit players are crucial, it can take on the vital role of coordinating and managing services where public and private services become complementary. Finally, a strong network, covering both the public and the non-profit sectors, can also be of economic benefit and generate considerable savings. Sharing patients' medical records between public and voluntary health services is

one example of the kind of benefit this kind of cooperation could bring in future. Today, if a public health physician refers a migrant patient to a non-profit clinic, medical tests, diagnoses and prescriptions already carried out or issued cannot be used, and have to be repeated. More effective coordination and formal agreements could improve the services provided and save resources.

Box 5. Progetto Prisma (Prisma Project)[19]

An excellent example of public and private sectors working together efficiently in the arena of health and migration, the *Progetto Prisma* was started by the *Passepartout* service of the Central Management Office for Social Policy and for Relations with Local Healthcare Units *(Direzione Centrale Politiche Sociali e Rapporti con le Aziende Sanitarie)*, of the *Regione Piemonte* Health Department, together with a network of non-profit associations.

One of *Progetto Prisma*'s most noteworthy initiatives is the Disability and Immigration Service (*Servizio disabilità e immigrazione)* providing support and help to migrants suffering from disabilities. The service attempts to cater to needs relating to health and other rights of disabled migrants, a particularly vulnerable group. The conditions inherent in their situation often lead them to experience problems such as difficulty in relations with others, isolation, and psychic distress.

The motivation to create this service arose from the realisation that neither the public administration nor the wide range of initiatives in the non-profit sector were able to respond adequately to the demand for assistance. This led to the idea of combining efforts and resources in order to improve the support available. In this project, the public sector is entrusted with the task of coordinating the various non-profit bodies, which provide financial resources as well as their specific knowledge and expertise.

The various forms of support provided include facilitating access to information on rights and the law, and access to health services, providing support in overcoming cultural and social barriers, and encouraging disabled persons to take advantage of various local opportunities. For each case, an effort is made to tailor support according to the particular needs of individuals. Thus, full use is made of the range of different services and expertise within the network which the *Prisma Project* is radicated in. In the past year, there were 59 interventions, and 18 of these related to young people aged under 18. Morocco and Romania are the most common countries of origin of the users of the service.[20]

This model appears to be highly effective, and could be replicated in a large number of fields and forms. It maintains a strong role for the public sector (not delegating its responsibilities entirely) and makes the most of the resources and expertise of the private sector.

19 For further information, see www.progettoprismatorino.org.

20 Data available on www.progettoprismatorino.org.

Box 6. GrIS - Gruppi immigrazione e salute (Immigration and Health Groups)

The *GrIS Piemonte*[21] network makes an important contribution to ensuring greater realisation of the right to health for migrants in Turin. The network's aim is to facilitate knowledge and collaboration among those involved in various ways in ensuring the right to, access to and use of health services by migrants.

The general objectives of the network are: 1) to provide information and promote discussion on certain national and local legal issues, and on initiatives undertaken in public services and in voluntary and non-profit services; 2) through networks, to bring together groups, services, people, competences and resources related to both welfare and to training; 3) to advance proposals that are political and organisational in nature; 4) to obtain support for the network through contact with institutions.

The Piedmont *GrIS* network is exceptionally active and provides an important opportunity for a range of professionals to meet and compare notes on migration and health in Piedmont. It provides concrete evidence of how productive networking can be.

21 *GriS* are the regional area branches of *SIMM* (*Società Italiana Medici per la Migrazione*, Italian Doctors for Migration Society). For further information, see www.simmweb.it.

5.1.2. CULTURAL ACCEPTABILITY

It is widely recognized that culturally based health beliefs and practices may have a significant impact on the way migrants seek to access and use health care services. Differences in approaching healthcare are in part grounded in the different meanings and interpretations attached by various cultures to terms such as "illness", "health", and "treatment". The way in which each individual relates to such concepts is strongly influenced by his or her cultural background, the environment in which he or she grew up in, or by religion. Equally, the way in which migrants relate to these notions will also have a significant impact on their ability to access and use a health system which, in the study area, is only partially equipped to deal with a culturally and linguistically diverse society.

The first part of the present chapter will provide some examples of the impact of culture on the provision of health care and 'cultural barriers' as they emerged from the interviews. It is highlighted that, when referring to specific cultures, it is not automatically suggested that all members of a certain group hold the same values and beliefs to an identical degree. The second part will be devoted to analysing the central role played by cultural mediation in ensuring the cultural accessibility of health services. An attempt will be made to investigate problems affecting the profession.

I. CULTURAL DIFFERENCES

In this first section, some of the most frequent cultural differences encountered during the study will be described through concrete examples reported by the interviewees. Although the examples provided are drawn from the experience of health service professionals interviewed in Turin, they can reflect cultural barriers that make access to and use of health services difficult for migrants in Italy and perhaps in many other European contexts.

A different conception of illness and health: One example described by a mental health practitioner concerns an autistic child from a rural area of an African country. We were told that in the child's village of origin this condition was considered a divine gift, and that the child had enjoyed the veneration of his community. Subsequently, when the family arrived in Italy and the child was diagnosed with autism, they were deeply shocked, as the child, instead of being venerated, was seen as suffering from a disease.

Another example emerged in the interviews. A cultural mediator explained that, for many cultures, illness exists only when visible or directly observable symptoms appear. For example, people suffering from cardiac conditions are sometimes not considered to be ill because there are no visible signs of any element indicating the illness, or no visible 'suffering'. This approach can have serious consequences in terms of treatment and following courses of treatment properly.

Other illustrations that surfaced in the investigation relate to the way women belonging to certain cultures experience pregnancy. For many women, pregnancy is experienced as a time of excellent physical health. For this reason, many women do not undergo the medical tests prescribed to monitor the course of the pregnancy and the health of the child, as consulting a doctor and undergoing tests are actions normally associated with illness or health problems. We were informed that this is why many women do not undergo medical tests prescribed during pregnancy and therefore, expose themselves to complications that may affect their health and the health of the unborn child.[1]

1 See data in Chapter 4, *The health status of the migrant population in Turin*.

Another illustrative example is reflected in the attitudes of different cultures towards mental health and the way mental illness is experienced. Several interviewed mental health practitioners noted that mental illness is not perceived as a health problem in many cultures. In some reported examples, mental health problems were associated the world of magic, such as possession by evil spirits. In general, it was noted that many communities had limited knowledge of mental illness. In those cultures where mental illness is recognised as such, it is often associated with 'madness', and members of those communities were reported to fear stigma and the idea of being 'locked away' in mental institutions. The foregoing examples illustrate some of the difficulties that may be encountered in the identification and treatment of mental health problems. One psychotherapist explained that the role played by cultural mediators is crucial. For example, mediators will need to explain to migrants what a psychotherapist does, since this profession often does not exist in the migrant's country of origin.

A last example is the way in which infectious diseases, and in particular HIV/AIDS, are viewed and experienced. Some interviewees emphasised the stigma associated with such conditions and the possible discrimination that can occur as a consequence. The fear of being identified as HIV-positive or as an individual affected by AIDS can prevent many people (both migrants and non-migrants) from seeking counselling and from undergoing diagnostic tests.[2] In addition, one of the effects of stigmatisation related to such diseases is that people often do not reveal their health status for fear of the negative consequences and of being marginalised by their community.

A different idea of treatment

The interviews revealed that different cultures define treatment differently. Certain communities more frequently adopt traditional remedies or treatments that are not related to bio-medical processes as defined by Western medicine. However, as is well-known, such treatments are not always effective: they may be inappropriate, or the disease may be untreatable. If communication is inadequate, this situation can create enormous frustration and disappointment for the patient. Many interviewees confirmed that certain communities use traditional medicines or methods to various degrees. Given the scarce quantitative data on the topic, it is difficult to evaluate the extent of the phenomenon, also because not all interviewees interpreted recourse to traditional medicine in the same way. Many acknowledged that the phenomenon existed, but differed in their assessment of its extent. Some had observed that migrants used traditional remedies only for common, everyday problems, and that for more serious illness they turned to the health service. It appears fairly accurate to assert that many migrant communities use traditional medicines or practices, even if only occasionally. This practice is particularly common among certain communities, for example from China and from sub-Saharan Africa. These communities often have traditional doctors or healers. On this topic, we were also told about African migrants who were prepared to travel to other cities in Italy in order to see traditional doctors, who were well-known within their community.

Some migrants' preference for traditional medicines and treatments need not necessarily be linked to lack of integration or as mistrust of Western medicine. In most cases, as we were informed by cultural mediators who had lived in Italy for many years, it is often only a symptom of difficulty in adapting, which in itself can be considered as physiological. Change linked to a long, slow process, and during this process many migrants may feel more inclined to use well-known, familiar methods. In this regard, the role

2 United Nations (2003). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. E/CN.4/2003/58., p.17.

played by communication difficulties must also be remembered. Because of the poor knowledge of the Italian language by certain individuals and the lack of linguistic accessibility of the health services,[3] as well as general adaptation difficulties mentioned above, some migrants may feel more comfortable turning to healers or treatments that are widely used within their community. This appears to be the case, according to many interviewees, with the Chinese community where language is known to be a particularly strong barrier.

In itself, the use of traditional medicines and practices is not an obstacle to realisation of migrants' right to health. On the contrary, the requisite of cultural acceptability means that health services should be open to multiculturalism, and not exclude, where appropriate, supplementary use of medicines or practices from other cultures.[4] Western-style bio-medical medicine should not be considered the only possible approach: many remedies and practices from other types of medicine are extremely safe and effective. In any case, the essential role played by information needs to be underlined. Only by transmitting correct, accurate information is it possible to attempt to use traditional methods or practices where possible alongside the bio-medical approach, and to discourage those methods which are harmful for health.

A different idea of body: it is interesting to note how the body is viewed differently in different cultures. Pain, for example, can also be culturally determined. Some doctors told us of the difficulties they encountered in carrying out simple procedures, such as injections or local anaesthetics, because of patients' reactions to pain and physical suffering. Violating the integrity of the body even with a straightforward, harmless injection can give rise to great distress among certain communities.

A different idea of the relationship between the individual and the health system: as is widely known, an individual's mindset may be shaped by factors that transcend cultural background. Further factors, such as historical, social and political context, may also influence the way in which an individual views and interacts with the surrounding environment. During interviews, the issue often arose of how migrants from some countries perceive the Italian health system.

In many countries, health care is not public, or private health care is considered to be of better quality than the public system. Interviewees often recounted that migrants from these countries often view the Italian public health system with suspicion. A number of times, we were told very clearly that the system is perceived as a second-rate choice because it is public and in many cases free of charge. It was also reported that certain individuals believe that some services have been specifically created to treat migrants and, for this reason, are inferior in quality. The *consultori* (local family health clinics) were often mentioned as examples of health services considered to be of poor quality and not intended to provide a service for the Italian population.

This attitude shows how socio-political and cultural background can be an obstacle to access and use of existing health services. Furthermore, all social levels are affected by this bias, which was found not only in less-educated migrants but also in the better-educated. Again we are reminded of how challenging it is for migrants to adapt to a new context. Even migrants who are better-equipped in terms of education and cultural level will need time in which to adapt, and this will vary in length depending on individual characteristics; and they will need time in order to be able

3 See Chapter 5.1.3. *Accessibility.*

4 See *infra* "Right to health and cultural acceptability: the crucial role of cultural mediators".

to move away from some notions inherited with their social, political and cultural background. The key means of facilitating this process of adaptation can only be by making accurate information widely available,[5] in order to limit as far as possible biases such as those discussed above.

Another problem worth mentioning in this regard relates to unrealistic health expectations. We frequently heard in interviews that many migrants view Italy as a country where it is possible to be treated for any illness or where physicians can solve health problems by prescribing simple medication. Such expectations create frustration and tension in migrants: their perceptions, however mistaken, are real and seeing such expectations disappointed – perhaps because certain tests have to be repeated or some treatment does not have the expected effects – can have powerful consequences. For example, we were told of a migrant family who had a daughter suffering from heart disease: because of her illness, the child had underwent numerous surgeries and followed various courses of treatment, none of which, however, led to her being cured. The parents found it extremely difficult to deal with the situation: they interpreted the child's lack of recovery as a lack of effort or commitment on the part of doctors, and they did not accept that the child's health problems were difficult to solve. In these cases, one solution is to strengthen information channels and provide enough space for cultural mediation in the doctor-patient relationship, so that mediators can communicate effectively and explain situations to patients.

Differences in gender roles: the particular vulnerability of women emerged a number of times during the interviews. As is known, the role of women and the degree of their independence vary significantly according to cultural context. This aspect can sometimes become a serious obstacle to migrant women's access to health services. Many interviewees stated that migrant women from certain communities frequently find it difficult to use health services, because they must wait until their husband is free to accompany them. Mention should be made of the well-known, still commonly-encountered situation regarding gynaecological examinations by male physicians: often migrant women's husbands will not allow examinations of this kind to take place.

Differences in sensitive areas: other important cultural differences can be identified when sensitive issues need to be handled, often where religious beliefs come into play. The classic examples are abortion, blood transfusions, and organ transplants, all practices that some religions place restrictions on. However, it should be remembered that such issues are also sensitive areas for the non-migrant population. Cultural mediators can play an important role in this regard as well, as they can provide migrants with all the necessary information to enable them to be fully aware of the implications of their choice.

Other cultural differences: finally, some cultural differences do not fit into the groups mentioned above. One typical example is time and punctuality. In many cultures punctuality is not a fundamental aspect of social relationships. However, if patients do not respect appointment times, it is very difficult for the health service to function. In this case as well, cultural mediators can explain how key aspects of the host society are organised and function differently, and help migrant patients understand they must respect appointment times and be punctual when using health services.

5 For further information, see Chapter 5.1.3. *Accessibility.*

II. RIGHT TO HEALTH AND CULTURAL ACCEPTABILITY: THE CRUCIAL ROLE OF CULTURAL MEDIATORS

As clearly stated in General Comment 14, discussed in depth above,[6] healthcare must be culturally appropriate: health services must respect the cultures of individuals, minority groups, peoples and communities. In an international study on health systems in 194 countries, P. Hunt and G. Backman recognised how important it is for differing conceptions of health and illness to be taken into account at local level, in order to facilitate access to health services by all parts of the population.[7] However, this cannot be interpreted as an obligation for countries to shape their health services to adapt to all cultures. This would be an impossible and undesirable objective, and would not be in tune with international human rights provisions.

Nevertheless, it is reasonable to require that the responsible authorities, health care professionals and, more generally, the entire health system fully recognise the multicultural nature of our society. States' obligation to provide health sector professionals with appropriate and adequate training and information must also include the duty to provide training on ethnicity and multiculturalism, in order to raise staff awareness on this topic.[8]

There is a need for health professionals to incorporate some knowledge about traditional beliefs and to develop the skills to work with patients from cultures other than their own. In concrete terms, this means first and foremost adopting an open approach towards different cultures. Physicians or health system professionals (including administrative personnel or management) are not required to be experts on all possible patient cultures; however, they must adopt an open, respectful approach towards other cultures, and they must not to be dismissive *a priori*. In other words, all healthcare sector personnel, whether they be managers, doctors, reception staff or nurses, must be trained to interact in the best possible way with patients from different cultures.[9] Providing health services in a multicultural society requires specific training in multiculturalism, an ability to relate to others patiently and without prejudice, willingness to listen and to take more time than usual, if necessary. Many interviewees reported that staff are often impatient and hasty when dealing with migrant patients. Such attitudes may be detrimental: they impede and discourage migrants' access to health services and gradually wear away one of the essential prerequisites for a healthy relationship between healthcare services and migrant users: trust. Migrant patients must believe that they will receive the treatment they need without discrimination and that they will be treated with respect. Even when there is no outright discrimination, any general lack of sensitivity towards their particular situation may alienate them, affecting their sense of belonging.[10] Seemingly minor episodes where scant attention and sensitivity are demonstrated towards migrants may have drastic effects on their relationship of trust with health care services: when these episodes are discussed and described, they quickly spread through the community and may negatively influence other people.

Hence it must be emphasised once again that health policy must take into account the need to respect diversity, to be open towards multiculturalism, and to pay attention to specific health needs and to the social determinants that influence the migrant health.

A particularly important point emerged in numerous interviews regarding the extent to which Mental Health Departments and Centres are able to respond adequately to multiculturalism. Many interviewees emphasised that the cultural aspect was neglected in patients' treatment

6 For further information, see Chapter 2, *The right to health.*

7 Hunt P., Backman G. et. al. (2008). "Health systems and the right to health: an assessment of 194 countries", *The Lancet* 372(9655), p. 2047.

8 United Nations (2008). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. A/HRC/7/11, par. 44.

9 See also Chapter 5.1.3. Section iii on the role of healthcare sector personnel and information on rights of migrants and healthcare services.

10 World Health Organization (2010). *How health systems can address health inequities linked to migration and ethnicity*, Copenhagen: WHO Regional Office for Europe, p. 19. See Chapter 5.1.3 Section iii, for further examination of the role of information in realisation of the right to health in migrants, and the most effective ways of spreading information.

and that in general, there was little ability to respond to users from different cultures. For example we learned that sometimes migrant patients were given a *Rorschach* test (a personality assessment test) and Leiter scale tests (a tool normally used to measure the intelligence of children who are cognitively delayed, are speech or hearing impaired or have behavioural problems). As was explained by mental health practitioners, the results of such tests may not be reliable when administered to children belonging to certain communities because of their specific cultural values, beliefs, rules, behaviours and symbols.

Because of a lack of cultural sensitivity of mental health services, it was referred that many migrant patients have difficulty in accepting the treatment they are given as an adequate response to their own perception of their condition. This situation may lead to the ineffectiveness of treatment.

The need to provide an adequate service to the different migrant cultures in Turin and migrants' demand for such a service, may largely explain the proliferation and success of non-profit sector initiatives which provide, for example, psychological and psychiatric assistance to migrants in contexts and with methods that are culturally appropriate for their particular needs.

Cultural mediators: In light of the above, it is important to recognise the fundamental role of cultural mediators in the relationship between health care professionals and migrant patients. Mediators must be seen as the only real means to bridge the gap between cultures, and to make the relationship work better and be more satisfactory for both sides.

Mediators will of course be able to provide linguistic assistance if necessary to facilitate communication. However, their role transcends translation mediators play an important role in establishing a connection between two different cultures, a connection that may otherwise be lost. As mentioned above, ideally cultural mediators are able to bridge the gap between migrant patients from various cultures and health care professionals. It emerged that well-trained, competent cultural mediators are essential figures to ensure the cultural acceptability of the health system. Clearly, mediators must be professional and well-qualified in order to be able to perform this essential task effectively. Mediators need to receive quality training, social and professional recognition, and appropriate remuneration. These requirements may not be always met in the profession as it is currently organised, at least insofar as the study area is concerned. The section below provides a more detailed discussion of the problems associated to the profession.

In organisational terms, there are often too few mediators to meet demand, or they are not available at times when they are needed. Our study found that in the main hospitals and Accident and Emergency departments, migrants require most health care in the evening and during the weekend. As interviewees frequently reported, it is difficult for migrants to obtain time off work in the daytime and on weekdays. In addition, migrant women from some cultures are more likely to wait for their husbands to return from work before going to see a doctor. The provision of cultural mediation services should, therefore, be adjusted according to these peak demand times.

It should be emphasised, once again, that the cultural mediator's role should generally extend well beyond the linguistic dimension. Support in overcoming cultural barriers lies at the core of the cultural mediator's work. As stated by a paediatrician who works closely with migrants and mediators, "cultural mediation has added value" because it enables health

service users to feel more confident, and it brings trust and balance to the doctor-patient relationship.

It should also be noted that mediators are important outside the context of health care as well. As they often represent figures of importance within their communities, they are often regarded with respect and trusted by community members. This is particularly important when it comes to the contribution they can make in terms of spreading information.

Mediators can in fact be one of the main channels, and one of the most reliable ones, for disseminating information among migrant communities. By ensuring that mediators are well-trained, that they have correct information, not only on matters regarding health but also on other matters of interest for migrants (such as social services, housing, and education), the spread of accurate information within a community can be facilitated. Indeed, our study suggests that the most common means by which information is spread in migrant communities is word of mouth.[11]

III. SOME AREAS OF CONCERN

Despite the central role of cultural mediation in ensuring that the right to health of migrant communities is respected and realised, it emerged that the profession suffers from a number of weaknesses that may undermine its effectiveness.

A precarious profession: the first problem to note is that the profession lacks formal recognition. Some important progress has been made in recent years,[12] especially in terms of clarifying the training that a cultural mediator should ideally complete. In addition, there is still no national professional association of mediators. This issue has implications in terms of professionalism, of professional protection, and of recognition in social terms. It not only makes the profession vulnerable generally, but it also undermines the motivation and enthusiasm of individual mediators. It was commented that mediators who perceive that their profession is not recognised or valued, despite its important role, will be more likely not to feel motivated to improve or undertake further professional training, in order to carry out their work in the best possible way.

Another issue contributes to making the profession increasingly vulnerable according to the interviewed mediators. In most cases, cultural mediators are not employed directly by the health services for which they work, but through cooperatives. Once these cooperatives have obtained a contract with the health service, they hire the mediators to work for them in the health services. The cooperatives act as middlemen between mediators and health centres or hospitals, following selection by public tenders. According to information gathered during interviews, mediators work in precarious conditions: public tenders are generally rather short in duration (on average around three years) and when they expire, those employed by the cooperatives have no guarantee of re-employment. Sometimes there is a decrease in the demand for mediators of some nationalities and the health centre may decide that the service is no longer required. Moreover, the cooperatives often have no incentive to provide further professional training for mediators, as we were told that, generally, tenders are awarded primarily on the basis of economic criteria.

Training: the interviews revealed that training is one of the profession's greatest drawbacks. Firstly, according to many professionals working

11 See Chapter 5.1.3 Section iii, for further examination of the role of information in realisation of the right to health in migrants, and the most effective ways of spreading information.

12 See, *inter alia*, Conferenza delle Regione e delle Province Autonome, *Riconoscimento della figura professionale del Mediatore interculturale*, 09/030/CR/C9, 8 April 2009; see also Consiglio Nazionale dell'Economia e del Lavoro, Organismo Nazionale di Coordinamento per le politiche di integrazione sociale degli stranieri (2009). *Mediazione e mediatori interculturali: indicazioni operative*.

in the sector, training is often still inadequate, despite efforts made at national level to better define the training required for mediators.[13] The main criticism reported was that training programs are often outdated; according to many mediators who were interviewed, training programs have remained largely unvaried in the past twenty years. However, migration in Italy has changed radically both in terms of numbers and in terms of types of migration over the past two decades. It is clearly unreasonable to expect a program designed twenty years ago, however good it was, to be able to continue to be used today; all the more so since clear guidelines have been provided about the courses that should be designed and implemented.[14] Moreover, some mediators interviewed pointed out that many trainers are not well-qualified. The teachers who should train the new mediators have a limited idea of the real requirements and daily challenges of the profession, and hence are unable to give their trainees the tools they need to prepare themselves for their work.

Some interviewees pointed out the need to train mediators to be impartial. In view of the important role that they play in the relationship between physicians and migrant patients, and given the possibility that certain ethically delicate issues may need to be dealt with, it is essential that mediators be trained to not influence the patient's decision in any way, and to limit themselves to transmitting the information provided by the physician, so that patients can make their choice independently and be fully aware of its implications.

Finally, mediators need to be trained to deal with the considerable responsibility that they often bear. For example, in one case, a mediator made an error in translating the dose of medicine to be given to a child, which could have been lethal. This discloses the level of responsibility that the mediator must sometimes assume, and it highlights, once again, the need for mediators to be adequately trained.

This last example points the way to a further requirement, which in reality is a fundamental prerequisite: adequate knowledge of the Italian language.[15] If mediators do not have a good knowledge of Italian, their work will clearly not be up to standard. Communication between medical staff and mediators will be difficult: the former will not be sure that information will be fully understood by the latter and transmitted correctly to the patient, opening the way for situations such as the one described above.

Resistance to mediation: some interviewees have reported that in certain situations there may be resistance to mediators by hospital administrations. We were told that this occurs in some health centres or hospitals, where mediation is perceived, in economic terms, as an 'extra cost'. Yet, it was highlighted how mediation may indirectly contribute to reducing the costs of health centres, for example by providing the kind of information that may help prevent hospital admissions or unnecessary diagnostic tests. A doctor in an key Turin hospital told us that in his experience it can be much more difficult to make a diagnosis when no cultural mediator is present. In such a situation, health care professionals sometimes are led to prescribe extra tests to eliminate all doubt; with a mediator present, many of these tests may no longer be necessary.

Another important issue, connected indirectly with the previously mentioned problem of the profession's lack of recognition, is the proposal to replace cultural mediation with a telephone service. Although the reasons for reducing expenditure and containing costs are understandable, many interviewees suggested that this solution is not advisable. The service provided by the mediator cannot be complete if there is no direct personal

13 See Footnote 14 above.

14 *Ibid*.

15 See Consiglio Nazionale dell'Economia e del Lavoro, *op. cit.*, p.3.

relationship. Given the ethical and moral responsibility often carried by mediators, who, for example, explain informed consent forms to migrant patients together with medical staff, a telephone may raise additional difficulties.

Difficulties interacting with doctors and patients: although most mediators interviewed generally believe that their role is understood and appreciated by health professionals and by patients, some difficulties exist. Many mediators stated, during interviews, that they noticed a degree of diffidence on the part of medical staff towards non-medical staff who wear hospital lab coats at work, as mediators do. Apart from this apparent diffidence, difficulties in coordinating and bringing together the two professions were also sometimes encountered. Sometimes physicians see mediators as introducing an element of interference in the doctor-patient relationship rather than providing help, and sometimes they believe that mediators should limit themselves to merely translating.[16] Moreover, more generally, difficulties that arise when physicians and mediators work together are often due to lack of time. Working with another professional practitioner requires time and often this time is not available, especially in emergency situations.

On the other hand, misunderstandings sometimes arise with migrant patients. Firstly, misunderstanding can be caused by the fact that mediators wear lab coats; this can create distance between mediators and patients, as they are assimilated to physicians. Secondly, sometimes patients will not accept help from a mediator of the same nationality. This may appear to counter, to some degree, the various statements on the 'trust' placed in mediators my members of the same community. However, this mostly happens with regard to small and close-knit communities. Members of such communities may be reluctant to share health problems, especially in sensitive areas such a reproductive health, for fear that the mediator will relate these problems to the rest of the community, or because of embarrassment, since the mediator is generally well-known or part of the community. The neutrality of mediators should be stressed and patients should be clearly informed that mediators are bound by confidentiality.

Conclusion: as highlighted above, it emerges from the study that cultural mediation plays a central role in ensuring the cultural acceptability of the health services which, as we have seen, constitutes one of the pillars of the right to health. Cultural mediation provides the health services with the degree of flexibility they need to be able to deal with the various cases that arise every day. However, although some progress has been seen in the last few years, some critical issues, such as professional recognition and training, have a negative impact on the profession and limit its effectiveness. Dealing with these problems must become a priority for the health authorities.

In the same way, in terms of the structural and financial organisation of healthcare services, it is recommended that fundamental role of cultural mediation be recognised. In particular, mediation should be viewed as an essential service, and mediators must be employed in sufficient numbers in all health care services, they must cater for the most numerous migrant communities, and they must be available at times when migrants need them most.

16 It must be stressed that sometimes, in particular cases, mediators must only translate: this is the case in emergency situations or in mediation at A&E. In these cases, information must be conveyed as quickly as possible and healthcare practitioners, especially, must have all necessary information as quickly as possible.

Box 7. Cultural mediators as essential players in intercultural healthcare: a socio-anthropological perspective[17]

Our study shows that for years both the world of non-profit associations and the world of healthcare institutions have been moving towards a more intercultural approach to medicine. Such an approach seeks to encourage accessibility of health care services. However, practitioners complain that every day they must operate in a workplace that is increasingly dominated by an approach based on cuts in spending, resulting in a health policy that is increasingly unable to communicate and listen to the needs and requirements of not only migrants, but also social and health care practitioners themselves.

On the one hand, it can be noted that institutions are becoming more rigid: this can be seen in increasing cuts in available social welfare and health care services. On the other, we note an increase in the needs of migrants, who seek treatment for the psychobiological body, as well as treatment for the *social body*.[18] As practitioners observe, a profession is required that can provide help to deal with suffering that extends beyond the psychobiological dimension of the body alone. It follows that migrants' misunderstandings and misplaced expectations are regular occurrences and not sporadic examples of non-compliance,[19] that is of not following a prescribed course of treatment. It is clear that our migrants continue to feel that they are in unfamiliar territory as regards an approach to medicine that they do not know or recognise, or share culturally.

In this broader context, especially when communication difficulties and misunderstandings[20] between social and health care practitioners and patient become more serious, the importance of the professional cultural mediator[21] emerges very clearly: a figure that mediates between two different social and cultural worlds, that is to say the world of healthcare institutions and the world the patient carries with him or her. With regard to this aspect, R. Beneduce notes[22] that the professional cultural mediator has become a victim of the patient's increasing expectations and misunderstandings, where conflict and frustration are normal, since the mediator is expected to do much more than simply speak about the Other's culture.

Cultural mediators are professionals who are often undervalued, so much so that a proposal has even been made to replace them with a call-centre service.[23] This proposal indicates how far the logic of reducing or containing costs has ended up by becoming more important that human and professional relations between medical practitioners and migrant users. Criticism of professional cultural mediators by social and health care practitioners is also levelled against their professional theoretical and practical training, which is considered to be inadequate for the work that they have to carry out.

Certainly training for cultural mediators is a fundamental issue. One mediator observed: "There are drawbacks to 600 hours of training provided by a training body which is unfortunately is not always qualified on the topic of mediation and does not always have qualified teaching staff. [...] Some training bodies have teachers who teach future mediators without really knowing what these people will be doing and without giving them the necessary skills. Another problem is that mediators access health services through tenders between the training body and cooperatives. The cooperatives are

17 Author: Eros Brunone Avena.

18 Duglas, M. (1996). *Natural Symbols, Explorations in Cosmology, Routledge*, New York.Taussig, M. (1993). *Mimesis and Alterity: A Particular History of the Senses*, Routledge, New York.

19 Taussig, M. (1993). *Mimesis and Alterity: A Particular History of the Senses*, Routledge, New York.Geraci, S; Maisano B, Mazzetti, M. (2005). "Migrazione e salute. Un lessico per capire. Studi Emigrazione." *International journal of migration studies*, pp. 157: 7-51.

20 Geraci, S; Maisano B, Mazzetti, M. (2005). "Migrazione e salute. Un lessico per capire. Studi Emigrazione." I*nternational journal of migration studies*, pp. 157: 7-51.

21 Fantauzzi, A. (2010). *Il rapporto medico-paziente immigrato. (In) comprensione e pratiche di mediazione linguistica e culturale*, Tendenze *nuove*.

22 Beneduce, R. (2007). *Etnopsichiatria*, Carocci, Roma, pp. 290-298.

23 Maria, a nurse, comments: «[...] They mentioned this thing to me yesterday, about mediation using a phone service. I'm wondering how you can communicate with a patient who's got a tube in the throat and is waiting to have it taken out. I don't think it's very nice to have to talk on the phone with a tube in the throat [...]. And I really think it diminishes all the work that we've done in the last two years, but once again it's a matter of saving money».

not interested in providing mediators with further training because this is expensive, even though training requirements are specified in tenders."

The qualification obtained by cultural mediators is not always synonymous with professional excellence, as Beneduce states:[24] "It soon emerged that it was a mistake to take it for granted that a would-be mediator was necessarily linguistically competent: no mediator is a "natural expert" in their own language and culture. But it was an even more serious mistake to believe that general courses would be adequate, where a range of subjects and topics were proposed without any particular underlying rationale (training mediators for which sectors for example), and aimed at trainees from very different backgrounds. Continuing obstinately to offer the same programme can only be explained by the economic interests supporting what can only be described as a kind of training factory".[25]

We believe that reflecting on and restructuring the training course for cultural mediators is a starting point in order to create a type of health response based on intercultural communication. It is not a question of bringing the cultural mediator into the ranks of biomedicine, in a "techno-integrationist" approach.[26] On the contrary, as Beneduce again comments, it is essential to break the ambiguous connection that the term cultural mediator still has today with the controversial colonial figure of cultural broker,[27] that is to say the figure who acted as go-between, between the colonial authorities and the local population, in tax collection. Cultural mediators, as concrete expression of a type of medicine based on interculturalism, must not put aside their own culture in favour of another, or vice versa. Interculturalism, both in theory and in practice, implies that the interaction between two different cultures leads to the creation of a third meeting point: «While the principle of autonomy leads to recognition of diversity, the principle of interculturalism expresses the need for communication and exchange between societies with different cultural origins».[28]

24 Beneduce, R., *op. cit.*

25 *Ibid*, p. 291.

26 Good, J. B. (1996). "Gli studi culturali nelle bioscenze, nella biomedicina e nella biotecnologia", in Donghi, P. (ed.) *Il sapere della guarigione*, Editori Laterza, Bari.

27 Beneduce, R., *op. cit.*, p. 293.

28 Sariego Rodriguéz, J.L., (2002). *El Norte Indígena Colonial: Entre la Autonomía y la Interculturalidad*, Desacatos, n. 10, *Centro de Investigaciones y Estudios Superiores en Antropología Social*, Messico, pp. 235-242.

This chapter will explore difficulties concerning *accessibility* of health facilities and services as they emerged during interviews. Emphasis will be placed on three categories of obstacles: generic difficulties related to bureaucracy and procedures (Section i), language barriers (Section ii), and accessibility as it relates to information (Section iii).

I. DIFFICULTIES ACCESSING HEALTHCARE SERVICES RELATED TO BUREAUCRACY AND PROCEDURES

The interviews carried out during the course of the investigation disclosed a number of problems that make access to health services increasingly difficult. The most serious barriers relate to understanding how the health system functions, an obstacle which is compounded by the complexity of procedures and bureaucratic requirements. For example, simply scheduling an appointment for a diagnostic test and collecting the results is an intricate process: it was reported that migrants can find it difficult to get a full grasp of the various steps to follow, the different places to go to, and the numerous documents that must be acquired and provided. It must be noted that this problem does not uniquely affect the migrant population, but may also apply to all users of the health service, regardless of their origin or citizenship, in varying degrees. The elderly, for example, often encounter difficulties in accessing or using services and adapting to changes that occur over time. As an overarching comment, it is fairly evident that the Italian health system is not particularly user-friendly. Hence, accessing it may be difficult for anyone, but may be particularly so for more vulnerable sections of the population, such as migrants.

In addition to possible difficulties finding their way around the system, migrants often have to overcome further hurdles. Examples of the latter, as they have been identified by interviewees, are language barriers or cultural barriers,[1] difficulties in obtaining sufficient and reliable information,[2] the lack of a network of family or friends, and a more vulnerable work situation that often makes it difficult for certain individuals to take time off when they need to use the health service.[3]

It was reported that sometimes the obstacles are so great that access to the system is practically impossible. Of relevance here is what was reported by a non-profit sector practitioner working closely with sex-workers, mainly from Nigeria: many migrant women in this situation of particular vulnerability and at great risk in terms of health fail to use healthcare services precisely because of their difficulties in finding their way around the system, in understanding the procedures they are supposed to follow, and in obtaining information on how to act. It may seem paradoxical that one of the user categories that are most in need of access to healthcare services and health care, given their experience of marginalisation and social exclusion, has the greatest difficulty of all in accessing and using the service.

The difficulties generated by excessively bureaucratic procedures affect not only access to and use of health services. The process of simply registering with the *SSN* (*Sistema Sanitario Nazionale*, Italian national health service), when the conditions enabling registration are satisfied,[4] is a further example of a major stumbling block. We were told about the great difficulties experienced by a migrant woman when renewing her daughter's registration with the *SSN*. Numerous stages and procedures were involved, because she had to renew her child's permit of stay (*permesso di soggiorno*) at the same time, a prerequisite for her re-registration with the *SSN*. A number of different steps were required, which entailed visiting different offices. One of the problems involved the difficulty that the

1 See Chapter 5.1.2. *Cultural acceptability*.

2 See Section iii). *The role of information*.

3 See *inter alia*, United Nations (2010) *Report of the UN Special Rapporteur on the human rights of migrants, Jorge Bustamante*, UN Doc. A/HRC/14/30, par. 16.

4 See Appendix 1, *Healthcare and the legal status of migrants.*

woman had finding the necessary time to complete the various steps that were essential for her child's health. The weakness of her working position did not allow her to take time off work, and this, combined with the many different steps required, had made renewal of her daughter's registration virtually impossible. As many interviewees explained, in situations such as these, unfortunately, migrants tend to prioritise work even at the cost of sacrificing important aspects of health.

Orientation difficulties and the role of the URP (Ufficio per le Relazioni con il Pubblico, Public Relations Office*)*: As mentioned above, in addition to the difficulties of a complex and excessively bureaucratic system, migrants also have the problem of obtaining information that can help them to orient themselves and understand how the system works.[5]

In this regard, it should be mentioned that one of the main problems lies in the interaction between migrants and staff working at the *URP* helpdesks or the various information points of the various services. These employees perform a vital role in providing information to migrants, in ensuring correct access to the appropriate services. In Section iii) we will look more closely at how these employees often do not have knowledge of the information required, which means are not in the position to provide information to migrants, or they provide them with incorrect information, about their rights, and on the health services available. On many occasions we were told that staff, and especially administrative staff, are not adequately qualified to interact correctly with migrant users. Regrettably, some cases have been reported of overt hostility and discrimination against migrants. Leaving aside cases of outright discrimination, it is clear that these employees receive no training on multiculturalism and in general on how to interact with migrant users in the best possible way.

It must be acknowledges that effective interaction and communication with migrant users is not always easy, especially given the lack of specific training in this area. Some interviewees explained that the real issue lies in the belief, by administrations, that these employees occupy a marginal position within the health system and that, consequently, giving them specific training on how to best interact with the migrant population is not a priority. Such a view is problematic. These employees constitute the first point of contact between migrants and the health service, and thus they play a crucial role in ensuring full access to services and hence realisation of the right to health. They are key figures who often determine whether and how migrants will be able to access and use the health service and, for this reason require high-quality, specific training.

Asylum seekers and refugees

Although legislation on the provision of health services to asylum seekers and refugees is absolutely clear on the right/duty of registration with the *SSN*,[6] there are certain practical obstacles that make such registration exceedingly difficult.

In this regard, the main issue that emerged during interviews was that concerning *residenza* ("residence") or the requirement to be registered as a resident. Residence, along with a permit of stay and *codice fiscale* (tax code), constitutes an essential prerequisite for registration with the SSN. However, we learned from the interviews that many asylum seekers and refugees have difficulty obtaining a residence certificate because their accommodation is often very precarious and the city council applies the regulations rather strictly.

It is generally known that in Turin a large number of refugees who

5 See Section iii), *The role of information.*

6 See Legislative Decree 286/1998, art. 34, according to which: "(...) the obligation to register with the SSN applies to migrants who have a permit of stay or have applied to renew their permit of stay, because they are employed or self-employed, for family reasons, or for reasons relating to political asylum, humanitarian asylum, application for asylum, or anticipated adoption, fostering, or acquired citizenship".

arrived in Italy in recent years live in informal housing. Although it was not possible to verify this, it is highly likely that many of them are not registered with the *SSN* because of difficulty obtaining a residence certificate as a result of living in such precarious situations. Many of them consequently use healthcare services provided by the non-profit sector, although they are fully entitled to be registered with the *SSN*; this situation points to causes for concern in terms of their right to health and sits uneasily with the provisions of Article 34 of the TUI (Immigration Act).

To solve this problem, protocols of understanding were signed between the *Prefettura* (Prefecture or local agency of the Ministry of the Interior), the *Questura* (Police), the Tax Department, and the *Regione Piemonte* (Piedmont Regional Authority), according to which it was established that those entitled to international protection could give the shelter facilities where they live temporarily as their place of residence. It is also important to emphasise that the same protocols have also provided that these users are exempt from paying healthcare fees (Exemption E92). This is a positive provision on the one hand; however, it does not resolve the issue of those asylum seekers and refugees not living in shelter facilities, but in whatever accommodation they can find, such as squats or abandoned buildings. A further drawback to these agreements was their short duration. They remained in effect, after several extensions, until December 2010, but since then have not been renewed.

The situation is further complicated by the events that have shaken Northern Africa since the beginning of 2011. In implementing Prime Minister's Decree of 5 April 2011, the *Regione Piemonte* established that – for those who had already completed their request for asylum or were already entitled to international protection – it was sufficient to have a tax code and give as their residence the shelter facility where they were living in order to registered with the *SSN*.[7] If they have no income at all, they are also entitled to Exemption E92. These provisions are in effect for as long as the emergency period lasts.

Although this has ensured good provision of healthcare services to those who arrived after the events in northern Africa, it has also brought about two kinds of distinct problems. On the one hand, a kind of implicit discrimination has come into being between refugees who arrived in Italy before the events in northern Africa, and those who arrived after these events. For the former, the rules apply that held before the crisis developed, and hence if they live in unofficial accommodation, they find it difficult to register with the *SSN*. On the other hand, since the provisions apply only for as long as the emergency period lasts, when it comes to an end, the situation will return to being as it was before, placing many asylum seekers and refugees in a situation of uncertainty as regards *SSN* registration. The issue of residence will again constitute a serious bureaucratic obstacle to asylum seekers' and refugees' realisation of the right to health.

Finally, it is important to mention the particular situation of asylum seekers held in the *CIE* (*Centri di Identificazione e Espulsione*, Identification and Repatriation Centers). Although, as mentioned before, the situation of migrants in these centres is not within the scope of this study, it is nevertheless appropriate to highlight the difficulties faced by asylum seekers, in this particular situation, as regards their right to health. Their legal situation does not permit them to be registered with the *SSN*. They are nevertheless ensured day-hospital care and urgent, essential (also ongoing) care for illness and injury. As other studies have demonstrated,[8] some well-founded doubt exists as to the real adequacy of the healthcare service they are provided with, given the notorious problems that make the

7 Regione Piemonte, Direzione Sanità, Prot. n. 12117/DB2006, 28 April 2011; Regione Piemonte, Direzione Sanità, Prot. n. 13605/DB2000, 12 maggio 2011.

8 Association for Legal Studies on Immigration (2011). *Il diritto alla protezione, La protezione internazionale in Italia, quale futuro? Studio sullo stato del sistema di asilo in Italia e proposte per una sua evoluzione*, p. 390. Legislative Decree 286/1998, art. 35.5: "Access to healthcare facilities by undocumented migrants cannot result in any kind of notification to the authorities, except for cases when reporting is obligatory under the same conditions as for Italian citizens."

state of these centres cause for concern.

Undocumented migrants

Finally, on the subject of problems limiting access to healthcare services for certain groups, undocumented migrants must be mentioned. As previously stated, this particularly vulnerable group has, at least on paper, access to healthcare services through the *ISI* Centres. However, in practical terms, a well-known episode in 2009, regarding physicians' obligation to report to immigration authorities these users, had consequences which are still felt.

The so-called "security package" draft law provided for repeal of Article 35.5 of the TUI,[9] which stated that it was forbidden to report undocumented migrants coming to healthcare services; at the same time, a new offence was introduced, described as "illegally entering and staying in Italy". The combined outcome of these two provisions would have had the effect that medical staff, as public officials or professionals responsible for a public service, would have been obliged to report undocumented migrants using health services, since this would have in the meantime become an offence. All public officials and those responsible for public services are obliged to report to the authorities or to the police any offence that they learn about in the course of their duties, or they risk being charged with failure to or delay in reporting of an offence.

Strong proposition and mobilisation by a large number of professional associations in the medical world and a large part of civil society led to modifications being made to the draft law regarding the intention to repeal the prohibition on reporting undocumented migrants, as per Article 35.5 of the TUI. This provision is no longer part of Law 94, of 15th July 2009,[10] although the offence of illegal immigration was introduced.[11] Hence, reporting on undocumented migrants is still not allowed for two reasons. Firstly, access to healthcare facilities by undocumented migrants not complying with regulations on the right to stay in the country still does not require medical practitioners to register any report, as per Art 35.5. It should be noted here that the notion of "access to facilities" which the article refers to is much wider that provision of healthcare services; the prohibition on reporting does not concern only medical or paramedical staff but all staff (public officials or those responsible for public services) working in facilities, hence also administrative staff. Secondly, healthcare practitioners are in any case exempt from the obligation to report, according to article 365.2 of the Criminal Code, when this would expose the person receiving care to criminal proceedings, as it would in the case of an undocumented migrant.

At the time of the debate on these provisions, the fear of being reported to the authorities certainly had an impact on access by undocumented migrants to healthcare services. Subsequently, numbers returned rapidly to the normal level although some fluctuation still occurs, as reported by interviewees. Because of difficulties in acquiring accurate information and in finding their way around the system, migrants are sometimes unsure as to whether they risk being reported when they access the health service, and in case of doubt, they often prefer to avoid running the risk, if it is not strictly necessary.

This does not occur frequently enough to warrant alarm, although cases have been reported to us. For example, the existence of the offence of illegal immigration means that undocumented migrants sometimes move around the city as little as possible to avoid the risk of being stopped by the police. Here it should be noted that after the Court of Justice's *El Dridi*

9 Legislative Decree 286/1998, art. 35.5: "Access to healthcare facilities by undocumented migrants cannot result in any kind of notification to the authorities, except for cases when reporting is obligatory under the same conditions as for Italian citizens."

10 Law 94, 15 July 2009, "Provisions on Public Security", *Gazzetta Ufficiale* (Official Gazette) 170, 24 July 2009 – Ordinary Supplement 128.

11 Legislative Decree 286/1998, art. 10 bis.

ruling of 28th April 2011 and the *Achughbabian* ruling of 6th December 2011, doubt appears to have increased over interpretation of the law[12] as regards compatibility of this offence with EU law and more specifically with the Repatriation Directive.[13]

With regard to problems affecting specific categories of undocumented migrants, the situation of drug users warrants particular attention. As already mentioned, treatment, prevention and rehabilitation in the area of drug dependency[14] are part of the "urgent or essential, also ongoing, treatment" provided for under Article 35.3 of the TUI. This is certainly positive; however, as highlighted by the manager of one of the *SerT* (*Servizio TossicoAlcoldipendenze*, Drug and Alcohol Dependency Service) centres in Turin, an essential piece of the overall picture is missing. Undocumented drug users who decide they want to start a rehabilitation programme have no chance of benefiting from 'reintegration programmes' because of their legal status. As undocumented migrants, they are not eligible for job training or housing assistance that would be part of their rehabilitation programme, were they documented.

Although this issue is not, strictly speaking, a problem in terms of *accessibility* to health services, it is an issue that seriously hampers the effective action of healthcare services and the possibility of recovery or rehabilitation for those who suffer from substance abuse. The situation, furthermore, appears rather paradoxical. On the one hand, the health system commits resources and funding to treatment for undocumented migrants in this particular context. However, deciding from the start that they are not allowed, once they are no longer dependent, to return to a normal life because they are undocumented, undermines potentially positive outcomes and frustrates the progressive nature of the legislative provisions.

II. LINGUISTIC ACCESSIBILITY

One of the most common obstacles to access to health services relates to language barriers. This was confirmed in almost every interview carried out during the course of the study. It is clearly one of the most important, most urgent problems to solve. However, the extent of this problem is difficult to gauge with precision. It appears that for some groups of migrants, such as the Chinese community, it is particularly serious. As mentioned in the previous chapter, the language obstacle is one of the main reasons why this particular group tends to rely on traditional health remedies.

Although the language barrier seems to be the most obvious hurdle, this has not meant that it is the first to be resolved. The measures taken to address these problems appear fragmented and generally insufficient; it emerged clearly during the study that the level of language accessibility of the services is not uniform. In many healthcare facilities there are no notices or signs in different languages, many services do not provide information in different languages and when they do, the supply is often less than the demand. This constitutes a serious obstacle to realisation of the right to health for those migrants without adequate knowledge of the Italian language. Indeed, the linguistic accessibility of health services is one of the key requirements specified by the normative content of the right to health.

In this regard as well, cultural mediators play a central role. Cultural mediators can act as interpreters, facilitating the relationship between physician and patient. During interviews, the employment of migrant healthcare staff emerged as another extremely useful practice; it has been

12 See, *inter alia*, Gatta, G. L. (2009) "Il 'reato di clandestinità' e la riformata disciplina penale dell'immigrazione" (The offence of illegal immigration and the reform of criminal law on immigration) in *Rivista italiana di diritto e procedura penale*, 11, p. 1323; as this article went to press, the outcome was still being awaited of the Sagor case, pending before the Court of Justice, and its ruling on the compatibility of the offence of illegally entering and staying in Italy with Directive 2008/115/CE.

13 Directive 2008/115/CE of the European Parliament and Council, 16 December 2008, giving common standards and procedures in member states for returning illegally staying third-country nationals. Official Journal of the European Union L 348/98, 24.12.2008.

14 Single Text of laws regulating drugs and psychotropic substances, and prevention, treatment and rehabilitation related to substance dependence, issued through DPR n. 309, 9 October 1990 and subsequent modifications and additions. See above, Chapter 3.1.

adopted by the Accident and Emergency Department of one Turin's most important hospitals. Although these are all extremely useful measures, it is unlikely that they can suffice to remove such a significant barrier. First and foremost, the vast range of languages and dialects must be taken into consideration. Even in cases where a certain language area such as Arabic has mediator coverage, the parties involved will not necessarily understand each other immediately and clearly. Even within the same language area, the many dialects and dialect variations may sometimes make communication impossible. However, it cannot be realistically expected that the health service hire staff and mediators able to communicate in all potentially relevant languages and dialects.

Interviewees suggested a range of possible measures that can be adopted. Alongside cultural mediation and migrant healthcare staff, other types of support should be provided, such as signs and notices in all health centres, as well as information on services, illnesses, methods of treatment, prevention, and healthy lifestyles. Some of these measures measures have been adopted in many healthcare services. However, during the study it emerged that this is often the result of individual initiative, and not of a general policy aimed at making all health services accessible in terms of language. As often stated, language accessibility is one of the essential conditions for realisation of the right to health; thus, the responsible authorities should take steps to ensure that all health services are easily accessible in these terms, at least by the most numerous migrant groups in Turin.[15]

III. THE ROLE OF INFORMATION

During the investigation, information clearly emerged as one of the key aspects determining whether or not the migrant population can access and use the city's healthcare services in practice. Overall, there appears to be a disturbing lack of information, affecting not only the migrant population but also healthcare sector personnel.[16] The right to seek, receive and provide information is an essential element of the right to health. Clearly, if both service providers and service users are uninformed, misinformed or under-informed, this constitutes a major obstacle to realising the right to health of the migrant population.

We will now examine a number of areas which appear to be particularly affected by this lack of information, according to the results of study. Where necessary, we will highlight those situations particularly relating to migrants, on the one hand, and healthcare service staff on the other. The following areas have been identified:

– Information on the rights of migrants
– Information on healthcare services
– Information on correct use of healthcare services
– Information on illnesses, on prevention, on treatment, and on healthy lifestyles

Information on the rights of migrants

During the interviews, one of the issues that emerged in almost every conversation involved the lack of information about the rights and entitlements that migrants have with regard to healthcare. This was mainly a lack of information on the part of the migrant population, but also, in worrying proportions, of healthcare service personnel (both medical and administrative staff).

The largest problem is understanding whether a migrant in a particular

15 See above, Chapter 3.1. *Health players*.

16 In this chapter, reference is often made to "healthcare sector personnel", generally meant to include all those working in the sector, such as management and administrative personnel, medical practitioners, nursing practitioners, and so on. On the best methods for spreading information in the migrant community, see the section in this chapter titled, "Channels of Information: word-of-mouth and peer education".

situation has the right to register with the *SSN* or not. Many cases were reported of migrants who were entitled to register, because they were not aware of this right, were using channels available to undocumented migrants. As mentioned above, newly arrived migrants often struggle to understand how the Italian system works.

They have difficulty obtaining all kinds of information, especially on the rights they are entitled to. This is particularly true for migrants from socio-political contexts where the right to health is very poorly realised and public health care is non-existent or inadequate.

From the interviews carried out during the study, it appears that healthcare service personnel whose work involves working in direct contact with migrants, fortunately, tend to be more informed about migrant rights. This was particularly true for non-profit associations working in migration and health: for example, *Sermig* or *Camminare Insieme*, but also general healthcare services such the *Pastorale Migranti* centres. *ISI* Centres in Turin obviously also play a key role. Such entities perform a fundamental function in explaining to migrants their rights and entitlements, especially, and when necessary, in advising them on how to proceed in order to register with the *SSN*. Nevertheless, as mentioned above, healthcare sector staff themselves are not always well informed and aware of the rights of the migrant population. Our interviews revealed many cases of staff who were extremely unclear about migrants' rights, especially in the public healthcare sector.

Overall, the greatest confusion seemed to surround the position of undocumented migrants. Although Legislative Decree 286, of 25th July 1998, established clearly the right of undocumented migrants to receive urgent or essential (as well as ongoing) treatment,[17] many healthcare sector staff are not sure about exactly what kind of health care such individuals are entitled to. This emerged clearly, and alarmingly, during an interview with a *SSN* manager, who stated that undocumented migrants were only entitled to urgent care; however, this is not an accurate interpretation of the provisions of Legislative Decree 285, enacted well over 10 years ago, as seen above.

On another occasion, we directly witnessed another example of serious misinformation about the rights of all migrants, not just undocumented migrants. When asking for information at the reception area of one of Turin's *ASL*, we realised that staff believed that all migrants, regardless of their situation, had to obtain health care services from *ISI* Centres. They believed this to be the case even for documented migrants with stay permits, hired on permanent employment contracts. Migrants with regular permits of stay are entitled to registration with the *SSN*,[18] and have no need to use *ISI* Centres. Lack of knowledge in this area is clearly very damaging. It is a cause for concern that healthcare staff be so misinformed as to confuse the situation of a documented migrant with a permit of stay, with an undocumented migrant. However, it must be admitted that the range and variety of cases[19] can contribute to creating confusion.

Nevertheless, better information and training must be provided for healthcare staff on all the rights that migrants are entitled to would contribute to solving the problem. As mentioned in Chapter 5.1.2, the role required of healthcare sector staff as regards cultural diversity should be highlighted. All staff, including administrative staff, physicians, reception staff and nurses, must be trained to interact with migrant patients. As seen in Chapter 5.1.2., on the one hand this requires a certain cultural sensitivity and openness in terms of multiculturalism.

17 Legislative Decree 286, 25 July 1998, Single Text of provisions regarding the law on immigration and migrants, art. 35.3: "Migrants who have entered and are living in Italy without a permit of stay are guaranteed urgent or essential care, even if it needs to be ongoing, in public and accredited clinics and hospitals, for illness and injury; they are also entitled to access to preventive medicine programmes protecting individual and collective health". For further information see Appendix 1, *Healthcare and the legal status of migrants*.

18 For further information see Appendix 1, *Healthcare and the legal status of migrants*.

19 *Ibid.*

Information on health services

The study also revealed a lack of information about the healthcare services available to migrants. In this case as well, the problem affects both migrants and healthcare sector staff.

Many migrants, we were told, often do not know which services exist, either in the public or the non-profit sector. This situation must be remedied, along with other problems analysed in this chapter. It is true that a number of awareness raising initiatives have been organised, both in the public and the non-profit sectors. However the problem is widely perceived as still existing, which suggests that not enough has been done yet, or that increased attention and action is warranted in this regard.

The same problem appears to affect healthcare sector personnel. Doctors, nurses, and other staff often appear not to have sufficient information on existing healthcare services. In this case as well, as above, most misinformation relates to undocumented migrants.

During an interview with a physician from an important Turin hospital, who worked in a service where over 50% of users were migrants, we realised he was not familiar with the exact procedure for assigning an *STP* (*Straniero Temporaneamente Presente*) code to undocumented migrants who arrived at hospital without one.[20] This simplified procedure, which can be done by fax, was established to issue an *STP* code to undocumented migrants who come to hospitals without first obtaining the code from an *ISI* Center. Similarly to the example described above, this physician was apparently not aware of the existence and role of the *ISI* Centers.

In an attempt to address, at least in part, this lack of information, the *LDF* updated the *Guida ai Servizi Sanitari per Immigrati* (Guide to Healthcare Services for Immigrants) published in September 2008 by the *Assessorato alla Tutela della Salute e Sanità* (Department for Health and Healthcare) of the *Regione Piemonte*. The guide aims to provide a practical tool to help healthcare personnel provide the best possible service to migrant patients. It lists all the healthcare services of use to migrants in Turin, as well as other useful services such as canteens and dormitories. It also provides some concise information on the rights of migrants with regard to health care, in an attempt to help to improve awareness of the problems discussed in the previous section. The guide is available on the *LDF* website.[21]

Information on the correct use of health services

In addition to the problem examined in the previous section, another serious issue we encountered relates to lack of information on how to use healthcare services correctly. In practical terms, this seems to take the form of incorrect use of certain services or under-use of others. The study shows that this is a widespread problem for migrants.

Accident and Emergency services are those misused most frequently: migrants tend to use A&E services even in a non-emergency situation that could be solved more effectively and more rationally using other services, such as a general practitioner, in most cases. This practice appears to be mainly due to a lack of information for migrants about the different services in existence; there is no information about the need to use the various services according to different types of health problem, and no guidance on which are the most appropriate services for the various types of problem. Consequently, migrants often turn to the most visible, most easily accessible service, i.e Accident and Emergency. The negative effects of this practice, especially on A&E services, can be easily envisaged. Emergency wards already struggle to respond adequately to the normal emergency demand because of the decrease in resources explained previously, and are

20 The STP code is necessary for undocumented migrants to be able to access health care. For further information see Appendix 1, *Healthcare and the legal status of migrants.*

21 www.labdf.eu

even further burdened by additional work. There is, therefore, an extremely urgent need to publish adequate information, given that it is economically more advantageous to dedicate resources to providing information about correct use of services, rather than allowing key services such as A&E to be overwhelmed by inappropriate requests for healthcare.

Another issue which was reports is a widespread mistrust towards publics provision of healthcare, especially by migrants coming from countries where a public health system does not exist or is inadequate. This appears to be particularly the case for *consultori* (local family health clinics), often viewed by migrants as low-quality services. This is certainly one reason why some migrants under-use some health services, especially *consultori*. It is therefore even more necessary to spread correct information to clarify the role of public healthcare services in general, especially the under-used services, and to explain how valuable they are because they extend the range of healthcare services provided.

Two additional points relate to correct information on how the health service works. We were told that many migrants are unaware that there is no charge for some essential health services, such as *consultori* or diagnostic tests for infectious diseases (i.e. HIV, STIs). It is essential to spread awareness that these services are free of charge, and at the same time to emphasise that they are quality services, in order to encourage migrants to access them and use them.

Information on illnesses, on prevention, treatment and on healthy lifestyles

Lack of information on illnesses, prevention, treatment and healthy lifestyles is also a problem that reportedly affects many migrants. The study revealed that particular causes for concern relate to reproductive health, preventive measures such as vaccines and screening, and infectious diseases. Infectious diseases, especially HIV/AIDS, cause most difficulty. Poor knowledge of the processes that cause infection and the subsequent progress of the illness lead many migrants, according to reports from those working in the field, to be less careful in consistently using the preventive measures necessary to stop infection. Many healthcare personnel also report that migrants often delay screening tests: many go to health facilities only when the first symptoms appear or with serious health problems related to AIDS. Currently over 60% of AIDS cases occur in people who have had no antiretroviral therapy before diagnosis, because increasing numbers (60%) discover they are HIV-positive when AIDS is diagnosed.[22]

This phenomenon may be related to low risk perception on the part of many migrants, as our interviews and some prominent studies reveal. Some Italian studies[23] suggest that one determining factor may be that HIV/AIDS is associated with poverty. Many migrants see the disease as related to the extreme poverty in some countries, and since Italy is perceived as a wealthy country, they feel it is unlikely that they will contract the disease. In addition, information and awareness-raising campaigns have decreased steadily since the 1980s and the 1990s; this has had an impact on the quantity and quality of information available, as well as on risk perception, especially in migrants. Many wrongly interpret the lower levels of attention and concern on the part of institutions as a sign that the problem no longer exists or has been solved.[24]

Another issue reported in relation to HIV/AIDS is that consistency in following courses of treatment is a problem: due to insufficient information or difficulties in communication, many migrants struggle to understand and to adhere correctly the complex antiretroviral treatment, thus further compromising their health, and, moreover, rendering useless the costly

22 Ministero della salute/Centro nazionale per la prevenzione e il controllo delle malattie (CCM) – Regione Marche (2009). *La salute della popolazione immigrata: metodologia di analisi*, p. 103. D'Amato S. and Pompa M. G. (2010). "Alcuni aspetti della normativa italiana correlati all'accesso del test HIV", *Annali dell'Istituto Superiore di Sanità*, vol. 46(1), p. 51.

23 D'Amato S. and Pompa M. G. (2010). "Alcuni aspetti della normativa italiana correlati all'accesso del test HIV", *Annali dell'Istituto Superiore di Sanità*, vol. 46(1), p. 51.

24 Martini M. and Di Pasquale L. (2006), "Valutazione del gradimento delle campagne di prevenzione HIV/AIDS italiane rivolte agli immigrati", in Colucci A., Gallo P., Rezza G., Luzi A.M. (ed.) *Convegno del National Focal Point italiano Infezione da HIV, AIDS e popolazioni migranti: quali possibili interventi in ambito psico-socio-sanitario*, Istituto Superiore di Sanità, Rapporti ISTISAN 06/29, pp. 48-54.As will be seen at the end of the chapter, word-of-mouth is one of the main channels for spreading information within a migrant community.

investment in medicines.

In terms of the role of information in HIV/AIDS, counselling provided at the time of testing is extremely important. It provides a crucial opportunity to communicate to patients at risk, both before and after the test, important information about how infection occurs, about prevention, about the illness, and about treatments; it is also an opportunity to identify social problems, related for example to housing and to work, that may negatively affect access to prevention and treatments, and that may be dealt with by other services.

It is clear that testing is crucial, not only in order to diagnose the infection or, unfortunately in many cases, the disease, but also in order to access the important information channel of counselling. Infectious disease specialists we spoke to emphasised the importance of this aspect: for each single individual who manages to receive counselling, another ten are reached through word of mouth.[25]

It is clearly important to make information on HIV/AIDS accessible, especially for the migrant population. In addition to counselling, the traditional channels of providing information, such as awareness-raising campaigns, must also be used. However, it now widely understood that people from other cultures are often not reached by prevention campaigns aimed at Italians. Campaigns must use types of language, means of expression, content and channels that take account of cultural variables and in this manner be effective in reaching migrant communities.[26] A number of campaigns have been carried out in Italy on HIV, but so far little attention has been devoted to studying determinants that influence migrants' perception of messages in these campaigns largely tuned for an Italian audience.[27]

IV. THE RIGHT TO HEALTH AND THE RIGHT TO INFORMATION

Information is essential in a right to health framework. The UN Committee on Economic, Social and Cultural Rights identified information as one of the key supporting elements of the normative content of this right: it is one of the pillars of of accessibility. In particular, information includes the right to seek, receive, and impart information and ideas about health problems.[28] In addition, access to information and education on health is one of the social determinants on which realisation of the right to health depends to a large extent.[29] Information obviously plays a crucial part in removing discrimination.[30]

The information component of the right to health places various obligations on States. According to the well-known, tripartite division of States obligations in relation to human rights, the authorities are obliged firstly to respect the right to health and refrain from acting in a way that may interfere with access to any kind of health-related information, and refrain from not imparting information which is essential for health. Secondly, healthcare practitioners and professionals must have adequate standards of education and skill, and respect ethical codes of conduct.[31] The authorities must also ensure that third parties do not restrict people's access to health-related information and services.[32] Finally, the authorities must realise and promote the right to health. In terms of information, this duty involves: i) recognising the importance of information in promoting positive health results; ii) requiring that the state fulfil its obligation to disseminate appropriate information about healthy lifestyles, nutrition, harmful traditional practices, and the availability of services; iii) supporting people to make informed decisions about their health.[33]

25 As will be seen at the end of the chapter, word-of-mouth is one of the main channels for spreading information within a migrant community.

26 Martini M. and Di Pasquale L. (2006), *op. cit.*

27 Martini M. and Di Pasquale L. (2006), *op. cit*. However it must be emphasised that information accessibility should not harm the right for personal health data to be treated with confidentiality; see General Comment 14, par. 12 (b) (iv).

28 However it must be emphasised that information accessibility should not harm the right for personal health data to be treated with confidentiality; see General Comment 14, par. 12 (b) (iv). General Comment 14, par. 11.

29 General Comment 14, par. 11.

30 *Ibid*, par. 18.

31 Comment General 14, par. 35.

32 *Ibid*.

33 *Ibid*, par. 37.

More specifically, international instruments require States to provide many types of information. Of most relevance to this study is the requirement that States provide information about healthcare services, their availability, and their location.[34] States must also provide education about health risks, and about the habits and behaviours that can be adopted to limit them. Health education must also provide information about HIV/AIDS, sexual and reproductive health, harmful traditional practices, domestic violence, alcohol abuse, and the use of cigarettes, drugs and other harmful substances.[35] Although information about health is not part of the minimum essential requirements for the right to health, the Committee on Economic, Social and Cultural Rights has often stated that in many cases obligations regarding information are comparable to minimum essential requirements. Information should also include health education ("education and access to information concerning the main health problems in the community, including method of preventing and controlling them") and training for those working in healthcare sector ("appropriate training for health personnel, including education on health and human rights").[36]

More generally, information on health policy is just as important, since it enables people to be involved in decision-making processes on the right to health. Again, it should be remembered that the Committee for Economic, Social and Cultural Rights explains that the right to health includes the right to share in all decision-making processes on health, at local, national and international level. Detailed information on healthcare planning is thus essential, so that individuals can effectively be involved.

Information and health education must be accessible to all individuals without discrimination. This is particularly important when it comes to vulnerable groups such as migrants. Thus State authorities must ensure that the more vulnerable parts of the population have access to health-related information. The Committee on Economic, Social and Cultural Rights has stated that health determinants, and it should be remembered information is one of these, must be accessible to everyone, both in law and in fact, without discrimination.[37] For example, General Comment 14 states, in regard to the condition of women, that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health".[38]

Other instruments such as the United Nations Population Fund,[39] and the Political Declaration on HIV/AIDS[40] have also expressed their views in this area. The Beijing Fourth World Conference on Women[41] and the UN Committee on Elimination of Discrimination Against Women (CEDAW)[42] both reiterated the importance of providing education and information on sexual and reproductive health to adolescents, in order to prevent the spread of sexually transmitted diseases and unintended pregnancies.

Equal importance should also be given to infants, children and adolescents: General Comment 14 refers to the Convention on the Rights of the Child and its emphasis on the need for children to have access to appropriate information about preventive and health-promoting behaviour, and for families and communities receive support in putting these practices into effect, as essential tools to ensure access to health services for children and for families, including pre- and post-natal care for mothers.[43] Significant attention should be afforded to adolescents so that they are provided with a safe, supportive environment that ensures they can take part in decisions concerning their health, acquire appropriate information, receive counselling, and be aware when making

34 *Ibid*, par. 36, 37 (iii).

35 *Ibid*, par. 36.

36 *Ibid*, par. 37. par. 44 (d) (e).

37 *Ibid*, par. 12 (b).

38 *Ibid*, par. 21.

39 United Nations (2008). United Nations Population Fund, *Unfpa at Work: Six Human Rights Case Studies*, New York: UNFPA. United Nations (2006). General Assembly Resolution, *Political Declaration on HIV/AIDS*, U.N. Doc. A/RES/60/262.

40 United Nations (2006). General Assembly Resolution, *Political Declaration on HIV/AIDS*, U.N. Doc. A/RES/60/262. United Nations (2000). General Assembly Resolution, *Further actions and initiatives to implement the Beijing Declaration and Platform for Action*, U.N. Doc. A/RES/S23/3, par. 79(f).

41 United Nations (2000). General Assembly Resolution, *Further actions and initiatives to implement the Beijing Declaration and Platform for Action*, U.N. Doc. A/RES/S23/3, par. 79(f).

42 United Nations (2004). Committee on the Elimination of Discrimination Against Women, *Angola - Concluding comments of the Committee*, U.N. Doc. A/59/38, par. 163.

43 General Comment 14, par. 22.

health-related choices.[44]

From the interviews conducted, it emerges that the central role of information and health education may not be sufficiently recognised in Turin. Many initiatives have been undertaken, but the question arises as to whether enough has been done to ensure the highest possible level of information for the migrant community as well as for healthcare practitioners and professionals. As seen in detail above, a lack of information affects both migrants and healthcare personnel in a number of areas; this is of particular concern regarding healthcare personnel working at various levels. It is paradoxical that such a lack of information should affect one of the most vulnerable categories of our population that, as such, often needs access to health services. All those involved in the sphere of health and migration in Turin need to work to improve the level of information available in these areas to migrants and where necessary to healthcare practitioners and professionals.

Health education

The authorities are required to provide individuals with health education, as an important part of the right to health. As stated by the Committee on Economic, Social and Cultural Rights, people must be educated about health so that they can take decisions about their health and lifestyle.[45] The State must support people in their choices, by implementing prevention and education campaigns on problems related to behaviours and health.[46]

Health education also includes the duty to disseminate appropriate information about healthy lifestyles, nutrition, behaviours harmful for health, and existing healthcare services.[47] The Special Rapporteur on the right to health has also confirmed that the right to health includes the right to access to information about behaviours that are good for the health and useful for prevention, as well as information about healthcare services.[48]

The need for culturally appropriate health education is particularly important in the context of the present study. Public health information campaigns and the materials used must adopt appropriate and culturally suitable language and media. Information must be tailored to the local context and awareness-raining initiatives should enable migrant communities to take an active role. The last section of this chapter looks at methods that could result in better organisation of health education initiatives.

Training for healthcare sector personnel

The right to health includes the right of healthcare sector personnel to be trained appropriately and to have access to the information required in order to provide the best possible care. The international organisations involved with the right to health, such as the Committee on Economic, Social and Cultural Rights, concentrate largely on the need to ensure adequate training for medical personnel, a concern that obviously does not apply to our health service. However, it would be reasonable to expand the extent of the information requirement to adopt a broader definition of the term. Healthcare sector personnel – medical and non-medical – must have the information required to ensure the best possible care to the whole population and especially to vulnerable groups such as migrants. Here, we can refer specifically to the Committee for Economic, Social and Cultural Rights: the requirement to train healthcare sector personnel includes the duty to ensure that they are able to recognise the specific needs of vulnerable and marginalised groups and intervene promptly.[49] Clearly the fact that many of those working at every level of the healthcare

44 *Ibid*, par. 23.

45 General Comment 14, par. 37.

46 *Ibid*, par. 16.

47 *Ibid*, par. 37 iii.

48 United Nations (2006). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt - Mission to Uganda*, UN Doc. E/CN.4/2006/48/Add.2, par. 33.

49 General Comment 14, par. 37(ii).

sector in our Turin study were misinformed or uninformed shows that this requirement is nowhere near fulfilled. As mentioned before, many did not know basic information about the rights of migrants, about the health services available to them and about their use of them.

Part of the appropriate and adequate training and information that should be given to healthcare sector personnel relates to ethnicity and multiculturalism.[50] The services provided must respect medical ethics and be culturally appropriate,[51] as mentioned in Chapter 5.[52] However, healthcare sector personnel are often poorly trained in the area multiculturalism. Many migrants, we were told, complain about the lack of attention and patience they are exposed to: this certainly makes the relationship between migrants and healthcare services even more difficult.

Human rights education

Education on human rights for healthcare sector personnel is equally important.[53] The importance of training on human rights is widely recognised at international level; the urgency of this need was stressed in the Vienna Declaration and the Action Program adopted in June 1993 by the World Conference on Human Rights. The World Medical Association also recommends that faculties of medicine include compulsory courses on medical ethics and human rights in their degree course programs. The International Council of Nurses also advises including the topic of human rights and the role of nurses in nursing training programs.[54]

However, in Italy human rights are still not afforded enough attention in training and updating courses for healthcare sector personnel. As the UN Special Rapporteur on the right to health pointed out, all healthcare sector personnel should, at the very least, receive training on patients' human rights, including the right to health, and the rights of vulnerable groups, such as women, children, migrants, and those suffering from disabilities.[55]

Training on human rights should always include practical training on how to integrate a human-rights-based approach in clinical practice: this should include how to respect patients' dignity, how to identify infringements of human rights, how to empower patients and colleagues, and how to promote accountability. Further specific training should be provided to healthcare sector personnel working in particularly complex contexts, such as prisons and mental health services.[56]

In Turin, and in Italy in general, the role and teaching of human rights is not at the level required by international legislation. Not only do healthcare sector personnel not receive specific human rights training in most cases, but law faculties often attribute little importance to the teaching of this subject.

Information channels: word-of-mouth and peer education

The interviews carried out during the study shed light on ways in which information is effectively disseminated within migrant communities.

Firstly, it seems that the most common way that information spreads in communities is by word-of-mouth. There are various reasons for this: primarily accessing and understanding other sources of information, especially institutional ones, is difficult because of language and cultural differences; also, migrants may have more initial trust in members of their own community.

An information campaign, however well-organised and tailored to the population, will inevitably fail if it does not take into account the fundamental question of how information is transmitted and how it then passes from person to person. This has a number of implications. Given the role of word-of-mouth communication in spreading information in

50 United Nations (2008). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. A/HRC/7/11, par. 44.

51 General Comment 14, par. 12(c).

52 See Chapter 5.1.2., *Cultural acceptability*.

53 See, *inter alia*, Backman, G. and Fitchett, J. R. (2008). "Health and human rights education: time to act", *The Lancet*, Volume 375(9718), p. 894.

54 See United Nations (2005). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. A/60/348, par. 12.

55 *Ibid*, par. 15. See also United Nations (2007), *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UN Doc. A/HRC/4/28, par. 43.

56 *Ibid.*

the migrant community, it becomes vitally important to identify the best channels through which to disseminate information in these communities. Traditional campaigns using information leaflets, posters and billboards will generally be less effective, although they are still important and necessary. A key role must be played by community leaders and other key figures within the migrant community, such as cultural mediators. Ensuring that these individuals are informed about a wide range of aspects of health and other areas can encourage the trickling down of correct information within communities, and allow to access members of communities that may be harder to reach.

Excellent results can be obtained by including a peer education component. Judging by successful initiatives already existing in the Turin area,[57] great benefits may be obtained by training a certain number of migrants within the community, if possible those who enjoy the greatest authority and respect such as community leaders and cultural mediators, and then ensuring that they are always adequately and correctly informed. As mentioned, this type of initiative already. However, since they are largely organised by the non-profit sector and on a voluntarily basis, they may not able to reach all parts of the migrant population. It is recommended that public authorities integrate such approaches systematically in training and awareness raising programs.

57 See Comitato Collaborazione Medica, progetto "Lo sapevi che...?", www.ccm-italia.org

5.2. THE RIGHT TO THE UNDERLYING PRECONDITIONS OF HEALTH

5.2.1 HEALTH INEQUALITIES AND SOCIAL DETERMINANTS

In Chapter 2[1] it was stated that the Committee on Economic, Social and Cultural Rights interprets the right to health as including both access to healthcare and access to the underlying conditions that allow for the full realisation of this right, or the so-called social determinants of health. However, in General Comment 14, aside from providing a number of examples, the Committee does not enter into detail as to what social determinants are. This chapter primarily seeks to sketch aspects of the 'determinants discourse', which traditionally belongs to the realm of public health, an identify how some of the key issues addressed by this discourse may also be framed in human rights terms. Secondly, this chapter will briefly point to possible linkages between social determinants and human rights with regard to the migrant population in Turin.

To support our discussion, we will draw on relevant epidemiological data at the local, regional and national level, as well as studies conducted at the international level and qualitative data which emerged from our interviews.

The first step involves the definition of what is meant by "inequalities" and "determinants" in public health. Many epidemiological studies have revealed that life expectancy and health status largely depend on the environments where people are born, grow up, live, work and grow old.[2] Poorer people have a high risk of illness and premature death, although obviously ill health is not exclusive to the more disadvantaged. Health and illness are related to socioeconomic status: socio-economic position and health status are often inextricably linked.[3] In developed countries, lower socio-economic position is often associated with a lower level of education, access to few services, unemployment, job insecurity, unhealthy working conditions, and living in dangerous areas, with a consequent impact on health.[4]

According to M. Marmot, a pioneer in the analysis of inequalities and their impact on health, if systematic differences in health exist between different groups of people, and if these differences can be avoided through reasonable actions, then it is the very existence of these disparities that is unfair. In public health, this imbalance is known as "health inequality".[5] This approach shows that there has been a shift from a purely medical or technological conception of public health towards an interpretation of health as a social phenomenon, related to a wider demand for social justice.[6]

The World Health Organization (WHO) established the Commission on Social Determinants of Health (CSDH) to research actions that could be adopted to promote equity in health. The Commission has drawn attention to the social, economic and political mechanisms that facilitate social stratification, according to factors such as income, education, work, gender, and ethnic origin. These are the so-called structural determinants of health and it is these factors that are referred to as the "social determinants of health".[7] According to the CSDH, the social determinants of health operate through a set of "intermediary determinants" that shape health outcomes.[8] The CSDH identified three subcategories of "intermediate" health determinants: 1) material factors (which include factors such as the salubrity of housing and working environment, neighbourhood, availability of means for acquiring food and clothing, etc.); 2) psycho-social factors (psycho-social stress, presence or absence of social support, methods of coping with difficulties, etc.); 3) behavioural and biological factors (unhealthy lifestyles, such as substance abuse; nutrition; sedentary lifestyle, etc.).[9] All these factors are distributed differently among different groups in society. Finally,

1 Chapter 2, *The right to health*.

2 Marmot, M., Friel, S., Bell, R., Houweling, T.A., Taylor, S. (2008). "Closing the gap in a generation: health equity through action on the social determinants of health", *The Lancet* Vol. 372 (9650), p. 1661. For general discussion on the topic, see also Diderichsen, F., Evans, T., Whitehead, M. (2001). "The social basis of disparities in health", in Evans, T. *et al*. (ed.) *Challenging inequities in health: from ethics to action*. New York: Oxford University Press.

3 Marmot, M. *et. al*. (2008), *op. cit*.

4 *Ibid*.

5 World Health Organization (2008). *Commission on Social Determinants of Health Final Report: Closing The Gap In A Generation: Health Equity Through Action On The Social Determinants of Health*.

6 World Health Organization (2010a). *A conceptual framework for action on the social determinants of health*, Social Determinants of Health Discussion Paper 2, Discussion Paper Series on Social Determinants of Health, p. 10.

7 WHO (2010a) p. 5.

8 Costa, G. (2009). "Le diseguaglianze di salute: una sfida per le discipline che si occupano di valutazione delle politiche" in Brandolini, A., Saraceno, C. and Schizzerotto, A. (eds.) *Dimensioni della disuguaglianza in Italia: povertà, salute, abitazione,* Secondo Rapporto dell'Osservatorio sulle diseguaglianze sociali (Ods). Modena: Fondazione Ermanno Gorrieri per gli Studi Sociali.

9 *Ibid*.

the CSDH identifies the health system itself as a determinant that stands alone, given the fundamental role it occupies in mediating the consequences of illness on people's quality of life. This category consists mainly of access to the system of diagnosis and treatment, which influences the possibility of health problems being solved.[10] The social disadvantage suffered by many migrants, reinforced by various processes of social exclusion and discrimination, may be perceived as an influence on health outcomes affecting this part of the population.[11]

5.2.2. A DIALOGUE BETWEEN PUBLIC HEALTH AND HUMAN RIGHTS

Ample literature demonstrates a willingness to initiate a dialogue between human rights and public health.[12] The potential dialogue hinges on the premise that both disciplined are targeted towards a similar objective: the promotion of human wellbeing and empowerment of the more disadvantaged and marginalised.

Ultimately, despite the difference between the two areas in terms of language and priorities, one link between human rights and public health consists of the conviction that where, on the one hand, health depends on social factors, on the other hand, these social factors may be influenced by the extent to which human rights are realised (or not realised). Practitioners and scholars in both fields recognize, for instance, that discrimination and other human rights violations have a direct impact on health and on the well-being of individuals, and that it is the underlying social issues – those which determine who lives and who dies, when and of what – that must be resolved.[13]

These underlying issues can also be perceived as obstacles to the full enjoyment of human rights, in particular of the right to health. Moreover, both public health and human rights clearly indicate that governments are responsible for creating the necessary conditions to enable individuals to make their own choices and be healthy.[14]

A further point in common between the two areas can be found in the weight given to the control people have over their destiny and their ability to use the resources needed to realise the destiny they believe is worth realising.[15] This approach is rooted in Amartya Sen's capabilities theory,[16] that replaces the traditional concept of material wealth – understood in terms of availability of resources – with the idea of well-being. Well-being is a broader concept, including what individuals can achieve or who they can become with the means and resources available, and with their ability to transform these means into the achievements, objectives and results they intend to reach. All potentially achievable or actually achieved objectives (referred to as the range of capabilities or "capability set") contribute in a significant way to determine people's well-being and quality of life.[17]

From a public health angle, health is a necessary prerequisite to ensure full personal autonomy. However, at the same time, the social conditions that allow people to take control of their lives are associated with better health conditions.[18] In the language of human rights,[19] the right to health aims to create the social conditions required to enable disadvantaged groups to reach the highest possible level of control over their health.[20] Control of the key factors influencing health is an essential element of people's (and communities') ability to decide how they want to live.

Former UN Special Rapporteur Paul Hunt tells us that a rights-based approach to health is unequivocally concerned with the social determinants

10 Costa, G. (2009), *op. cit.* p. 6.

11 *Ibid*.

12 See, *inter alia*, Gruskin, S., Mills, J.D. and Tarantola, D. (2007). "Health and human rights 1: History, principles and practice of health and human rights," *The Lancet* Vol. 370 (9585) p. 449 e ss.; Mann, J., Gruskin, S., Grodin, M., Annas, G. (eds.) (1999). *Health and Human Rights: A Reader*, New York: Routledge; Gruskin, S., Grodin, M., Annas, G., Marks, S. (2005). *Perspectives on Health and Human Rights*, New York: Routledge; Wilson, B. (2009) "Social Determinants of Health from a Rights-Based Approach" in Clapham, A. and Robinson, M. (eds.) *Realising the Right to Health*, Geneva: Ruffe & Rub; Hunt, P. (2002). "The right to health: from the margins to the mainstream", *The Lancet* Vol. 360 (9348) p. 1878; International Federation of Red Cross and Red Crescent Societies and François-Xavier Bagnoud Center for Health and Human Rights (1999). "The Public Health – Human Rights Dialogue", in Mann, J. *et. al., op. cit.*, pp.45-53; Susser, M. (1993). "Health as a Human Right: an Epidemiologist's Perspective", *American Journal of Public Health*, Vol. 83, p. 418; Mann, J. (1999). "Medicine and Public Health, Ethics and Human Rights," in Mann, J. *et al*., *op. cit.* p. 439.

13 Mann, J. et. al. (2009) *op. cit.*, p. 3.

14 Gruskin, S. and Tarantola, D. (2009) "Health and Human Rights" in Detels, R., McEwan, J., Beaglehole, R. and Tanaka, H. (ed.), *The Oxford Textbook of Public Health* (4th edition). Oxford University Press.

15 Costa, G. (2009) *op. cit.*, p. 4.

16 Sen, A. (1999). *Development as Freedom*. Oxford: Oxford University Press. See also Sen, A. (1993). "Capability and well-being", in Nussbaum, M. and Sen, A. (eds.). *The Quality of Life*. Oxford: Clarendon Press, p. 31.

17 Biggeri, M. and Bellanca, N. (2011). *L'approccio delle capability applicato alla disabilità: dalla teoria dello sviluppo umano alla pratica*, Progetto Increasing the capacities of local administrators and officials in defining policies consistent with the Sustainable Human Development Approach (UmanamENTE), pp. 12-17, www.umanam-ente.org.

18 WHO (2010a) *op. cit.*, p. 12.

19 Considerable research exists on the dialogue between human rights and the capabilities-based approach. Some examples of the many are: Nussbaum, M. (1997). "Capabilities and Human Rights", *Fordham Law Review* Vol. 66, p. 273; Nussbaum, M. (1999). "Capabilities, Human Rights and the

of health, and this clearly has its origins in the explicit language of General Comment 14 and Fact Sheet 31.[21] Almost all of the Reports he submitted over the course of his mandate touch upon social determinants in some way, with a recurring focus on discriminations and poverty. Many of the key social determinants of health identified in the CSDH report can be recast in terms of access to economic and social rights, such as nutritious food, safe working conditions, adequate housing, clean water, and education, which are enumerated as rights or components of rights in the ICESCR.

In a comment to the CSDH Report, Hunt argues that the document is essentially "a human rights report" as it exposes systemic inequality and discrimination on a global scale, and, after all, "the struggle against inequality and discrimination lies at the heart of human rights".[22] He further argues that the human rights approach cannot be considered as conceptually separate from the movements for social determinants.[23] As we have stated in our introduction, human right places legal obligations, and in this particular context they place obligations on governments to tackle social determinants where they harm health. Hunt explains that, while the CSDH correctly argues that addressing harmful social determinants is an ethical imperative, it is actually more than that, as from a human rights perspective, tackling social determinants is becomes "a legal imperative" and reinforced by law, human rights are "equity and ethics with teeth".[24] Thus, human rights can be understood to offer a solid framework for action and for health programming, as they provide a more than compelling argument for government responsibility both to provide health services and to alter the conditions that create, exacerbate, and perpetuate poverty, deprivation, marginalization, and discrimination.[25] This was explicitly recognised, two years after the CSDH Report was published, in a new document aiming to define the conceptual framework of social determinants, where the WHO stated that human rights provide "the appropriate conceptual structure within which to advance towards health equity through action on social determinants of health".[26] The WHO recognises that human rights transform generic social demands into specific legal and political demands, and that they provide, as seen in Chapter 2, a series of criteria according to which action by political authorities to promote well-being can be evaluated. Hence human rights can provide a solid basis for action and for planning in the area of the right to health, because they provide an extremely convincing argument that governments are responsible both for delivering healthcare services and modifying the conditions that create, worsen, and perpetuate poverty, marginalisation and discrimination.[27]

5.2.3. HEALTH INEQUALITIES AND SOCIAL DETERMINANTS IN TURIN

An important epidemiological study carried out in Turin in 2006[28] reveals that health is unevenly distributed across the city's population according to different areas. This disparity reflects what is referred to as the "geography of poverty".[29]

Universal Declaration", in Weston, B.H. and Marks, S.P. (ed.) *The Future of International Human Rights*. Ardsley: Transnational Publishers; Nussbaum, M. and Sen, A. (1993). (eds.), *The Quality of Life*. Oxford: Oxford University Press.

20 Yamin, A. E. (1996). "Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law", *Human Rights Quarterly*, Vol. 18 (2), p. 398.

21 As we have seen in Chapter 2, General Comment 14 interprets the right to health as "extending not only to timely and appropriate health care but also to the underlying determinants of health

22 Hunt, P. (2009) "Missed opportunities: human rights and the Commission on Social Determinants of Health" *Global Health Promotion* 1757-9759; Supp (1): pp. 36–41.

23 *Ibidem*, p. 39.

24 *Ibidem*, p. 38.

25 Gruskin Health and Human Rights, Vol. 9, No. 2, Rights-Based Approaches to Health (2006), pp.5-9

26 WHO (2010a), *op. cit.* p. 12.

27 Gruskin, S. (2006). "Rights-Based Approaches to Health", *Health and Human Rights*, Vol. 9 (2) p. 5.

28 Città di Torino-Divisione Servizi Sociali e rapporti con le Aziende Sanitarie-Servizio Sovrazonale di Epidemiologia-ASL 5 (2006), *La salute a Torino...verso un profilo di salute*.

29 *Ibid*.

Figure 16. Mortality in areas of Turin; standardised rates (per 100 person-years), Turin population in 2001-2011. Males[30]

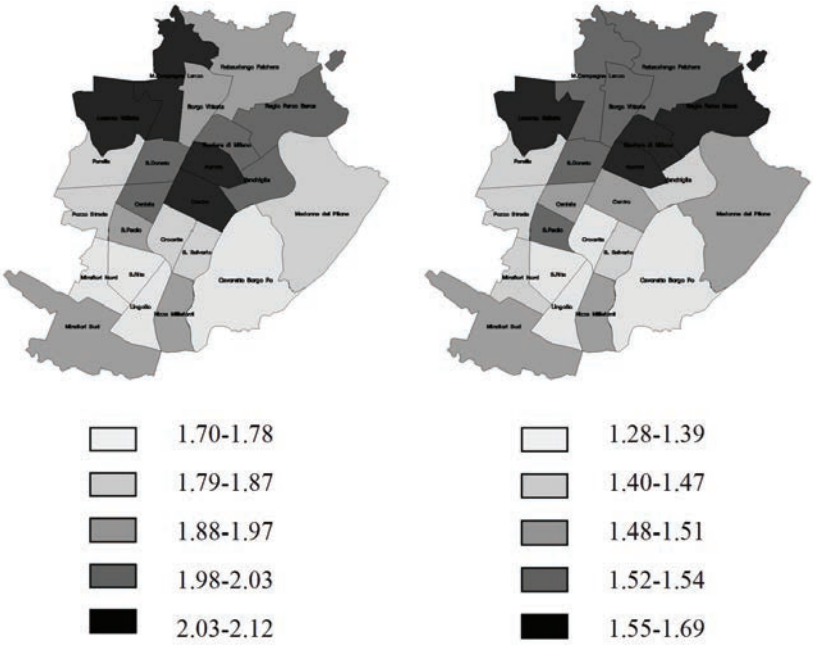
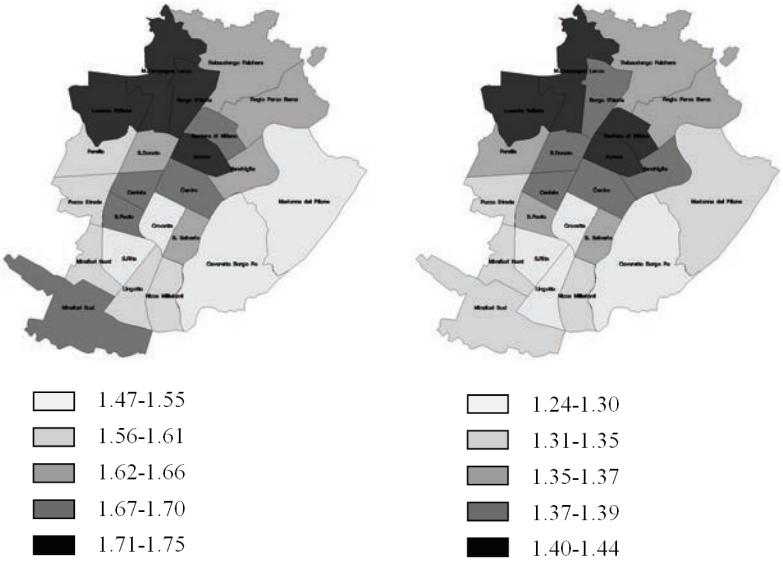


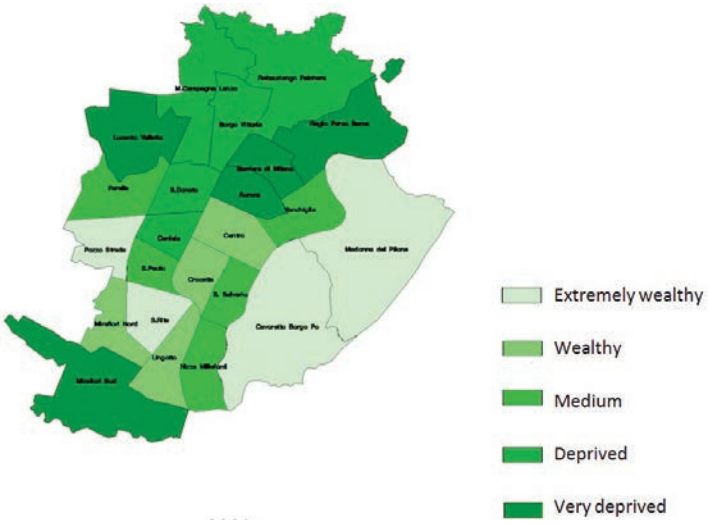
Figure 17. Mortality in areas of Turin; standardised rates (per 100 person-years), Turin population in 2001-2011. Females[31]



30 Data processed by Servizio Sovrazonale di Epidemiologia ASL TO3 (Regional Epidemiology Unit). Figure translated by Anthony Olmo and Irene Biglino.

31 Data processed by Servizio Sovrazonale di Epidemiologia ASL TO3 (Regional Epidemiology Unit). Figure translated by Anthony Olmo and Irene Biglino.

Figure 18. Index of socio-economic deprivation at census, in areas of Turin[32]



The data from the above study disclose that socio-economic factors are key determinants of health differences in Turin. Estimates from the first decade of this century show that life expectancy differs by 4 years between the male population living in 20% of the wealthiest areas and the male population in 20% of the poorest areas. As fare as the female population is concerned, life expectancy differs by 2 years. This gap has widened over the years: in the first decade of this century, the population in the poorer areas of the city reached the same life expectancy that the population in the wealthier areas had reached 15 years earlier.[33]

I. STRUCTURAL DETERMINANTS

Further examination of structural determinants of health would require investigating a series of extremely complex variables which extend beyond the scope of this study. What is interesting for our purposes is the identification of how certain social determinants, especially those linked to poverty and deprivation, may affect health outcomes as far as the migrant population is concerned. In this section an attempt will be made to identify the origin of differences in health outcomes, focusing in particular on the key structural determinants (income, education, occupation, social class, gender and ethnic origin), and to understand how migrants may be affected.

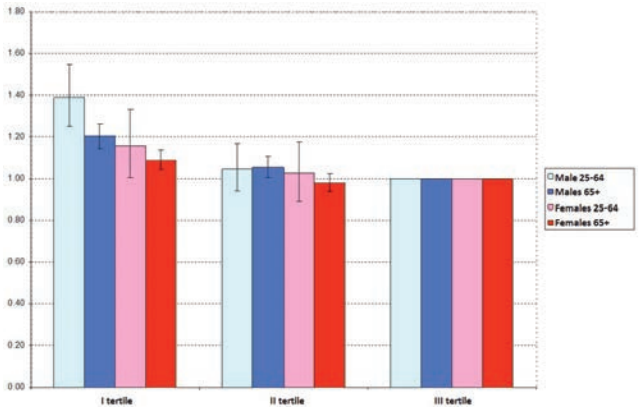
a) Income:[34] Income impacts on a series of material circumstances that, in turn, impact directly on health, such as being able to purchase nutritious food, to live in adequate housing and to access services that can influence health (not only health care, but also sports or leisure facilities).

32 Data processed by Servizio Sovrazonale di Epidemiologia ASL TO3 (Regional Epidemiology Unit). Figure translated by Anthony Olmo and Irene Biglino.

33 *Ibid*.

34 WHO (2010a). See also Galobardes, B. *et al*. (2006). "Indicators of socioeconomic position (part 1)" *Journal of Epidemiology and Community Health*, Vol. 60, p. 7.

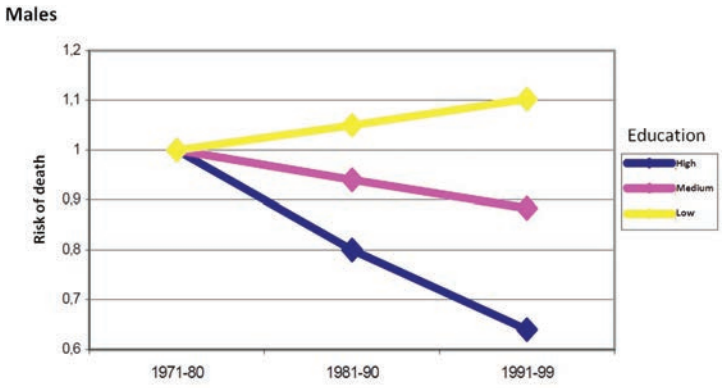
Figure 19. Relative risk of death[35] per tertile of median income 2008, according to census area of residence (reference: third tertile). Resident population in Turin in 2008, with mortality follow-up until September 2011[36]



According to ISTAT data, income for families with migrants is slightly more than half of Italian families' income.[37] The same data reveal that 43.9% of people who live in a family with migrants are at risk of poverty. The percentage rises to 49.1% if the family is composed only of migrants, and falls to 32.7% if it is mixed. People in families composed only of Italians have a 17.4% risk of poverty.[38]

b) Education: Education level is often used in epidemiology as an effective indicator of socioeconomic position. Education has a strong influence on income, on the possibility of finding employment. In our local context, the results of the *Studio Longitudinale Torinese*[39] show that mortality risk for the same age groups increases steadily as the level of education decreases both for men and for women. For men aged between 25 and 64, the mortality risk for less educated individuals is more than double the rate of those who are more educated. For women the figure is slightly lower.[40]

Figure 20. Temporal trend of mortality risk[41] according to education. Turin residents. 0 to 64-year-olds[42]



Although migrants in Italy generally have a good level of education, a smaller percentage of migrants have a university degree (10% of migrants against 13.3% of Italians)[43] and a greater percentage are only educated up to age 14 (49.7% of migrants against 46.32% of Italians).[44] The percentage of migrants with high school diplomas is about the same as Italians (40.3% of migrants against 40.4% of Italians).[45]

35 Adjusted for age, area of birth, civil status and education.

36 Data processed by Servizio Sovrazonale di Epidemiologia ASL TO3, in collaboration with the Direzione Servizi Tributari del Comune di Torino. Figure translated by Anthony Olmo and Irene Biglino.

37 ISTAT (2011). *I redditi delle famiglie con stranieri: periodo di riferimento 2008-2009*.

38 *Ibid.*

39 The Studio Longitudinale Torinese (SLT) is "a system that has access to demographic and socio-economic information from census and registry office sources, both individual and aggregate data, interconnected with indicators of use of healthcare services retrievable from healthcare information systems, through record-linkage procedures". The information resources and design of the SLT enable prospective monitoring of mortality and of healthcare services delivered to the Turin population in relation social and demographic profile, as retrieved from population censuses and registry offices. At present the study involves, to differing degrees of coverage, the whole population of Turin, drawing on registry office data from 01.01.1971 to 30.10.2011, for a total of over two million individuals registered in municipal records. Costa G., Cardano M., Demaria M. (1998). *Torino, Storie di salute in una grande città*. Torino: Osservatorio Socio-economico Torinese, Ufficio Statistico Città di Torino.

40 Studio Longitudinale Torinese, *op. cit.*

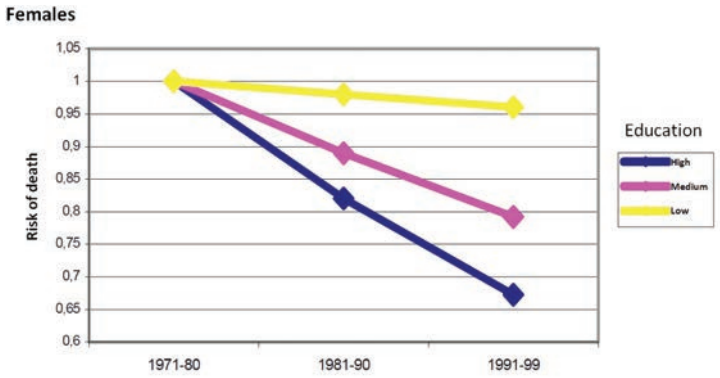
41 Adjusted for age, area of birth, type of housing and poverty level of the area.

42 Città di Torino-Divisione Servizi Sociali e rapporti con le Aziende Sanitarie-Servizio Sovrazonale di Epidemiologia-ASL 5 (2006) *op. cit.*, p. 25. Figure translated by Anthony Olmo and Irene Biglino.

43 ISTAT (2010). Data available on noi-italia.istat.it

44 *Ibid.*

45 *Ibid.*



In light of our attempt to identify possible meeting points between social determinants and human rights, it can be recalled that education is a fundamental human right. The right to education is provided for by Articles 13 and 14 of the International Covenant on Economic and Social Rights. A particularly interesting aspect is the interconnection between the right to education and other rights. Although it is true that human rights are interdependent and interconnected,[46] it is also true that once the right to education is realised it becomes an essential condition for other rights. It makes the full realisation of other rights possible. Conversely, if the right to education is denied, it precludes the enjoyment of all human rights.[47] Hence the right to education is the instrumental right *par excellence*.[48] Returning to the subject of capabilities, referred to above in Section 2.2, it is clear that education is one of the key factors enabling people to enjoy wider choices, broader empowerment, and informed participation in decisions about behaviours that affect health. The enjoyment of many economic and social rights is directly linked to realisation of the right to education: the educational qualifications held by those entering the job market determine to a great extent how successful they will be, and competencies acquired through education play a direct role in ensuring the right to health. In previous chapters[49] highlighted the crucial role of information in ensuring realisation of the right to health and especially in ensuring access and enjoyment of healthcare services. The more educated a person is, the greater their awareness of their rights and their access to information on health-related areas will be. The right to education also influences health itself, in that it makes people better-informed to take decisions about health and it encourages the adoption of healthier lifestyles.

c) Occupation: Occupation as a social determinant, according to the definition provided by the CSDH, entails not only exposure to certain risks (environmental, injury, chemical agents) which will be addressed below, but the influence that this factor exerts on the position a person had in the job market. Occupational indicators, however, can describe the condition of migrants only in part, as these indicators do not usually include those who work in the informal economy, a phenomenon that particularly affects undocumented migrants.

d) Gender: According to the WHO, the term gender encompasses the "cultural conventions, roles and behaviours that influence relations between men and women".[50] Disparities often mirror relationships of power at various levels, including at the "micro level of individual households".[51] In many societies gender differences impact on health both directly, as in domestic violence[52] and harmful traditional practices,[53] as well as indirectly, as in lower social status and lack of control over decisions, over resources

46 The United Nations World Conference on Human Rights, held in Vienna from 14 to 25 June 1993, stated in the Declaration and Programme of Action that: "All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis".

47 Tomasevski, K. (2006). *The State of the Right to Education Worldwide*. Free or Fee: 2006 Global Report, p. xxi.

48 Mustaniemi-Laakso, M. (2007). "The right to education: instrumental right par excellence", in Salomon, M.E. *et. al.* (eds.) *Casting the net wider: human rights, development and new duty-bearers*. Mortsel: Intersentia.

49 See Chapter 5.1.3. Section iii. *The role of information*.

50 See Krieger, N. (2001). "Theories for social epidemiology in the 21st century: an ecosocial perspective". *International Journal of Epidemiology*, Vol. 30(4), p. 668, in WHO (2010a) *op. cit.*

51 WHO (2010a) *op. cit.*, p. 22.
52 See Cook, R. (1999). "Gender, Health and Human Rights", in Mann J., Gruskin S., Grodin M., Annas G. (eds.). *op. cit.*

52 See Cook, R. (1999). "Gender, Health and Human Rights", in Mann J., Gruskin S., Grodin M., Annas G. (eds.). op. cit.

53 See Annas, C. L. (1999). "Irreversible Error: The Power and Prejudice of Female Genital Mutilation", in Mann J., Gruskin S., Grodin M., Annas G. (eds.). *op. cit.*

and consequently also over health. Various epidemiological studies have shown that many preventable health problems suffered by women are linked directly or indirectly to gender inequality.[54]

During interviews conducted for the study, examples were provided in connection with migrant women's health being compromised because of the way women's roles are perceived in their society of origin. In some communities, women's subordinate status, influenced by religious and social beliefs, increased conditions of vulnerability. Considerable space was devoted, in the interviews, to reproductive health issues. It was noted, for example, that in certain communities women were deprived of effective control over sexual relations. This often translates into greater difficulties in women imposing the use of condoms, even when partners have a sexually transmitted disease or, more simply, when planning pregnancy.[55] A number of health practitioners stated that women in certain communities often only attend medical appointments with their husbands, who in many cases also act as their interpreters. Women in these communities often depend economically on their husbands and have no network of family or outside support to rely on.

Further problems relating to gender dynamics concern domestic violence, which will be addressed below, and female genital mutilation (FGM).[56] During an interview with a female physician who is specialist in this area, it emerged that FGM is widespread in the migrant population in Turin. Although quantitative data is lacking, health practitioners believe that the practice is frequent. This impression is supported by evidence emerging when women give birth in hospital.

According to WHO data, between 100 million and 130 million women in the world have undergone genital mutilation (around 2 million every year). Of these, around 500,000 are migrants or refugees. It is estimated that 38,000 women and 20,000 girls living in Italy have undergone FGM. According to ISTAT, over 7000 women and girls aged under 18 who come from countries where this practice is carried out live in Piedmont. These women are exposed to greater risk of physical, psychological, sexual and obstetric complications.

e) Country of origin: Epidemiological research shows how the health of minority groups and migrant communities is often worse than the health of the average population. As stated above, the greater vulnerability of migrants to health problems, in comparison to other parts of the population, is a central issue in human rights. Research has shown that voluntary migrants, thus not victims of human trafficking or asylum seekers and refugees, generally enjoy good health at the beginning of the migratory process, a phenomenon known as the "healthy migrant effect".[57] However, this tends to change as migration stabilises in the receiving country, a phenomenon known as "exhausted health effect".[58] The health of migrants tends to worsen in receiving countries as a result of the less than optimal conditions they find themselves living in. As seen in Chapter 4, the health indicators that reflect the disadvantages experienced by the migrant population are reproductive outcomes (including low weight at birth and infant mortality) and work-related injuries among young male adults.[59] Moreover, this situation of disadvantage may increase when factors such as insufficient income, poor education, inadequate nutrition and and inadequate housing are combined.

An example of disparities in health outcomes that was mentioned in Chapter 4 is the higher rate of problems related to reproductive health that migrant women experience when compared to Italian women. In particular,

54 Doyal L. (2000). "Gender equity in health: debates and dilemmas", *Social Science and Medicine*, Vol. 51 (6), p. 931, in WHO (2010a) *op. cit.*, p. 34. See also Doyal, L. (1995). *What makes women sick: gender and the political economy of health.* New Brunswick: Rutgers University Press.

55 Du Guerny, J. and Sjöberg, E. (1999). "Interrelationship between Gender Relations and the HIV/AIDS Epidemic: Some Possible Considerations for Policies and Programs", in Mann J., Gruskin S., Grodin M., Annas G. (eds.). *op. cit.*, p. 203.

56 Genital mutilation, according to definition by the WHO, comprises all "procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons". World Health Organization (2012). *Fact sheet N°241: Female genital mutilation.* Available at www.who.int/mediacentre/factsheets/fs241/en/.

57 The concept of 'healthy migrant effect', understood as the result of a pre-departure process that selects individuals who are in general good health, may be applied to emigration driven by economic necessity and aimed at the search for work which is generally manual work. The concept is very valid in the early stages of migration but tends to become less relevant as migration stabilises in the host country. See *infra* Odone, A. Appendix 2: *Migrant health: health status of migrant populations in Italy*, pp. 10-12.

58 *Ibid.*

59 Città di Torino (2006) *op. cit.* p. 26.

problems surfacing in connection with pregnancy can be mentioned. An important epidemiological study presented a review of 65 studies published between 1966 and 2004 on 18 million pregnancies, and compared birth outcomes for migrant women and receiving-country women in 12 European countries. The study focus areas were low weight at birth, pre-term births, perinatal mortality (within the first week of life) and congenital anomalies. The results of the study suggest that migrant women generally display an overall 'worse health profile' in these areas.[60] The situation in Piedmont reflects the results of this international study, as mentioned in Chapter 4.1.2. Maternal and child health in Piedmont is cause for grave concern: problems such as pre-term births, perinatal mortality and low weight at birth are much more widespread among migrant women in the region.

Another reproductive health issue which appears to be a cause for concern for migrant women is the high level of terminations of pregnancy (TOPs). As the data presented in Chapter 4.1.2 reveal,[61] hospital admissions for TOPs in Piedmont are much higher for migrant women than for Italian women and are growing steadily as the migrant population grows. Terminations by Italian women in Piedmont are decreasing. Both these trends are in line with national figures.

A multi-centre survey carried out by the *Istituto Superiore di Sanità* (National Health Institute) together with the *Agenzia di Sanità Pubblica del Lazio* (Lazio Regional Public Health Agency) between 2004 and 2005[62] revealed four distinct profiles for migrant women undergoing TOPs:

1. women experiencing extremely precarious social situations, young, recent migrants (less than a year), undocumented, unemployed, from Romania or Nigeria;
2. women who are employed (housemaid, child-carer, domestic workers), well-educated, socially integrated, documented, in Italy for some time, mostly from South America;
3. women who are less integrated, younger and less educated than the above group, unmarried or separated, in Italy from between 1 to 2 years, mainly from Moldova and Ukraine ;
4. women who are married or cohabiting, with partner or family from country of origin, older, housewives or in employed work, mainly Chinese or Moroccan.

More than half of those interviewed in the study had used no contraception to avoid pregnancy, while 20% had used effective methods but in an incorrect way.[63] The study identified different reasons underlying the choice to undergo the procedure, including the fear of losing their current employment and consequently the *permesso di soggiorno* (permit of stay), lower awareness in managing reproductive health and less use of contraceptives, unstable socio-economic conditions, and prostitution.[64]

60 *Ibid*.

61 Chapter 4.1.2. *Reasons for admission of women*.

62 Spinelli, A., Forcella, E., Di Rollo, S., Baglio, G., Grandolfo, M. (2006). Gruppo di studio sull'interruzione volontaria di gravidanza tra le donne straniere. *Indagine sull'interruzione volontaria della gravidanza tra le donne straniere*. Rapporti Istituto Superiore di Sanità, Vol. 6(17) p. 25.

63 *Ibid*

64 Ministero della salute/CCM – Regione Marche (2009). *La salute della popolazione immigrata: metodologia di analisi*, p. 75.

II. INTERMEDIATE DETERMINANTS

The structural determinants mentioned in the section above operate by means of a second category of determinants, referred to as "intermediate" determinants. These are intervening variables that may directly influence health.

a) Material circumstances

In the context of social determinants, the expression "material circumstances" refers to material factors affecting people's lives, such as

housing, access to nutritious food, and working and living environment. Such elements are also of great relevance in the human rights sphere. Article 25 of the Universal Declaration of Human Rights provides for the right of every person "to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". Article 11 of the International Covenant on Economic, Social and Cultural Rights contains similar provisions. Although absolute destitution, where families are not able to meet essential needs, is often associated to developing countries, relative poverty is also widespread in developed countries.[65] In Italy, many families live in poverty. The following paragraphs will address specific material circumstances that may have an impact on health.

Housing

The impact of the quality of housing on health is significant. In Turin, mortality risk is higher with regard women who live in inadequate housing (i.e. without heating or adequate sanitation) than in those who live in better conditions.[66] Some infectious diseases are facilitated by overcrowding in houses, the most obvious example being TB. The most recent epidemiological data show a steady decrease in tuberculosis in the host population and an increase in cases in the migrant population.[67] This increase is related to the increasing numbers of migrants in our country. In many migrant countries of origin, tuberculosis is widespread: although many migrants are not ill when they arrive in Italy, if the disease is latent, in conditions of poverty and deprivation they are more likely to develop it than the host population born and living in Italy. However, it is recognized that the precarious living conditions of many migrants do constitute a risk factor for tuberculosis.

Poor living conditions, coupled with limited space, overcrowding, and inadequate ventilation, often associated with unemployment, low income and consequently malnutrition, increase the risk of both exposure to the tubercle bacillus (and thus infection) and to reactivation of latent disease.[68] These factors explain why undocumented, temporary, seasonal or homeless migrants who suffer greater economic and social marginalisation, are more vulnerable to the risk of tuberculosis. Research carried out in Turin between 1973 and 1999 showed that people living in "very poor" housing were twice as likely to become ill with tuberculosis as those who lived in "large properties".[69]

Table 22. Relative risk of developing Tb disease in Turin between 1973 and 1999[70]

Risk Factors	Crude (univariate analysis) OR (95% CI)	Adjusted ** OR (95% CI)
Place of Birth		
Northern Italy	1	1
Central Italy	0.85 (0.72 – 1.01)	0.88 (0.73 – 1.06)
Southern Italy-Islands	1.50 (1.39 – 1.62)	1.08 (0.98 – 1.19)
Europe+North America+Australia	1.19 (0.92 – 1.54)	1.14 (0.85 – 1.53)
South America+Africa+Asia	2.33 (1.79 – 3.03)	1.38 (0.99 – 1.92)
Marital Status		
Married	1	1
Widowed	0.88 (0.74 – 1.03)	0.79 (0.65 – 0.96)
Separated+Divorced	1.64 (1.31 – 2.05)	1.48 (1.14 – 1.91)
Single	1.48 (1.36 – 1.62)	1.26 (1.12 – 1.41)
Level of Education		
University Degree+Secondary Education	1	1
Middle School	1.57 (1.37 – 1.78)	1.35 (1.17 – 1.56)
Primary	1.90 (1.68 – 2.14)	1.64 (1.42 – 1.89)

65 Center for Economic and Social Rights (2009). *Human Rights and Poverty: Is poverty a violation of human rights?,* CESR Human Rights Insights No. 1, available on www.cesr.org/article.php?id=277.

66 Studio Longitudinale Torinese, *op. cit.*

67 Ministero della salute/CCM – Regione Marche (2009), *op. cit.* pp. 104-106.

68 Elender, F., Bentham, G., and Langford, I. (1998). "Tuberculosis mortality in England and Wales during 1982-1992: Its association with poverty, ethnicity and AIDS", *Social Science & Medicine*, vol. 46(6), p. 673; Wanyeki, I., Olson, S., Brassard, P. *et al.* (2006). "Dwellings, crowding, and tuberculosis in Montreal". *Social Science & Medicine*, vol. 63, p. 501; Beggs, C.B., Noakes, C.J., Sleigh, P.A. *et al.* (2003). "The transmission of tuberculosis in confined spaces: An analytical review of alternative epidemiological models", The *International Journal* of Tuberculosis and *Lung Disease*, vol. 7, p.1015.

69 Studio Longitudinale Torinese, *op. cit.*

70 Vigna-Taglianti F. (2002). *Tendenze temporali e determinanti socio-ambientali dell'incidenza di tubercolosi a Torino, dal 1973 al 1999*, Thesis for Post-Graduate Degree in Hygiene, Preventive Medicine and Public Health, Università di Torino. Figure translated by Anthony Olmo and Irene Biglino.

The second most frequent infectious disease affecting the migrant population is acariasis, more commonly known as scabies. It is generally transmitted by direct human-to-human contact and, like TB, is connected with poor economic and social conditions and, particularly to overcwrowded living conditions with little access to essential facilities such as bathrooms and washing machines.[71]

Inadequate housing is a frequent problem as far as migrants are concerned, including documented migrants with regular employment contracts. One study demonstrates that the rate of housing distress is higher in migrants when compared to the rest of the population in Italy.[72] Research also shows that the average size of migrants' houses is considerably smaller, and that the space per capita available, according to the average size of migrant families, is half that which Italians enjoy.[73] According to ISTAT, 7.5% of migrants and 0.9% of the host population live in seriously overcrowded conditions.[74]

The right to adequate housing is recognised as one of the key economic, social and cultural rights.[75] From a human rigths perspective, housing must meet a series of minimum criteria in order to be defined as adequate.[76] For example, housing is considered inadequate if the occupants do not have access to running water, sanitation, energy for cooking, heating, lighting, and space to keep food and store waste. In addition, housing cannot be defined as adequate if it does not provide physical safety, sufficient space, protection from cold, dampness, heat, rain, wind, and other risks. It cannot be defined as adequate if it is physically distant from work opportunities, from sanitation, from schools and from other social services, and if is located in polluted or dangerous areas. Clearly, housing in the more deprived areas of Turin cannot be described as adequate according to the above criteria. This was also confirmed during interviews, when many practitioners expressed criticism of the alarming conditions in which many migrant families live.

Work environment

It can be fairly safely stated that migrants are more vulnerable to injury at work or to occupational health problems. Many international studies show a higher rate of such problems in migrant populations than in host-country populations.[77] This also applies to Italy and to Piedmont, as explained in Chapter 4.1.1.[78]

The qualitative data emerging from the interviews conducted during our study also confirmed this. Many practitioners, in both public and private sectors, indicated work-related injuries as one of the key health problems, especially for male migrants. We were informed of many cases where employers confiscate documents from migrant workers so that, in case of injury, they will be deterred from accessing Accident and Emergency departments or to reveal the real cause of their injury. As previously mentioned, this phenomenon is particularly widespread among undocumented migrants, who can easily fall through the cracks of social and health care networks. The causes underlying such high rates of injury in male migrants has bee attributed by many interviewees to conditions these young men work in. It is widely known that demand for migrant labour is primarily for work which is physically demanding, precarious, dangerous, poorly paid, and socially stigmatised.[79] Generally it is migrants, both documented and undocumented, who satisfy the demand for jobs that require unskilled labour in precarious conditions. Because of their situations of need, they often agree to flexible shifts, low pay, and other working conditions that are not generally accepted by host-country

71 See *infra.* Odone, A. Appendix 2, *Migrant health: health status of migrant populations in Italy,* p. 33.

72 Ponzo, I. (2009). "L'accesso degli immigrati all'abitazione: diseguaglianze e percorsi" in Brandolini, A., Saraceno, C. e Schizzerotto, A. (ed.) *Dimensioni della disuguaglianza in Italia: povertà, salute, abitazione*. Secondo Rapporto dell'Osservatorio sulle diseguaglianze sociali (Ods), Fondazione Ermanno Gorrieri per gli Studi Sociali. pp. 3-4.

73 *Ibid.*

74 ISTAT (2005).

75 United Nations (1991). Committee on Economic, Social and Cultural Rights. *General Comment 4 - The right to adequate housing* and United Nations (1997). Committee on Economic, Social and Cultural Rights. *General Comment 7 - Forced Evictions.* See Hurtig, A.K., Porter, J.D.H. and Ogden, J (2005). "Tuberculosis Control and Directly Observed Therapy from the Public Health/Human Rights Perspective" in Gruskin S., Grodin M., Annas G., Marks S. *op. cit.*

76 United Nations (1994). Office of the High Commissioner for Human Rights and UN HABITAT. *Factsheet Number 21: The Human Right to Adequate Housing*.

77 See Ahonen, E., Benavides, F.G. and Benach, J. (2007). "Immigrant populations, work and health – a systematic literature review", *Scandinavian Journal of Work and Environmental Health*, Vol. 33(2), p. 96.

78 Chapter 4.1.1. *Reasons for admission of men.*

79 Città di Torino (2009) Settore statistica, Prefettura di Torino, Osservatorio Interistituzionale sugli Stranieri in Provincia di Torino, Rapporto, p. 310.

workers.[80] Employment is also often temporary or seasonal, which also considerably increases occupational risk.[81]

Another specific problem which emerged during the study relates to domestic workers. Female domestic workers, especially if undocumented, are an extremely vulnerable group, a finding also supported by ample international research.[82] The UN Special Rapporteur on the human rights of migrants has criticised the widespread physical, sexual and psychological violence suffered by women domestic workers. He also pointed out that these migrants are more exposed to health problems because of lack of information about risks and precautions.[83]

One of our interviewees, who worked for an NGO supporting migrant domestic workers, noted the risks that those caring for elderly people with hepatitis C are exposed to. Most women advised by the association were not aware of the fact the person they were caring for had the disease, or were not informed about methods of transmission of infection and were not supplied with protective gloves. Mention must also be made of women sex workers. Clearly they face a series of issues in relation to their reproductive health, exposing them, amongst other things, to the risk of contracting sexual transmitted diseases.

The link between working conditions and human rights is strong. The International Covenant on Economic, Social and Cultural Rights recognises the right to work generally in Article 6, and then more specifically in Article 7, where it provides for the right to fair and favourable working conditions, including safety and good sanitation.[84] Internationally, this right is widely-recognised and agreed on, as expression of the right to personal integrity, which is one of the fundamental human rights principles. Unfortunately, as demonstrated by the foregoing considerations and events reported in the media almost on a daily basis, this right is far from being fully realised.

b) Psycho-social factors

Stressful life circumstances

Members of disadvantaged or marginalized groups will generally face more uncertainty, more insecurity and experience stressful events in their lives. [85] Individuals in disadvantaged social positions often have less control over their lives, especially with regard to control over the resources required to achieve their aspirations. Thus, they are often prevented from adequate social participation and an adequate level of satisfaction and compensation. It was reported that this can lead to health problems, through chronic stimulation of stress mechanisms, with repercussions on cardiovascular health, the metabolic system, the immune system, mental health, and a general reduction in ability to resist disease.

The health problems related to these factors are exacerbated in contexts where people are exposed to greater threats, for example environmental risks, or where the context is more competitive leading to more stress, or where people are not able to find the help needed to deal with problems and challenges.[86] In Turin, in a sample of workers interviewed between 1999 and 2000, the distribution of the gap between demand and control[87] was clearly worse for lower income groups, with a significantly higher number of blue-collar workers than white collar workers exposed to high stress at work (what is referred to as "job strain"). [88]

80 Capacci, F., Carnevale, F., Gazzano, N. (2005). "The Health of Foreign Workers in Italy", *International Journal of Occupational and Environmental Health* , Vol. 11(1), p. 66.

81 United Nations (2010) *Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante*, UN Doc. A/HRC/14/30, para. 23.

82 See, *inter* alia, D'Souza, A. (2010). *Moving toward Decent work for Domestic workers: An Overview of the ILO's work.* International Labour Organization Bureau for Gender Equality; United Nations (2008). Committee on the Elimination of Discrimination against Women. *General Recommendation No. 26 on women migrant workers*, UN Doc. CEDAW/C/2009/WP.1/R; United Nations (2010). Office of the High Commissioner for Human. Rights, Europe Regional Office. *Human Rights of Migrant Domestic Workers in Europe*.

83 United Nations (2011). *Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante*, UN Doc. A/HRC/17/33.

84 International Covenant on Economic, Social and Cultural Rights, art. 7.1, lett. b); see also United Nations (2006). Committee on Economic, Social and Cultural Rights. *General comment No. 18 - The Right to Work,* UN Doc. E/C.12/GC/18.

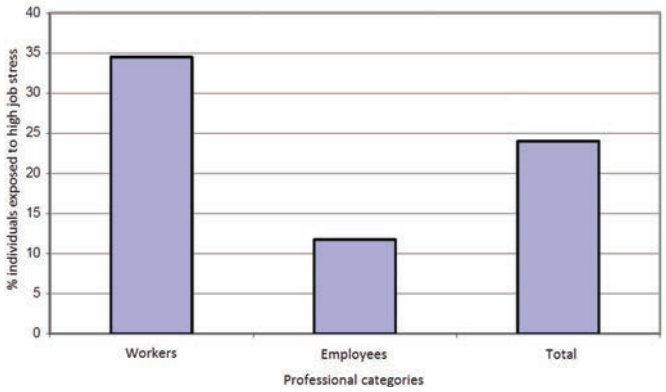
85 WHO (2010a), *op. cit.* p. 38.

86 Città di Torino (2006) *op. cit*., p. 32.

87 The "Demand-Control" scale measures the unbalance between quantity and intensity of demands and degree of control granted to people when organising their work; it consistently shows negative effects both on biological indicators and on risks for health, such as cardiovascular risks. Città di Torino (2006) *op. cit.*

88 Città di Torino (2006) *op. cit.*

Figure 21. Proportion of people in work exposed to job strain – sample of 1,479 workers in Turin (797 blue-collar workers and 682 white-collar workers)[89]



As seen above, migrants are often employed in more dangerous and more physically demanding work.[90]

The issue of mental health has been highlighted a number of times in this study.[91] The mental health of migrants is a cause of great concern: they often need to cope with a range of factors, such as separation from family and social networks, job insecurity, difficult living conditions, and exploitation, that have serious repercussions on mental health. Although a better economic situation than in the country of origin may have a positive effect on mental health, some studies show that migrants are still more exposed to stress, anxiety and depression than the host population.

During our study, many physicians and health practitioners particularly emphasised the negative effects of disappointed expectations. On arrival in Italy, many migrants find that the expectations that have given them the strength to leave their country of origin disintegrate. This, along with the ensuing sense of disappointment and failure for not only the individual but also family members from the country of origin, lies at the core of many health problems. This particularly applies, we were told during interviews, to asylum seekers and refugees. The latter may leave their country of origin with high expectations, perhaps even greater than in the case of voluntary migrants. In addition, they have often been victims of particularly traumatic events earlier in their lives. In this area, unaccompanied minors must also be mentioned, as the burden of disappointed expectations and can be extremely heavy. Many unaccompanied minors reach Italy with expectations not only for their own life but also for their family in their country of origin. Feeling responsible for disappointing family expectations and investment (often economic) can be even more problematic for a young migrant than for an adult migrant. We were told of many cases of minors suffering from serious psychological, at time psychiatric and substance abuse problems.

Interviewees also expressed further concern about the stressful conditions and the mental health of migrants in the *CIE* (Identification and Repatriation Centres) and in prisons, especially in terms of access to psychological care and insufficient allocation of resources. As explained in the introduction, this area is not within the scope of our study, because of the special nature of these two contexts. However, we recognise the importance of these areas and the highlight the need for further research.

Isolation, lack of network

The intersection between health and support from societal networks is extensively studied in epidemiology[92] and relates closely, and at times even

89 Città di Torino (2006) *op. cit*., p. 33. Figure translated by Anthony Olmo and Irene Biglino.

90 Città di Torino (2009) Settore statistica, Prefettura di Torino, Osservatorio Interistituzionale sugli Stranieri in Provincia di Torino, Rapporto, p. 310.

91 See Chapter 4, *The health status of the migrant population in Turin,* and Chapter 5.1, *Availability and quality*.

92 Costa, G. (2009*) op. cit.* p. 4.

overlaps, with stress. It is also of particular relevance for migrants: one of the distinguishing features of migration often involves the separation from one's family, the breaking of social ties, and separation from cultural and social contexts. Although this is certainly true for most migrants, it was highlighted that the situation of women warrants special attention. The interviews carried out revealed that many migrant women live in conditions of extreme isolation, without being able to leave the house on their own, learn the language or achieve a degree of independence. Many depend on their husbands for their economic, language and relational needs. Isolation and separation from societal network is especially serious when migrant women are also victims of domestic violence. It was suggested that, in their countries of origin, such women would in many cases have been able to turn to their parents or siblings for help and protection, a type of support often not available in their new environment. A health practitioner and specialist in providing care for women who are victims of domestic violence explained that, to a certain extent, this phenomenon is confirmed by the greater use of A&E services by migrant women in domestic violence cases. The interviewee reported that many migrant women in this predicament had no network of family or friends and had no alternative but to make use of a public service which is immediately and easily accessible, such as emergency rooms.

Networks are also particularly important for refugees and asylum seekers, as they are often exposed to the effects of isolation, separation from family and absence of networks even more than voluntary migrants. In addition, in a broader sense, the importance of support networks for asylum seekers and refugees is highlighted in relation to the SPRAR program (National System of Protection for Asylum Seekers and Refugees).[93] For these migrants, SPRAR is vital: it is a first attempt to build a network of connections or support for people who have none. Inclusion or exclusion from the programme has fundamental consequences for migrants, although unfortunately the limited number of places available results in not all demand being satisfied. This means that there is a risk of compromising the rights of asylum seekers who, without the programme, generally have no form of sustenance, of guidance or of support, a situation which may also compromise the outcome of their application for international protection.

Finally, mention must again be made of the situation of unaccompanied minors. Absence of networks is particularly serious and this was repeatedly highlighted by interviewed practitioners employed in providing assistance to unaccompanied minors. In addition to the problems faced by most migrants, they also have the problems related to their younger age, that generally entails having fewer resources to draw on for dealing adequately with the difficult migratory process and the equally difficult conditions that they find on arrival in Italy. According to information emerging during interviews, unaccompanied minors are most vulnerable to substance abuse and psychiatric problems.

Discrimination

According to CSDH, discrimination is a social determinant of health. During the World Conference against Racism, participating states declared the need to recognise racism as an important social determinant of health.[94] The UN Special Rapporteur on the right to health has pointed out that social inequalities, fuelled by discrimination and marginalisation of some groups, lead to the spread of disease and to negative effects on health for the individuals involved. As a result, the burden of disease is sustained mainly by the vulnerable and marginalised groups of the population.[95] At the same

93 System of Protection for Asylum Seekers and Refugees (Sistema di protezione per richiedenti asilo e rifugiati, SPRAR).

94 See World Health Organization (2001). *WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance*. Health & Human Rights Publication Series Issue No. 2.

95 United Nations (2002). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*. UN Doc. E/CN.4/2003/58, par. 59.

time, discrimination and stigma against certain health problems such as mental health or HIV/AIDS tend to strengthen pre-existing disparities and inequalities. The UN Committee on Economic, Social and Cultural Rights emphasised that the principle of non-discrimination prohibits any form of discrimination in access to healthcare services and access to social determinants that have the aim or effect of denying or preventing equal enjoyment of the right to health.[96] The link between stigma, discrimination and the right to health is complex. Discrimination and stigma constitute a failure to respect human dignity and the principle of equality, generally overlapping with disparities which already exist with regard to vulnerable and marginalised groups. This increases vulnerability to health problems and limits the effectiveness of health treatments. The effect is greater when the individual is subjected to double or multiple discrimination.[97] Effective promotion of the right to health requires identification and analysis of the complex ways in which discrimination and stigma impact on enjoyment of the right to health, with special attention for the condition of women, children, and marginalised groups such as minorities, those affected by disabilities, and refugees.[98] This requires obtaining and analysing data so that the relationship between forms of discrimination as social determinants can be identified and understood, recognising the effect of multiple discriminations and recording how discrimination and intolerance limit access to health and healthcare services.[99]

We can define the term discrimination more clearly by distinguishing between two types: direct discrimination and indirect discrimination. The first type is better known and is more commonly associated with the term discrimination. Direct discrimination exists when, due to race or ethnic origin, a person is treated less favourably than they are, were or would be treated in a similar situation. From the interviews carried out it emerged that direct discrimination does constitute a problem. The present study does not present quantitative data on the subject, but a number of practitioners interviewed observed that direct discrimination is more widespread than is believed, especially in the non-profit sector.

Institutional or indirect discrimination relates to the institutions that, originally aiming to meet the requirements of a particular group, place other groups in a position of disadvantage. It is not the result of individual action but the effect of an institution's defective organisation. It exists when provisions, criteria or practices which are apparently neutral can place people of a particular ethnic group in a position of disadvantage in relation to other people. This type of discrimination is almost inevitable when, as in Italy, a society which was once homogeneous becomes multiethnic and multicultural in a relatively short period of time. Institutions have greater difficulty adapting to the needs and characteristics of new arrivals, and cases of indirect discrimination occur without there being any specific intention to discriminate, or without there being any awareness of it.[100] However, when evidence emerges of cases of indirect discrimination occurring, if measures are not then adopted to eliminate the causes of these cases, indirect discrimination becomes direct discrimination and the result of intentional and conscious action.

Indirect discrimination as defined above is common in Turin. Although the healthcare system has changed rapidly to meet the requirements of the migrant population, there is still room for improvement. Aspects such as the poor linguistic accessibility of many services may indicate discriminatory limitation of migrants' ability to access and enjoy healthcare services.

96 United Nations (2000). Committee on Economic, Social and Cultural Rights. *General Comment 14 - The right to the highest attainable standard of health*, par. 18.

97 United Nations (2002). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*. UN Doc. E/CN.4/2003/58, par. 62.

98 *Ibid*, par. 63.

99 *Ibid*.

100 WHO (2010b), *op. cit*., p. 7.

c) Behavioural factors

Finally one last area relates to exposure to risk factors through adoption of certain behaviours, another phenomenon closely connected to social stratification. We will concentrate on one particular behaviour, unprotected sexual intercourse, although we are aware there are other important examples such as nutrition, smoking, and lack of exercise. According to the WHO, those who are disadvantaged in socio-economic terms, including migrants, are more likely than those who are more privileged to adopt behaviours that are harmful rather than beneficial to health.[101] In addition, stress, a factor examined above and found to be widespread among more disadvantaged groups and especially migrants, has been indicated as an indirect threat because it facilitates the adoption of unhealthy behaviours.[102] In short, it should be recalled that the adoption of certain behaviours relating to lifestyle or habits of groups or individuals cannot be judged outside the societal context in which the behaviour takes place. This has been recognised by Anand Grover, the Special Rapporteur on the right to health, who, especially in his reports focusing on HIV/AIDS, has emphasised that the social dimension must be included when working with this illness in order to understand the degree of control people have over their health.[103]

Once again the human rights approach is not only perfectly in harmony with public health, but can also provide a solid conceptual framework with which to analyse problems related to social justice. Sofia Gruskin and Paula Braveman highlight this point, explaining that at times defining an inequality as an injustice can become a matter of heated debate. Often, unfortunately, more privileged groups tend to claim that poorer people have greater health problems because they adopt behaviours that are harmful for their health, such as eating food which is not nutritional, or smoking.[104] This view sees behaviours exclusively as the result of a free choice that is not in any way influenced by the conditions surrounding the individual. Conversely, a view human rights standpoint argues for the right to enjoy standards of living that are necessary for a good state of health; this presupposes that the state will take action to address conditions that tend to lead disadvantaged communities to adopt behaviours that are harmful to health.

Various epidemiological studies have analysed the impact of social and cultural changes on the health of migrants and have shown that they are more vulnerable to HIV and to other sexually transmitted diseases (STDs).[105] In a UNAIDS study on international labour migrants, the risk of contracting such diseases is largely attributable to unprotected sexual relations, or risky sexual behaviours, and these are often facilitated by changes connected with the experience of migration.[106] The factors increasing vulnerability to such behaviours can be summarised as: individual characteristics present before migration, changes in individual characteristics occurring during migration, and exposure to a physical and social environment that is completely new and different from the country of origin.[107] Moreover, elements such as information about HIV/AIDS, specific health services for STDs, and access to condoms are not always available for migrants. Furthermore, as seen in Chapter 5, access to existing services may be made difficult by language and cultural barriers.[108] Migrants often have to cope with various problems living in a new environment. Risk behaviours such as multiple sexual partners may be linked to alienation, loneliness, separation from families, and the dissolution of family units.[109] The hypothesis has also been advanced that, with the anonymity that being in a new country often brings, men and women are readier to adopt risky sexual behaviours, especially if

101 WHO p. 40

102 Costa, G. (2009) *op. cit*.

103 United Nations (2011). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*, UN Doc. A/HRC/17/25. See also Lazzarini, Z. and Klitzman, R. (2002). "HIV and the Law: Integrating Law, Policy and Social Epidemiology" *Journal of Law and Medical Ethics* Vol. 30(4), p. 533; United Nations (1998). Joint United Nations Programme on HIV/AIDS, *Expanding the Global Response to HIV/AIDS through Focused Action: Reducing Risk and Vulnerability: Definitions, Rationale and Pathways*, UNAIDS Best Practice Collection; Gruskin, S. and Tarantola, D. (2000). "HIV/AIDS, Health, and Human Rights", in Lamptey, P., Gayle, H. and Mane, P. (ed.) *HIV/AIDS Prevention and Care Programs in Resource-Constrained Settings: A Handbook for the Design and Management of Programs*. Arlington: Family Health International; Mann, J. (1999) "Human Rights and AIDS: The Future of the Pandemic," in Mann, J., Gruskin, S., Grodin, M., and Annas, G., *op. cit.*, p. 216.

104 Gruskin, S. and Braveman, P. (2006) "Addressing Social Injustice in a Human Rights Context" in Levy, B.S. and Sidel, V.W. (ed.) *Social Injustice and Public Health*, Oxford: Oxford University Press, p. 410.

105 Tarantola, D. (1999). *Impact of travel and migration on the spread of HIV: risk, vulnerability and mobility.* Paper presented at the '6th Conference of the International Society of Travel Medicine', June 6-10, Montreal; Brockerhoff, M. and Bidd Lecom, A. E. (1999). "Migration, Sexual Behavior and the Risk of HIV in Kenya", *The International Migration Review*, Vol. 33(128), p. 833; Decosas, J.F., Kane, J.K., Anarfi, K.D., Sodji, K.D. and Wagner, H.U. (1995). "Migration and AIDS", *The Lancet*, Vol. 346 (8978), p. 826.

106 United Nations (2008). Joint United Nations Programme on HIV/AIDS, *HIV and International Labour Migration*, UNAIDS Policy Brief, available on www.unaids.org/en/resources/presscentre/featurestories/2008/.

107 Brummer, D. (2002). *Labour Migration and HIV/AIDS in Southern Africa*, International Organization for Migration Regional Office for Southern Africa.

108 See Chapter 5.1.2. *Cultural acceptability.*

109 Brummer, D. (2002) *op. cit.*

they are from countries with strong traditional rules.[110] Moreover, migration may lead to the dissolution of families and communities, and women and children may fall victim to violence and sexual exploitation. Trafficking victims are often directed towards prostitution and may well be subjected to violence by their exploiters or clients. As emerged from the interviews, most of these migrants are young women, often aged under 18. Because of their limited bargaining power and scant control over their sexual health, sexual relations in these cases are often unprotected.

110 *Ibid.*

CHAPTER 6.
CONCLUSIONS

6. CONCLUSIONS

The present report sought to investigate the relationship between migration and health in Turin from a human rights perspective, in general, and from a right to health angle in particular. Our conceptual starting point was the identification of the key components of the normative content of the right to health as articulated in international human rights instruments.[1] The next step involved conducting 96 interviews with health sector professionals in the Turin area in order to gauge possible discrepancies between the entitlements provided for by legislation and the reality on the ground. We used as our key clusters of analysis the macro-elements of the right to health, namely access to adequate healthcare and the social determinants of health. As described in the text, the latter consist of social factors, such as income, education, and housing, that have a concrete influence on people's health outcomes, with particular repercussions on vulnerable or marginalized groups in society. The results of the study underscore that full realization of the right to health for migrants rests heavily on the improvement of access to healthcare on the one hand, but is also greatly influenced by health determinants.

What emerges quite clearly for the foregoing analysis is that the city of Turin is characterized both by the presence of good practices and positive examples, and by a number of causes for concern. As to positive findings, undocumented migrants, for example, are entitled to an overall adequate level of access to healthcare services. In comparative terms as well, the *ISI* Centres and, more generally, national healthcare legislation concerning undocumented migrants, are examples of excellence. It must be recalled that in certain European countries undocumented migrants are provided with no public healthcare. Furthermore, Turin is characterized by an especially active non-profit sector: a number of organizations, differing in mandates and resources, provide healthcare services and make a crucial contribution to ensuring an adequate level of care. The wealth of services provided by the non-profit sector appears to be a special feature of the geographical area under scrutiny. Another extremely positive aspect is the large number of examples of successful integration between public and private sectors: despite the economic crisis that has been affecting the city now for some years, subsidiary integration between the public and private sectors seems to be a successful method of maintaining services while avoiding both an excessive burden on public resources and total reliance of the public sector on the non-profit sector.

Nevertheless, numerous areas of concern emerged. As an overarching consideration, the data presented in Chapter 4 that the overall health of migrants is a cause for concern. A number of areas appear to be particularly critical, such as maternal and reproductive health for women and work-related injuries for men. Both phenomena are closely connected to the conditions of vulnerability and social fragility faced by migrants.[2] Against this backdrop, we sought to investigate the reasons for such vulnerability by placing the problems identified within the conceptual framework of the normative content of the right to health. We first found how various problems impose limitations – sometimes very serious ones – on accessing and utilizing health services by some categories of migrants. We encountered problems relating to availability and quality[3] of health services, caused by constantly diminishing resources, and leading to increasing difficulties in responding, in an adequate manner, to the health needs of the population in general and of more vulnerable segments of the migrant population in particular.

It was found that barriers related to cultural acceptability[4] of services, stemming from the intersection of different cultures, represent a significant

1 See Chapter 2, *The right to health*.

2 See Chapter 4, *The health status of the migrant population in Turin*.

3 See Chapter 5.1.1, *Availability and quality*.

4 See Chapter 5.1.2, *Cultural acceptability*.

hurdle to both access and use of services, although the introduction of cultural mediators was found to be an affective way of tackling the problem. Nevertheless, some concerns emerged with regard to the latter professional figure,[5] in a society that still struggles to fully come to terms with its multicultural nature, and with a health system that is excessively slow in responding to changing conditions.

The importance of adequate and accessible information emerged as vital in ensuring that migrants have access to health services.[6] Many individuals have insufficient knowledge about their rights and entitlements under the law, of health-related information on diseases, prevention and treatment. Information gaps on what services exist and how to use them also surfaced. The problem of inadequate or insufficient information also concerned healthcare professionals, a portion of whom appeared to be unaware of or underinformed with regard to the healthcare-related entitlements of both regular and irregular migrants and existing services. It also emerged that certain categories of migrants, such as asylum seekers and refugees, encounter specific access barriers.[7]

Secondly, it emerged that health and the enjoyment of the right to health are determined both positively and negatively to a considerable extent by socioeconomic conditions. Health is the outcome not only of an effective and inclusive health system, but also, and perhaps especially, of policies and initiatives aimed at ensuring that health is promoted and protected in terms of the so-called social determinants. Health should not be uniquely associated to hospitals and physicians, but, rather, links with factors such as education, housing policies, social welfare, urban inclusion, and nutrition should be highlighted. Upon closer inspection, when addressing the issue of inequalities and health determinants in Turin, it was found that there were very clear data on inequalities, reflecting a rather stark divide in terms of health and health prospects between more vulnerable groups and more advantaged groups.[8]

Another key objective underlying the present study involved the promotion of the adoption of a human rights based approach to healthcare. The right to health in all its various components – availability, accessibility, acceptability and quality as well as health determinants – provides a useful interpretive lens. An analysis rooted in human rights helps identify a set of indicators and benchmarks. Secondly, adopting such an approach assists in the identification vulnerable and marginalized groups in particular as the primary recipients of state action. This action must then focus on eliminating all forms of direct or indirect discrimination. In doing so, the need to deal with inequalities in health, as a possible source of indirect discrimination, must be faced. State action must also always provide for direct participation by citizens, who will also be called on to play an important role in drawing attention to the authorities' obligations and responsibilities. The latter criteria and principles are extremely useful when health policies need to be developed and implemented, as they indicate to decision-makers which areas and initiatives ought to be prioritized and what needs deserve particular attention. This is particularly important at a time of crisis and of scarce resources, when the authorities are required to balance diverging interests. These criteria and interests are also useful because they point to the best ways to develop and implement policies. It is significant to note that these principles are found in a range of fields: for example, *equity audits* are a public health instrument that appears to go hand in hand with the principle of non-discrimination. Moreover, participation of affected individuals and groups is being increasingly considered as an essential element of public health policy.

5 See Chapter 5.1.2, Section ii, *Right to health and cultural acceptability: the crucial role of cultural mediators*, and Section iii, *Some areas of concern.*

6 See Chapter 5.1.3, Section iii, *The role of information*, and Section iv, *The right to health and the right to information*.

7 See 5.1.3, Section i, *Difficulties accessing healthcare services related to bureaucracy and procedures*.

8 See Chapter 5.2, *The right to the underlying preconditions of health*.

Finally, this approach is anchored in a solid normative base. The Italian Constitution specifies that health is a fundamental right to which everyone is entitled. Italy, moreover, voluntarily committed to realizing the right to health (and to several other human rights) by ratifying a considerable number of international treaties that specifically provide for this right. Ratification entails the obligation by state authorities to realize rights that are recognised. This is of great importance: the right to the highest attainable standard of health, in a such a framework, is not a mere programmatic objective or a potentially achievable outcome. On the contrary, it is an objective that government authorities are obliged to pursue and that citizens have the right to claim.

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1 Box by Eros Brunone Avena.

APPENDIX 1. HEALTHCARE AND THE LEGAL STATUS OF MIGRANTS

The present study revealed that migrants encounter significant obstacles in accessing and using healthcare services. Differences regarding the extent of healthcare provided hinge, first and foremost, on legal status. Access to healthcare services depends on factors such as country of origin, possession of a stay permit (*permesso di soggiorno*) and the type of permit. Migrants from EU countries and migrants from non-EU countries have different status in this respect.

Healthcare for EU citizens is guaranteed in Italy, as provided by Legislative Decree 30/2007 which implements EU Directive 38/2004.

The key Italian legislation relating to non-EU citizens is Legislative Decree 286, of 25 July 1998, or the "Single Immigration Act" containing provisions on immigration and regulations regarding the status of migrants, which we shall refer to from now on as the *TUI* (*Testo unico sull'immigrazione,* Single Text on Immigration)[1]; the law sets out the different legal situations of non-EU migrants, administratively speaking, and the kind of access to health care they are entitled to.

However, relevant legislation is not restricted to the national level. It should be remembered that, under Article 117 of Constitutional Law 3/2001 (Amendments to Title V of Part II of the Italian Constitution), competencies in the area "health and immigration" are shared between central and regional government regarding who is responsible for legislation: immigration is an area where the state holds full legislative power under Article 1.3 of Law 59/1997, while health care is one of the areas where local regional authorities hold full legislative power.

Thus, although immigration policy is decided at national level, and the state is responsible for ensuring equity in implementation of the right to health,[2] the pathways by which migrants enter the system, become integrated and receive support, including healthcare, must be planned and achieved at the local level. Ample research has shown that gradual political and administrative decentralisation is producing a considerable degree of heterogeneity throughout the country, and a high risk of creating disparities in health and in access to healthcare services, often to the detriment of the migrant population.[3]

Given the scope of this study, we will address relevant aspects of the regulations and provisions laid down by the Piedmont Regional Authority, to enable us to better understand the study area.

1. EU citizens

With regard to the registration of EU citizens with the *SSN (Servizio Sanitario Nazionale,* Italian national health service) and access to medical treatment, a distinction is drawn between:

- indsividual staying for a short time (less than three months)
- individuals staying for a long time (more than three months)

1.1 SHORT STAY (LESS THAN 90 DAYS)

The only formal requirement for EU citizens who want to stay in Italy for less than 3 months is possession of a valid passport or other identity document that can be used to enter or leave the country. There are no other requirements.[4]

Registration with the *SSN* is not possible for periods of less than 3 months, except for seasonal employees on employment contracts of less

1 See also Implementation Regulations, DPR (Decree of the President of the Republic) of 31 August 1999, n. 394 (art. 42, 43 and 44) and Circular no. 5, 24 March 2000.

2 See "Essential Levels of Care" and State-Regions agreements.

3 Geraci S. and Baglio G. (2010). *Salute degli immigrati*, in Osservatorio nazionale sulla salute nelle regioni italiane, *Rapporto Osservasalute 2010 – Stato di salute e qualità dell'assistenza nelle regioni italiane*, p. 275; Associazione per gli studi giuridici sull'immigrazione (ASGI) (2011), progetto co-finanziato dall'Unione Europea e dal Ministero dell'Interno, Fondo europeo per i rifugiati 2008-2013, *Il diritto alla protezione, studio sullo stato del sistema di asilo in Italia e proposte per una sua evoluzione*, p. 9.

4 Art. 6, Legislative Decree 30/2007.

than 3 months where registration is compulsory,[5] and sometimes for holders of three-month E106 forms.[6]

Healthcare services can be accessed upon presentation of a European Health Insurance Card (EHIC), or the certificate that temporarily replaces the EHIC, issued by the country of origin. If an EU citizen goes to a local health service authority (*ASL*) without an EHIC or other valid document certifying their right to health care, the relevant institution in the citizen's country of origin may need to demonstrate that the citizen is registered with their system. Otherwise, the patient will be expected to pay for the health care received and subsequently to apply for reimbursement by the relevant institution in the country of origin.[7] Holders of EHICs or an equivalent document have the right to urgent and necessary care at appropriate healthcare facilities, and to any services the patient's state of health may necessitate, to enable him or her to continue to stay in Italy without medical risk.

Pregnant women receive healthcare services and care during labour and delivery (only for urgent, premature births) if they have an EHIC. If delivery is planned, the special E112 form must be requested.[8] Women who are not covered by an EU country's health service system (and are not registered with the *SSN*) must have private health insurance or pay for the services they receive. In the same way, the EHIC cannot be used for other types of planned treatments, such as highly specialised healthcare: in these cases, too, the E112 form is required.

1.2 LONG STAY (OVER 90 DAYS)

– EU citizens are *required* to register with the *SSN*, under the same conditions granted to Italian citizens living in Italy in the following cases:[9]
– Employed or self-employed workers:[10] *SSN* registration is valid for the duration of the contract or work;
– Family members, even if not EU citizens, of employed or self-employed workers;[11]
– Family members who are financial dependants of an Italian citizen;[12]
– Holders of a certificate of permanent stay (*attestazione di soggiorno permanente*) which can be obtained after 5 years' residence in Italy;[13]
– Unemployed people on job-seekers' lists or enrolled in job training programmes;
– Holders of the following forms: E106/S1,[14] E109/S1,[15] E120/S1,[16] E121 S1;[17]
– Victims of human trafficking or slavery;
– Previously employed or self-employed workers, temporarily unable to work because of illness or injury;
– Individuals who have been made redundant (on *mobilità* lists);
– Prisoners or detainees;
– EU citizens who are mothers of Italian minors;
– Minors in foster care.

The following are permitted to register with the *SSN* if they pay an annual fee:
– EU citizens entitled to the exemptions and privileges provided for under the Vienna Conventions on diplomatic and consular relations;
– EU citizens who are not legally entitled to registration in the *SSN;*
– Students and au pairs;

5 See *infra*.

6 Ministero della Salute (Health Ministry), informative note of 3 August 2007.

7 *Ibid*.

8 Only in the following cases: women who wish to give birth in the member state where their husband is living, women who are holders of scholarships and who give birth during the period when they are doing their research abroad.

9 Ministero della Salute (Health Ministry), informative note of 3 August 2007.

10 After implementation of European Directive 2004/38/CE through Legislative Decree 30, 6 February 2007, those who intend to stay in Italy for work (self-employed or employed) for longer than 3 months, no longer need to apply for a *carta di soggiorno* (stay card); instead they must register with the local municipal registry office.

11 According to Ministry of Internal Affairs Circular no. 19, 6 April 2007, the following are considered to be family members are: 1. spouse; 2. direct descendants who are aged under 21, or financially dependent, and the spouse's descendants; 3. financially-dependent direct ascendants and the spouse's ascendants.

12 *Ibid.*

13 In this case registration is permanent.

14 1. Employees (and their family members) on secondment in Italy for a European (non-Italian) company; in this case the state where the company is based and where contributions are paid is responsible for the cost of *SSN* registration at the relevant *ASL* (local health service authority) for the duration of the employee's secondment. It should be remembered that not all states issue E106 forms that are valid for one year. If the form's validity is related to the duration of the employment contract, registration must be annual, renewed each year, after effective continuation of employment has been verified. Employees on secondment are entitled to a GP (and/or pediatrician), but not to an Italian EHIC, which must be issued by the country of origin. 2. Foreign students who come to Italy for study (e.g. Erasmus students); like employees on

– Employees of international organisations based in Italy (who are not obliged to register as residents with their municipal registry office nor to pay income tax on their earnings);
– EU citizens who work in Italy and are still subject to the social security provisions of their country of origin, unless, as holders of EU forms, they must be registered.

The registration fee is valid for a year from the date of registration, may not be paid for smaller periods than a year, and cannot be started retroactively. Registration also covers family members who are financial dependants, with the exception of students and au pairs.

People who are resident in Italy or intend to stay for a period of more than 3 months, who are not legally entitled to register in the *SSN*, and who have no health cover in their country of origin, must have sufficient economic resources to prevent them and their families becoming a burden on social welfare for the period they are resident; they must have health insurance or any other appropriate insurance that provides cover against all risk anywhere in the country.[18]

Those intending to stay in Italy for study purposes for longer than 3 months[19] but not intending to move permanently because they want to maintain their main interests and affairs in their country of origin, may use the EHIC, or the temporary substitute certificate, to receive any care considered medically necessary given the duration of their stay and their state of health. In this case registration with the *SSN* is not possible. The EHIC gives EU citizens direct access to health services.

1.3 EU CITIZENS NOT REGISTERED WITH THE *SSN* AND WITH NO MEANS OF SUPPORT

EU citizens in Italy who have no cover from the health system of their state of origin, no private insurance, and no means of support, do not have access to the *SSN*. The Health Minister has clarified that they have the right to urgent and essential services.[20] These include services related to:
– healthcare for minors, under the New York Convention on the Rights of the Child, 20 November 1989, ratified and implemented through Law 176, 27 May1991;
– maternity healthcare, and voluntary termination of pregnancy, under the same conditions as women registered in the *SSN*, according to Law 409 of 29 July 1975, Law 194 of 22 May 1978 and Ministerial Decree 10 September 1998.

Finally, services related to vaccination campaigns, international prevention programmes, and the prevention, diagnosis and treatment of infectious diseases can also be accessed.

The *ASL* (local healthcare authority) responsible in each area must keep separate accounts for these services in order to attempt to recover or negotiate costs with the States concerned.[21] This separate accounting is done through the regional *ENI* code (*Europeo Non Iscritto*, non-registered European), which is assigned when a health care services is first used, or when the code is applied for. It is valid for six months and is renewable.

It is worth noting that the *Regione Piemonte* was the first regional authority in Italy to deal with the problem of health care for EU citizens unable to register with the *SSN*. The *Regione Piemonte* first came up with the idea of the regional *ENI* code in its Circular of 9 January 2008.

secondment, registration with the *ASL* expires when the course of study ends (date on E106 form). The same regulations apply as for employees on secondment. 3. Family member of unemployed person; entitled to GP (and/or pediatrician) and to healthcare, but not to an Italian EHIC which must be issued by country of origin. The *ASL* must issue holders of the E106 form with Attachment 5, as per ministerial note Prot. DG RUERI 2276, 8 March 2005, which must be given to the GP (and/or pediatrician).

15 Family members of a non-Italian person employed in another Member State who are resident in Italy (including students). They are entitled to *SSN* registration with the relevant ASL (local health service authority), and to choice of GP (and/or pediatrician) and to an Italian EHIC.

16 Applicants for pensions in another EU Member State (and their family members) who are resident in Italy; they are entitled to registration with the *SSN* with choice of GP (and/or pediatrician), but not to an EHIC, which is issued by the Member State of origin for possible use in other EU states aside from Italy.

17 EU pensioners and their family members (with pensions from another EU Member State, but residing in Italy); they are entitled to *SSN* registration with the relevant *ASL*, and choice of GP (and/or pediatrician) and Italian EHIC.

18 Art. 7.1(b) and (c) of Legislative Decree. no. 30/2007.

19 See above, for status of EU citizens who intend to stay in Italy for no more than 3 months.

20 Ministero della Salute (Health Ministry), informative note 3 August 2007.

21 *Ibid*.

The code must be used:
– for prescriptions on regional prescription forms for healthcare services (clinical and instrumental tests, specialist consultations);
– for prescriptions for drugs provided by subsidised pharmacies, under the same conditions as Italian citizens as regards payment of any charges;
– when accounts are rendered, for reimbursement, for services provided by the *SSN* facilities.

Services are provided under the same conditions as Italian citizens, as regards any payments required.

2. NON-EU CITIZENS

Migrants from non-EU countries are classified as either documented, that is staying legally in the country because they have a permit of stay (*permesso di soggiorno*), or undocumented, that is in a situation of non-compliance with legal requirements on entering and staying in the country.

Legislative Decree 286/98 (arts. 34-36) identifies five distinct categories of non-EU recipients of health care:
– those who have a permit of stay and are automatically entitled to be registered with the *SSN*
– those who have a permit of stay and can if they wish be registered with the *SSN*
– those who comply with legal requirements on immigration but cannot be registered with the *SSN*;
– those who do not comply with legal requirements on immigration and cannot be registered with the *SSN*;
– those who come to Italy for medical treatment;

2.1. NON-EU DOCUMENTED MIGRANTS WHO ARE AUTOMATICALLY ENTITLED BE REGISTERED WITH THE SSN

The right to automatic registration with the *SSN* derives from the reason for issue of the permit of stay (*permesso di soggiorno*), with which it is then possible to stay in Italy. Mandatory registration guarantees the same treatment by law as the Italians as regards choice of general practitioner and pediatrician, and any payments of charges. Other services guaranteed, and under the same conditions as Italians, are rehabilitation support, supplementary support (for incontinence, diabetic and dietary products), prosthetics support and transfer abroad for treatment.

The right to mandatory registration applies to migrants who have a permit of stay based on:[22]

1) employment;
2) self-employment;
3) family reasons;
4) political asylum or refugee status;
5) humanitarian asylum, humanitarian reasons, or subsidiary protection status;
6) application for international protection;
7) application for asylum under the Dublin Convention;
8) expected adoption;
9) foster care, including foster care of unaccompanied minors;
10) acquisition of citizenship;

22 Art. 34 *TUI* and Art. 42 implementing regulations; Ministero della Sanità (Health Ministry), Circular no. 5, 24 March 2000 and subsequent legislation. See also Direzione Generale Diritto alla Salute e Politiche di Solidarietà Coordinamento Interregionale in Sanità – Tavolo interregionale "Immigrati e Servizi Sanitari" Coordinamento: Osservatorio sulle Diseguaglianze nella Salute – Regione Marche, Indicazioni per la corretta applicazione della normativa per l'assistenza sanitaria alla popolazione straniera da parte delle Regioni e Province Autonome italiane, p. 13.

11) possession of a card of stay (*carta di soggiorno*)[23] and long-stay status;
12) status as non-EU family member of EU citizen registered with the *SSN;*
13) expected employment;
14) expected regularisation;
15) status as migrant minor in Italy irrespective of possession of a permit of stay;
16) status as parent who works with permit of stay for care of a minor;[24]
17) study reasons for those aged 18 and over who were previously entitled to compulsory registration;[25]
18) prisoner and detainee status; status as prisoner allowed to leave prison during the daytime, serving alternative sentence to imprisonment;
19) judicial reasons;
20) religious reasons for members of religious orders working and receiving pay from which withholding tax is deducted;
21) stateless person status;
22) study reasons for working students;
23) choice of residence and status as holder of Italian pension;
24) health or humanitarian reasons (apart from those staying in Italy under art 36 *TUI*);[26]
25) pregnancy or 6-month period after childbirth for female migrants (and cohabiting spouse) who have applied for a (non-renewable) permit of stay for medical treatment.[27]

Family members who live with an applicant for a permit of stay and are financial dependants are also automatically entitled to health care provided that they are legally resident in Italy.[28]

Registration with the *SSN* is valid for as long as the permit of stay is valid, for the period of application for renewal and, should the permit expire, while appeal is made. Registration also has retroactive validity, from the date when the permit of stay first becomes valid.

2.2 NON-EU DOCUMENTED MIGRANTS WHO CAN IF THEY WISH BE REGISTERED WITH THE SSN

Migrants with a permit of stay for over three months, who do not belong to any of the categories of those who are entitled to be registered, are obliged to insure themselves against illness, injury and maternity, either under an Italian insurance policy or foreign insurance policy valid in Italy, or through voluntary registration in the *SSN*, also covering dependants.[29] This is a form of insurance cover, and entails paying the relevant Regional Authority an annual fee which is proportionate to overall income earned in Italy and abroad in the year before registration.[30] Migrants with permits of stay for study reasons and au pairs pay a fixed fee.

Voluntary registration is possible for documented non-EU citizens who are in Italy:

– because they have chosen to live here, and do not work here;
– for study reasons;
– for religious reasons (where conditions do not exist applying to those who are automatically entitled to be registered);
– as au pairs;
– as family members aged over 65 entitled to enter Italy to join family after 5 November 2008;

23 Art. 9.1 *TUI* and Art. 16.2, *DPR* (Decree of the President of the Republic) 394/1999.

24 Art. 29.6 *TUI*.

25 Ministero della Salute (Health Ministry), Circular of 16 April 2009.

26 See *infra*.

27 Art. 19. 2 (d) TUI and Art 28.1 (c) of *DPR* (Decree of the President of the Republic) 394/1999.

28 Art. 42, *DPR* (Decree of the President of the Republic) 394/1999.

29 Art. 34.3 *TUI* and art. 42, DPR (Decree of the President of the Republic) 394/199931; Ministero della Sanità (Health Ministry), Circular no. 5 *cit*.

30 Ministero della Sanità (Health Ministry), Circular no. 5 *cit*.

– as foreign workers not required to pay personal income tax in Italy;
– as foreign employees of international organisations operating in Italy, and as accredited embassy and consular personnel, excluding those hired in Italy who are automatically entitled to be registered with the *SSN*;

As stated above, applicants for voluntary *SSN* registration must have permits of stay that are valid for over 3 months, unless they are students or au pairs who may register with permits that are valid for less than 3 months. Registration is carried out at the *ASL* (local health service authority) in the area where the applicant is officially resident, or, in the absence of official residence, where the applicant is currently domiciled. This is the address given on the permit of stay. Registration expires without exception after a year, regardless of whether or not the permit of stay is valid for longer.

2.3 DOCUMENTED NON-EU CITIZENS WHO CANNOT BE REGISTERED WITH THE SSN

SSN registration is not possible for non-EU citizens who have permits of stay for medical treatment reasons, under article 36 of the *TUI*, [31] or for tourism, or who have any other type of permit that is valid for less than 3 months (except for those cases where registration is allowed, as in the case of students, au pairs and seasonal workers).[32] These citizens are guaranteed urgent healthcare, in public or subsidised private medical centres, hospitals, and day hospitals, which must be fully paid for when the patient is discharged; they may also access non-urgent healthcare services which must be paid for by the patient when the service is delivered.[33]

2.4 UNDOCUMENTED NON-EU CITIZENS WHO MAY NOT BE REGISTERED WITH THE SSN

Non-EU citizens who are undocumented (*STP* or temporarily present migrants), that is they do not comply with requirements for entering and staying in Italy, are not entitled to registration with the *SSN*.

The *TUI*, in line with Article 32 of the Constitution, provides that migrants staying illegally in Italy are nevertheless guaranteed urgent or essential (and possibly ongoing) treatment for illness and injury, at a medical centre or in a hospital.[34] Urgent treatment means treatment that cannot be delayed without putting at risk a person's life or health. Essential treatment means healthcare services, diagnostic services and treatment for conditions which are not dangerous immediately or in the short-term, but which could in time result in greater damage to health and risk to life (complications, chronification or deterioration). Undocumented migrants must also be able to benefit from preventive medicine programmes, to protect individual and collective health. They are also entitled to the same treatment as Italian citizens as regards transplants, including bone marrow transplants, which are considered as essential treatment.

Undocumented migrants are guaranteed the following:

a) pregnancy and maternity social care, under the same conditions as Italian citizens, according to Law 405 of 29 July 1975, Law 194 of 22 May 1978, and Health Minister Decree 6 March 1995, published in Official Gazette 87, 13 April 1995, under the same conditions as Italian citizens;

b) health care for minors according to the Convention on the Rights of

31 See *infra*.

32 See above.

33 Ministero della Sanità (Health Ministry), Circular no. 5 *cit*. However international agreements still remain in place regarding reciprocity in healthcare services delivery.

34 Legislative Decree 286/98, art. 35.3.

the Child, 20 November 1989, ratified by Law 176, 27 May 1991;
c) vaccinations required by law and as part of collective prevention campaigns authorised by the Regional Authorities;
d) international prevention campaigns;
e) prevention, diagnosis and treatment of infectious diseases, and possible sanitising of points of outbreak;
f) treatment, prevention and rehabilitation for drug addiction.[35]

Article 43 of Decree of the President of the Republic (*DPR*) 394/99 delegates Italy's regional authorities to organise health services, or to define who must deliver primary health care:[36] "the Regional Authorities identify the best means of ensuring essential and ongoing treatment, which may be delivered by national health service centres or authorised clinics, in multi-service medical facilities or hospitals, possibly together with non-profit organisations with particular experience. These services, functioning as primary care facilities, must provide for direct access without booking or referrals".

The Piedmont Regional Authority has been in the forefront since 1996 when the *ISI* (Migrant Health Information) Centres[37] were created, which have been responsible since 2004 for delivering health care to undocumented migrants. Health care can be delivered once a card with an individual *STP* regional code has been issued; the card identifies the user for all services prescribed, and for accounting purposes. To obtain the code, migrants provide personal details, but no identity document is required; with the code they can receive essential health care services under the same conditions as Italian citizens, in terms of what charges must be paid. The code is valid for six months and is renewable.[38] In Turin the code is issued by the *ISI* Centres the first time a migrant receives health care, or before if possible, to make access to treatment easier.

The STP code must be used for:
– prescription on regional prescription forms for health services (clinical and instrumental tests, specialist consultations)
– prescription of medicines issued, under the same conditions as Italian citizens, by subsidised pharmacies;
– account rendering, for reimbursement purposes, for services delivered by accredited healthcare facilities

As regards payment of charges, Article 35 of the *TUI* reiterates the principle according to which the *SSN* delivers "free" services (unless there is a charge) only for those registered with the *SSN* (Italians and migrants) and recorded on *SSN* lists. Health services are therefore provided free to users, and if there is a charge, it is the same as that for Italian citizens.

Undocumented migrants, if they have declared their state of poverty, may be exempt from payment of charges, like Italian citizens, by using the X01 exemption code which applies only for each specific service delivered. This state of poverty must be declared on the appropriate form, as per Ministerial Circular 5/2000, 24 March 2000, and is valid for 6 months.

Preventive medicine procedures and related treatments, aimed at protecting individual and collective health, are also provided free of charge. These include: pregnancy and maternity social care; health care for minors; vaccinations specified by the law and as part of prevention campaigns authorised by the Regional Authority; international prevention campaigns; prevention, diagnosis and treatment of infectious diseases and sanitising of possible points of outbreak of disease; services for the prevention, treatment and rehabilitation of drug addiction; and services related to

35 Single Text of laws on narcotic drugs and psychotropic substances, prevention, treatment and rehabilitation of the related states of drug addiction, issued through DPR (Decree of the President of the Republic) no. 309 of 9 October 1990 and subsequent modifications and additions.

36 Art. 43.8, DPR (Decree of the President of the Republic) 394/99.

37 Regione Piemonte, Regional Deliberation no. 56-10571, 15 July 1996.

38 Direzione Generale Diritto alla Salute e Politiche di Solidarietà Coordinamento Interregionale in Sanità, *cit.* p. 31.

diseases where charges are exempt.

For all other situations, such as secondary care, diagnosis and treatment, rehabilitative and preventive medicine, special diets, and certain healthcare centres, the same conditions apply as for Italian citizens.

The importance should be emphasized of ensuring access to health treatment for undocumented or illegal migrants, not only as a necessary effect of the right to health that the Italian Constitution establishes under Article 32, but also as a necessary instrument to protect public health and hence the collective interest.

ISI Centres (*Centri di Informazione Sanitaria per gli Stranieri*, Migrant Healthcare Information Centres) have been operating in Piedmont since 1996. There are 14 centres in Piedmont, and of these, 6 are in the Province of Turin, and 4 in the Municipality of Turin. Like Italian citizens or migrants registered with the *SSN*, undocumented migrants who go to *ISI* Centres receive health care from doctors at the centres: consultation, prescriptions and feedback on diagnostic test results, drug prescriptions, and referrals for specialist visits or hospital admission.

Given the increasing number of undocumented migrants with chronic or debilitating diseases who access *ISI* Centres, in a circular dated 3/8/2004 the *Regione Piemonte* Department of Health and Health Care clarified when migrants are exempt from health care charges, and confirmed that the procedure is the same as for Italian citizens; doctors in *ISI* Centres, which have full patient records, start off the procedures for issue of certificates of exemption for illness or rare diseases.[39]

3. STAY FOR MEDICAL TREATMENT

Article 36 of the Single Text and Article 44 of the implementation regulations provide for entry and stay in Italy for medical treatment. There are three distinct cases:

1) application for entry visa for medical treatment;
2) transfer for treatment in Italy as part of humanitarian action;[40]
3) transfer to Italy as part of regional humanitarian action.[41]

Application for entry visa for medical treatment: issue of the visa by the Italian Embassy or Consulate requires the following documentation:

a) statement by the relevant Italian healthcare facility indicating type of treatment, start date, and expected duration;

b) document certifying that the health facility has received payment of a deposit in euros or dollars equal to 30% of the overall predicted cost of the services requested

c) documentation, possibly a guarantor's statement, demonstrating availability of sufficient resources in Italy for full payment of healthcare expenses, of living and accommodation expenses outside the healthcare facility, and of repatriation, for patients and anyone accompanying them.

Issue of a permit of stay for medical treatment does not permit registration with the *SSN*. Healthcare services must be paid in full by the user.

Transfer for treatment in Italy as part of humanitarian intervention: This takes the form of authorisation by the Ministry of Health together with the Ministry of Foreign Affairs, for foreign citizens resident in countries lacking suitable or adequate healthcare facilities, to enter Italy for treatment. Identification of beneficiaries of this intervention is at the

39 Regione Piemonte - Assessorato alla tutela della Salute e Sanità, *Guida ai servizi sanitari per immigrati*, p. 68.

40 Under Art. 12. 2 (c), Legislative Decree 502, 30 December 1992, as modified by Legislative Decree no. 517, 7 December 1993.

41 Under Art. 32.15, Law 449, 27 December 1997.

political discretion of the two ministries. The Ministry of Health, on the basis of documentation acquired, identifies healthcare facilities best able to deliver the necessary healthcare services, and directly reimburses of the cost of the relative healthcare services to the facilities.

Transfer to Italy as part of humanitarian intervention by regional authorities: within the quota attributed to the regions by the national healthcare fund, the Regional Authorities and the Health Ministry together authorise local health service centres and hospitals to deliver highly specialist health services, as part of the care programs approved by the Regional Authorities, for:

a) citizens from non-EU countries where the necessary medical specialist services are not available or not easily accessible for treatment of certain serious diseases and where there are no reciprocal agreements in place for healthcare treatment;

b) citizens of countries where, for political, military or any other reasons, the particular situation makes it impossible for current agreements relating to delivery of healthcare services by the *SSN* to be implemented.

4. ASYLUM SEEKERS OR REFUGEES

The last decade has been particularly important for legislation on asylum in Italy. This institution, grounded in Article 10 of the Italian Constitution, has been virtually ignored for years. Only in 1990, with Law 39 also referred to as the Martelli Law, did it receive any attention. This law was replaced, although without substantial modification, by Legislative Decree 286 of 1998, the so-called Single Text on immigration mentioned above.

Law 189 of 2002, known also as the Bossi-Fini Law, brought some significant changes by decentralising asylum procedures and establishing local Area Commissions, one of which is in Turin, with responsibility for deciding on applications for international protection.

Between 2005 and 2008, further important modifications took place, due to implementation of important EU legislation. In 2005 Legislative Decree 140/2005 implemented Directive 2003/9 which contains minimum regulations regarding reception of asylum seekers in Member States.

In 2007, Legislative Decree 251/2007 implemented the "Qualification Directive" (2004/83) which established the criteria to be used by EU Member States in deciding whether an asylum seeker has the right to international protection or not, and which form of protection should be received, refugee status or a form of subsidiary protection. Legislative Decree 25/2008 implemented the "Procedures Directive" (2005/85) introducing minimum common regulations in Member States for recognition and revocation of refugee status.

Today three types of international protection are possible: refugee status; subsidiary protection; and recognition of serious humanitarian reasons. The conditions required for recognition of the various positions are different, just as, at least in part, the consequences of the type of protection granted also differ; the administrative procedure is the same. Here we are interested in the type of healthcare the law permits for international asylum seekers in the various stages, from application until the decision about the application has been taken.

It should also be remembered, as stated above, that under Article 34 of the *TUI* and according to the provisions of Ministry of Health Circular

5, 24 March 2000, migrants with permits of stay for political asylum,[42] for humanitarian asylum,[43] and for application for asylum[44] must be registered with the *SSN*.

Anyone who on entry into Italy applies for asylum is issued with a permit of stay – not valid for work for the first 6 months of stay in Italy - with a validity of 3 months and which can be renewed on expiry, until the Area Commission hearing. This permit of stay gives both asylum seekers and family members, as seen above, the right to obligatory registration in the *SSN*, and to exemption from charges, since they are not entitled to work for the first 6 months.[45]

When asylum seekers are initially held in identification centres under Law 189/2002 while awaiting issue of their permit of stay, they are ensured urgent or essential, possibly also ongoing, treatment for illness or injury, in health service medical centres and hospitals, delivered by the *SSN*, through the channels in place for undocumented migrants.

Once refugee status has been recognised, they are entitled to remain in Italy, and everything said previously about automatic registration in the *SSN* applies.

Here it should be remembered that Article 28 of Directive 2004/83/CE provides that, in order to prevent the risk of social distress, citizens of an EU state and those who have been granted refugee status or subsidiary protection are entitled to equal treatment, in terms of access to social welfare.[46]

As other studies have pointed out ,[47] when implementing the Directive, Italy did not make use of the option to limit access to only essential services, for those entitled to subsidiary protection to social care services under equal conditions of treatment with Italian citizens; Article 27 of Legislative Decree 251/07 expressly provides that "those with refugee status are entitled to the same treatment as citizens in terms of social and health care".

Finally, it must be remembered that if the Area Commission does not grant international protection status to the applicant and does not invite the *Questura* (Police) to issue a permit of stay for humanitarian reasons, the permit of stay for application for asylum is withdrawn and the person is invited to leave the country. If the person decides to remain, they become an illegal, undocumented person, and hence health care can only be delivered in the ways defined for undocumented migrants as explained above. Nevertheless, registration with the *SSN* continues to be valid if the person appeals against the Area Commission's decision.

Although national legislation is clear about the automatic right to be registered with the *SSN* for asylum seekers and for those who have been granted international protection, during the study it emerged that, in practical terms, bureaucratic and administrative difficulties exist that can sometimes make registration in the *SSN* in Turin particularly problematic for these individuals.[48]

42 Ministero della Sanità (Ministry of Health), Circular no. 5, 24 March 2000, reference to *TUI* Article 2, Article 10.4, and Article 19.1; to Article 1 of Decree-Law no. 416, 20 December 1989, converted to Law 39, 28 February 1990; to the Geneva Convention of 28 July 1951 on political refugees (ratified with Law 722, 24 July 1954, in Official Gazette no. 196, 27 August 1954) and the New York Convention of 28 September 1954 on stateless persons (ratified with Law 306, 1 February 1962, in Official Gazette no. 142, 7 June 1962); to the Protocol of New York, 31 January 1967, and to the Dublin Convention, 15 June 1990, again on refugees.

43 *Ibid*, humanitarian asylum: reference to *TUI* Articles 18. 1 (stay for reasons of social protection), 19. 2 (a) & (d) (prohibition on repatriation and non-reception of those aged under 18, and women in pregnancy and in puerperium up to a maximum of 6 months after birth), 20. 1 (extraordinary measures of reception for exceptional events) and 40.1 (migrants in reception centres, when they have no other compulsory insurance or on delivery of healthcare services).

44 *Ibid*, application for asylum: reference to Art. 1 of Decree Law 416, 30 December 1989, converted into Law 39, 28 February 1990. Compulsory *SSN* registration extends those who have applied for either political or humanitarian asylum. This includes healthcare cover during the period from application to issue of the permit of stay, including the period of any appeal against non-issue, and is documented by showing the receipt provided when the application is presented to the police.

45 See Ministero della Sanità (Ministry of Health), Circular no. 5 *cit.* It should be specified that migrant citizens with permits of stay for application for asylum, given that they are not able to work during the period of application for asylum, are entitled to healthcare services and are exempt from paying charges, like unemployed individuals on job-seeker lists.

46 "1. Member States shall ensure that beneficiaries of refugee or subsidiary protection status receive, in the Member State that has granted such statuses, the necessary social assistance, as provided to nationals of that Member State. 2. By exception to the general rule laid down in paragraph 1, Member States may limit social assistance granted to beneficiaries of subsidiary

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Regione Piemonte, Assessorato alla Tutela della Salute e Sanità, Guida ai servizi sanitari per immigrati, settembre 2008. (Piedmont Regional Authority, Department for Health and Health Care, Guide to Healthcare Services for Immigrants, September 2008.)

protection status to core benefits which will then be provided at the same levels and under the same eligibility conditions as nationals*".*

47 ASGI *cit.* p. 296.

48 See Chapter 5.1.3, Section i) *Accessing healthcare services related to bureaucracy and procedures*.

APPENDIX 2. MIGRANT HEALTH: HEALTH STATUS OF MIGRANT POPULATIONS IN ITALY

Anna Odone

1. CHAPTER AIMS

Objectives of the following section are:

- to describe the demographic context of LDF's study setting, highlighting how increasing migration flows in Italy make it of fundamental importance to analyze the political, legislative and cultural barriers faced by migrants in accessing healthcare;
- to distinguish between the terms "migrant" and "foreigner", to describe the data available to assess migrant health in Italy and the methodological challenges involved in such process;
- to describe the risk factors associated to each phase of the migration process, their interaction and relative importance.
- to present data on migrants' access to healthcare in Italy though which to infer elements to describe their health status;
- to provide epidemiological data and background context on the main areas of concern in migrant health.

2. DEMOGRAPHIC CONTEXT

With regard to migration flows, two important processes should be described. First, Italy in the last twenty to thirty years has shifted from being a country of emigration to a country of immigration. In the 1960s and 1970s, strong outward migratory flows made Italy a country with one of the highest levels of emigration in Europe. A shift in the opposite direction emerged in the 1980s (in 1981, for the first time, a net inward migration flow was registered); since then, immigration flows have been progressively increasing. Second, more recently, not only Italy has become host country for millions of foreign-born subjects, but also migrations pattern have changed. In fact, we observe a growing female migrant population, migrants rejoining their families, second generation migrants, and the participation and integration of the migrant community in the Italian social, working and economic context.

Estimates on numbers of foreign residents in Italy vary according to the source of data used.

The Ministry of Internal Affairs keeps account of the numbers of permits of stay issued while the Italian Institute of Statistics (ISTAT) draws on registry office figures. Other non-governmental institutions such as Caritas include in their estimates also other categories of migrants such as minors, unprocessed applications for residence, new hires, and irregular migrants.

As of January 2008, Italy accounted for 3.5 million foreign-born residents (ISTAT, 2008). Caritas estimated a total of 3.8/4 million foreigners living in Italy in the same year. Considering a total population of 60 million residents, such figures correspond to - respectively - 5.8% (according to ISTAT) and 6.7% (according to Caritas) of the total Italian population. In both scenarios, Italy's immigration is above the average among EU countries, immediately after Germany. Spain, like Italy, is a country where immigration is relatively recent; in 2007, 11.3% (5.2 million people) of the total resident population were foreigners.

Today, Italy accounts for 4.6 million foreign-born residents. ISTAT estimates around 400,000 of them to live in Piedmont, of whom 207,000 in the Province of Turin , study setting of LDF's work.

3. DEFINITIONS AND METHODOLOGY

In this section we provide a definition of "migrant" (case definition), we define the study population and the control population, and we describe the sources of demographic data and the flows of data used to draw the health profile of the migrant population in Italy. The methodological limits related to use of these data will also be discussed.

Case definition, study population and control population

The study population in our work is the migrant population. In such context, it is important to stick to a consistent definition of "migrant".

Epidemiological studies carried out at the national, regional and local level have adopted different criteria to define their study populations, and have used the terms "foreigner", immigrant" and "migrant" without distinguishing between them, making it difficult to compare their results.

In the context of a project called "The Health of the immigrant population: methodology of analysis", coordinated by the Disparities Observatory of the *Regione Marche*, and promoted by the National Centre for the Prevention and Control of Disease (*Centro Nazionale per la Prevenzione ed il controllo delle Malattie, CCM*), a single definition was adopted, in order to harmonise research methodology and assess migrants' health status in Italy. Authors identified migrants as subjects born in "Strong Migratory Pressure Countries" (SMPCs), this definition including both EU and non-EU countries.[1] According to this definition, the term "foreigner" is not a synonym of "migrant". The project' documents highlighted how nationality is the most appropriate criterion for defining migrants for the purpose of estimating this population in Italy. One limitation of such method is that people from SMPC who have acquired Italian nationality are excluded from the definition of "migrant". However, they account for only a small share of the population (182,000 subjects in 1996-2007 according to ISTAT).

To assess migrant health in Italy, a control population should be defined. In fact, it allows to identify critical areas of interest for migrants as compared to the control population and to plan, implement and evaluate targeted public health actions. The control population defined in the Disparities Observatory's project included: holders of Italian citizenship, Italian residents, people who are settled in Italy, and are holders of citizenship of one of the defined "more developed countries" (MDC).[2] In defining the control population, it is assumed that all the above-described groups share similar socio-economic conditions and health risk factors, and that these differ from those of subjects from Strong Migratory Pressure Countries (SMPC).

Assessing migrant health: sources of data and limitations

When assessing migrants' it is important to obtain detailed and reliable data both on cases of disease (numerators) and on the background populations (denominators). With regard to denominators, migrants' legal status influences their visibility in demographic information flows.

In the light of the definition given above, migrants in Italy may:

– hold a regular permit of stay, if from a non-European SMPC (traceable through records of permits of stay)

– be registered with the municipal registry office if from a European Union SMPC and have the right to stay in Italy (traceable through municipal registry office records)

– be undocumented migrants (Stranieri Temporaneamente Presenti *STP* or Temporarily Present Foreigner), not traceable in information sources on population.

1 Strong Migratory Pressure Countries (ISTAT, Epidemiological Observatory of Disparities/ARS Marche, Sources: World Bank, 1 July 2006): EUROPE: Bulgaria, Czech Republic, Cyprus, Estonia, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia, Hungary, Albania, Belarus, Bosnia-Hercegovina, Croatia, Kosovo, Macedonia, former Yugoslav Republic, Moldova, Montenegro, Russian Federation, Serbian Republic, Switzerland, Turkey, Ukraine. ASIA: Afghanistan, Saudi Arabia, Armenia, Azerbaijan, Bahrein, Bangladesh, Bhutan, Brunei, Cambodia, People's Republic of China, North Korea, United Arab Emirates, Philippines, Georgia, Jordan, India, Indonesia, Iran, Iraq, Kazakhstan, Kyrgyzstan, Kuwait, Laos, Lebanon, Malaysia, Maldives, Mongolia, Myanmar (ex Burma), Nepal, Oman, Pakistan, Qatar, Singapore, Syria, Sri Lanka, Tajikistan, Taiwan, Palestine Autonomous Territories, Thailand, East Timor, Turkmenistan, Uzbekistan, Vietnam, Yemen, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Palau, Papua New Guinea, Solomon Islands, Samoa, Tonga, Tuvalu, Vanuatu. AFRICA: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comore, Congo, Ivory Coast, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Djibouti, Guinea, Guinea Bissau, Equatorial Guinea, Kenya, Lesotho, Liberia, Libia, Madagascar, Malawi, Mali, Morocco, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Ruanda, São Tomé and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zimbabwe. AMERICA: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Jamaica, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadine, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

2 Advanced Developing Countries: (from : ISTAT, Epidemiological Observatory of Disparities/ARS Marche, Sources: World Bank, 1 July 2006): Europe 15 (Austria, Belgium, Denmark. Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Sweden, United Kingdom) + Andorra, Australia, Canada, Japan, Iceland, Israel, Liechtenstein, Monaco, New Zealand, Norway, San Marino, South Korea, Switzerland, USA, Vatican City State.

As above-stated, migrants are traceable in population information flows only when they have a permit of stay or are registered with registry offices. Irregular presence is difficult to quantify. The fact that irregular migrants are not counted in the denominators distorts estimates on prevalence and incidence of disease. To resolve this problem, and in compliance with European regulations according to which all EU countries must produce reliable data on resident foreign population, ISTAT committed to produce new, more reliable estimates on the number of migrants in Italy, accounting for irregular presences, according to gender, age and nationality. The combined use of different demographic sources (both institutional and non-institutional) makes it possible to minimise the limits of each system of measurement. Over the years, the *Dossier Statistico Immigrazione Caritas/Migrantes* has refined methods for estimating the numbers of undocumented migrants.

With regard to numerators, given increasing use of current health data in epidemiological studies, in the last decade there has been steady improvement in information flows, both in terms of areas covered (regional and local), and in terms of completeness of information. The data sources that can be used to describe the demand for healthcare in Italy come from both public and private facilities providing health care. Flows which provide information on numerator estimates are:

– **Hospital Discharge Documents (HDD)**: HDDs contain information about hospital inpatients" discharges according to gender, age and nationality. The holders of this documentation are the Ministry of Health, Regional Authorities and Autonomous Provinces. Data are gathered annually.

– **Pregnancy of Termination (TOP)**: information on TOPs according to age, civil status, nationality and reproductive history. ISTAT holds this information and data is gathered annually.

– **Miscarriage**: information about miscarriage according to age, civil status, nationality and previous reproductive history. ISTAT holds this information and data is gathered annually.

– **Labour and Delivery Certificate**: include parents'socio-demographic data, pregnancy, labour and delivery data as well as data on the newborn, neonatal mortality and anomalies.

– **Oncological screening programmes**: information about the population screened for breast, cervical and colon cancer, individuals invited to participate, those who actually participate, and other relevant diagnostic or treatment information. The Health Ministry holds this information and the data are gathered annually.

– **Infectious Diseases Notifications System**: data on infectious diseases that must be notified by law, according to gender and age, According to specific institutional area of competence, this information is held by ISTAT, Health Ministry, *Istituto Superiore di Sanità* (the technical and scientific public body of the Italian National Health Service.), the World Health Organisation and the European Commission. Data are continuously gathered.

– **Death certificates**: death certificates' data according to gender, age,

nationality and cause of death. ISTAT holds this information and data is gathered continuously.

– **Workplace injury**: information on workplace injuries, according to Region, gender, year, INAIL (*Istituto Nazionale per l'Assicurazione Contro gli Infortuni sul Lavoro,* national institute for insurance against work-related injury) regime, economic sector, country of birth, age group and type of consequence. INAIL holds this information and the data are gathered daily.

The Disparities Observatory's project identified 36 indicators that can be derived from the data flows above-described and used to assess and describe migrant health in Italy.

The selected indicators relate in particular to:

– Hospital admission
– Maternal and child health
– Workplace injuries
– Infectious diseases
– Mortality

Using these indicators makes it possible to consistently analyse migrant demand for health care, to compare studies carried out in different Italian settings, and to plan targeted public health interventions.

The table below provides the list of 36 indicators, and specifies the area, source, and temporal availability and of the data

Migrant population health: indicators selected by the working group coordinated by the Marche Regional Authority, 2007.

Indicatore	Descrizione	Fonte dati	Primo anno disponibile
La popolazione: quadro demografico			
1.	N. e proporzione di PFPM regolari in Italia	ISTAT	2002
2.	N. e proporzione di minorenni stranieri residenti in Italia	ISTAT	2002
3.	N. e proporzione di neonati PFPM regolari nati in Italia	ISTAT	1998
La popolazione: lavoro			
4.	N. e proporzione di lavoratori assicurati all'INAIL per paese di nascita	CEDAP	2002
Domanda di salute e ricorso ai servizi: il ricovero ospedaliero			
5a.	N. e proporzione di ricoveri totali e ordinari ,per cittadinanza, erogati dalle strutture della regione	SDO	1997
5b.	N. e proporzione di ricoveri totali e ordinari ,per cittadinanza, dei residenti nella regione	SDO	1997
6.	Tasso grezzo di ospedalizzazione per i ricoveri ordinari dei residenti, per cittadinanza	Numeratore: SDO Denominatore: ISTAT	1997
7.	Tasso standardizzato di ospedalizzazione per i ricoveri ordinari dei residenti, per cittadinanza	Numeratore: SDO Denominatore: ISTAT	1997
8.	Distribuzione dei ricoveri ordinari dei residenti per causa, per cittadinanza	SDO	1997
9.	N. e proporzione dei ricoveri ordinari in urgenza, per cittadinanza	SDO	1997
10a.	N. e proporzione dei ricoveri in Day Hospital, per cittadinanza	SDO	1997
10b.	N. e proporzione dei ricoveri in Day Hospital, per sesso e per cittadinanza	SDO	1997
11.	Primi 10 DRG dei ricoveri in Day Hospital, per cittadinanza	SDO	1997
Domanda di salute e ricorso ai servizi: la salute materno infantile			
12.	N. e proporzione dei ricoveri totali delle donne residenti, per cittadinanza	SDO	1997
13.	N. e proporzione dei ricoveri ostetrici delle donne residenti, per cittadinanza	SDO	1997

14.	N. e proporzione dei ricoveri ostetrici in età fertile per causa, per cittadinanza	SDO	1997
15.	N. e proporzione dei parti, per cittadinanza	SDO	1997
16.	N. e proporzione dei parti cesarei, per cittadinanza	SDO	1997
17.	Assistenza in gravidanza, per cittadinanza		
17a.	N. dei parti avvenuti in regione	CEDAP	2002
17b.	Età media delle madri al parto	CEDAP	2002
17c.	Scolarità media: proporzione madri con titolo di studio pari alla licenza media (inferiore o superiore)	CEDAP	2002
17d.	Scolarità bassa: proporzione madri con titolo di studio pari alla licenza elementare	CEDAP	2002
17e.	Stato civile: proporzione madri coniugate, madri nubili	CEDAP	2002
17f.	N. di visite insufficiente: proporzione madri che hanno effettuato meno di 4 visite in gravidanza	CEDAP	2002
17g.	Prima visita tardiva: proporzione madri che hanno effettuato la prima visita dopo le 12 settimane di età gestazionale	CEDAP	2002
17h.	N. insufficiente di ecografie effettuate in gravidanza: proporzione madri che hanno effettuato meno di 3 ecografie in gravidanza	CEDAP	2002
17i.	Indagini prenatali invasive: proporzione di madri che hanno effettuato almeno un esame invasivo (amniocentesi, villi coriali, fetoscopia/funicolocentesi)	CEDAP	2002
17k.	Struttura utilizzata: distribuzione di frequenza del tipo di struttura (privata, consultorio, ospedale, nessuna) prevalentemente utilizzata in gravidanza dalle madri	CEDAP	2002
17l.	Ricorso al taglio cesareo: proporzione di parti con taglio cesareo	CEDAP	2002
18.	N. e proporzione di ricoveri per IVG in età fertile, per cittadinanza	SDO	1997
19.	Proporzione di gravidanze che esitano in IVG, per cittadinanza	SDO	1997
20.	Distribuzione di IVG per classi di età e cittadinanza	SDO	1997
21.	Fenomeno IVG, per cittadinanza		1982
21a.	N. di IVG avvenuti in regione	ISTAT-IVG	1982
21b.	Proporzione IVG su totale IVG	ISTAT-IVG	1982
21c.	Età media	ISTAT-IVG	1982
21d.	Proporzione di donne di età inferiore a 18 anni	ISTAT-IVG	1982
21e.	Scolarità alta: proporzione donne con titolo di studio pari alla laurea o superiore	ISTAT-IVG	1982
21f.	Scolarità media: proporzione donne con titolo di studio pari alla licenza media (inferiore o superiore)	ISTAT-IVG	1982
21g.	Scolarità bassa: proporzione donne con titolo di studio pari o inferiore alla licenza elementare	ISTAT-IVG	1982
21h.	Stato civile: proporzione donne coniugate e nubili	ISTAT-IVG	1982
21i.	Occupazione: proporzione donne occupate o non occupate	ISTAT-IVG	1982
21k.	Proporzione di donne senza precedenti IVG, con 1,con 2+ IVG precedenti	ISTAT-IVG	1982
21l.	Proporzione donne con età gestazionale al momento dell'IVG<90.90+ giorni	ISTAT-IVG	1982
21m.	Proporzione donne con tempo di attesa per l'IVG <14,14+ giorni	ISTAT-IVG	1982
21n.	Proporzione donne con certificato per IVG presso il consultorio, il medico, il servizio ostetrico, strutt. socio-sanitaria, certificazione mancante per pericolo di vita	ISTAT-IVG	1982
22.	Proporzione di gravidanze che esitano in aborto spontaneo (AS),per cittadinanza	SDO	1997
23.	Distribuzione di aborti spontanei (AS) per classi si etò e cittadinanza	SDO	1997
24.	Condizioni del neonato, per cittadinanza	CEDAP	2002
24a.	N. e proporzione di nati	CEDAP	2002
24b.	Proporzione di nati sottopeso	CEDAP	2002
24c.	N. nati morti/(nati morti+nati vivi)*1.000	CEDAP	2002
24d.	Proporzione APGAR<8	CEDAP	2002
24e.	Proporzione di nati necessitanti di rianimazione	CEDAP	2002
25.	N. e proporzione dei ricoveri entro il primo anno di vita, per cittadinanza	SDO	1999
26.	Distribuzione dei ricoveri per causa, per cittadinanza	SDO	1999
Domanda di salute e ricorso ai servizi: infortuni sul lavoro			
27.	N. e proporzione di infortuni riconosciuti, per paese di nascita	INAIL	1994
28.	N. e proporzione di infortuni indennizzati in morte, per paese di nascita	INAIL	1994
29.	Indici di incidenza infortunistica nel settore Industria e servizi, per paese di nascita	INAIL	1994
Domanda di salute e ricorso ai servizi: malattie infettive			

30.	N. e proporzione di casi AIDS, per cittadinanza	Notifiche di malattie infettive	1986
31.	Tasso grezzo di incidenza di casi di AIDS, per cittadinanza	Notifiche di malattie infettive	1986
32.	N. e proporzione di casi di TBC, per paese di nascita	Notifiche di malattie infettive	1996
Domanda di salute e ricorso ai servizi: mortalità			
33.	N. e proporzione di PFPM deceduti/totale decessi avvenuti nella regione	Schede di morte	1969
34.	Tasso grezzo di mortalità per cittadinanza	Schede di morte	1969
35.	Distribuzione delle cause di morte per causa e cittadinanza	Schede di morte	1969
36.	N. di decessi al primo anno di vita ,per cittadinanza	Schede di morte	1969

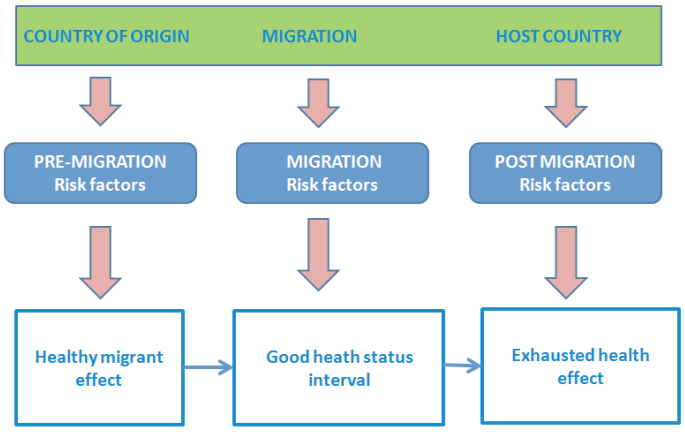
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I3488/P/F3 ad, 2007).

4. RISK FACTORS ASSOCIATED WITH THE MIGRATION PROCESS

This section aims to describe the subsequent stages of the migration process and the risk factors for health associated with each stage. In particular, the aim is to provide an overall view of their role, interdependence and relative weight in a space-time theoretical framework.

The figure below shows the different stages of the migration process, indicates where the various risk factors are situated and outlines the possible clinical consequences over time. Heath outcomes at different stages are influenced both by migrants' individual characteristics and by the geographical, social and political environment around them.

Stages of the migration process.[3]



Pre-migration risk factors

Pre-migration risk factors act on migrants in their country of origin, prior to the start of the migration process.

They are:

– "Non-risk" (protective) factors: the healthy migrant effect.
– Genetic risk factors and hereditary characteristics
– Exposure to environmental risk factors in the country of origin

3 Source: Odone 2009.

– Exposure to infectious risk factors in the country of origin
– Cultural and behavioural risk factors

The concept of *healthy migrant effect*, understood as the outcome of a pre-departure process that selects individuals in good overall health, can be applied to a type of emigration driven by economic and employment needs. This concept is very valid in the initial phases of the migratory process, but tends to weaken as immigration flows stabilise in a given host country. According to the *healthy migrant effect model*, migrants tend to be young, generally male, in good health in relation to the rest of the population, of relative higher socioeconomic position (with the necessary resources to make the migratory journey) and higher level of education as compared to the general population in the country of origin.

Studies show that individuals most likely to attempt to migrate, especially at an early stage, are those who, because of their socio-economic position and their personal characteristics, have the greatest possibility of success in the migration process.

Three models have been described to explain the healthy migrant effect:
– self-selection in the country of origin of migrants in good health and with economic resources (exposed to fewer pre-migration risks);
– health monitoring and screening by host country authorities regulating migrants' entrance;
– healthy behaviours and habits adopted by migrants previous to the time of migration

Although the three models are not mutually exclusive and can all underlie the healthy migrant effect, the self-selection model is prevalent, especially in a country such as Italy where immigration is a relatively recent process.

In line with the healthy migrant model, a study on migrants' health and use of healthcare services carried out by ISTAT in 2005 showed how migrants had better health as compared to the Italian population. Better health in the migrant population emerges both by measuring perception of health (80.3% of migrants stated they were "well or very well" vs. 71.8% of Italians, age-standardized) and also by analysing information gathered on key diseases(22.8% of migrants reporting at least one illness in the four weeks preceding the interview, against 27.4% of Italians). In interpreting these data, it should be remembered that one possible source of bias is the so-called "Italian paradox" according to which level of health and quality of health care services provided are perceived by Italian citizens are being worse that they are in reality.

Finally, it should be emphasised that the healthy migrant effect does not apply to those who are victims of forced migration, such as refugees, or displaced persons, who are obliged to flee for political reasons, war or persecution. Unlike those who voluntarily decide to migrate, these individuals are more likely to be in a worse state of health because of the suffering and violence they may have experienced in the country of origin.

The very concept of healthy migrant effect is in contrast with the idea of migrants importing diseases (in particular infectious diseases such as malaria, HIV, tuberculosis and Hepatitis B) in the host countries. Situations where migrants may be carriers of infections contracted in the country of origin are limited to the following cases:

– latent or asymptomatic infections in the early stages of migration;
we will detail later in the chapter how precarious sanitation and health conditions in the host country can act as risk factors, causing latent infections to emerge or worsen (tuberculosis and hepatitis B);

– infections not correctly diagnosed in the country of origin because of poor healthcare or for cultural reasons.

Moreover, evidence available from both national and international statistics does show increased risk of transmission of infectious diseases (eg Tuberculosis) from migrants to the native population in the host country. These data have contributed to discrediting the stereotype, sometimes referred to as the "Salgari syndrome", that migrants carry an import in the host countries exotic diseases.

Migration risk factors

Migration risk factors refer to the physical and psychological distress arising from the migration journey; difficult and dangerous travelling conditions, psychological stress related to the possible failure of the migratory process, and cultural shocks.

Post-migration risk factors

Post migration risk factors impact on migrants once they arrive in the host country. They play a more important role than pre-migration and migration risk factors and compromise migrant health to a greater extent. A recent article published in the Lancet titled "*Migration and health: a complex relation*" pointed out how migrants are at a greater risk of suffering from bad health as a result of the precarious living and work conditions and poor social support they experience in host countries. The risk factors migrants are exposed to in the host country are responsible for what is defined *Exhausted health effect*. The *exhausted migrant effect* contrasts with the above-described *healthy migrant effect*.

Post-migration risk factors can be classified as:

– Socio-economic risk factors: low income, unemployment, engagement in unsafe jobs, poor housing, lack of family support, psychological distress related to the migrant condition, cultural changes related to climate and nutrition.

– Healthcare access-related risk factors: legal barriers (influenced by legal status), logistic and organisational barriers, language and cultural barriers.

The main problems related to migrant health, as *LDF*'s work seeks to demonstrate, are not just related to clinical problems or healthcare management, but also to the political, economic, legal and social dimension. A key point when dealing with migrant health is to assess migrants' access to healthcare and quality of care migrants are provided with. In this respect, it should be emphasised how the lack of national-level data makes it difficult to have a clear picture of the situation. The greatest amount of evidence on migrant health status is derived from regional or local-level data. Some models have been created in order to describe which factors are associated with migrant's health status in the host countries, as well as how these factors relate to each other and what weight they have at the various stages of the migratory process. One important distinction must be made between the individual temporal dimension (stages of the migration process for individual subjects, described in this section) and the collective temporal dimension (stages of the migration process as the migrant population becomes better situated in the Italian social fabric).

Individual temporal dimension: in this section we have described how risk factors associated with each stage of the migration process influence migrants' health status in the host country. In particular, it has been emphasised that post-migration risk factors related to social deprivation

have a considerable effect on migrant health as compared to the protective factors acting at the pre-migration stage.

Collective temporal dimension: data available have been analysed with the aim of evaluating how migrant health is evolving as migration flows in Italy increase and migrants communities are integrated in the country. The models created to describe this process of transition take into consideration:

– demographic changes: as compared to the early stages of the immigration flows in Italy - where the migrant population mainly consisted of young male adults - today, migrants population increasingly include females and extreme age groups (children and elder people);
– migrants' progressive achievement of greater economic wellbeing as the migratory process stabilizes;
– assimilation of western models of behavior by migrants, including sedentary lifestyle, eating habits and pleasure-seeking habits;

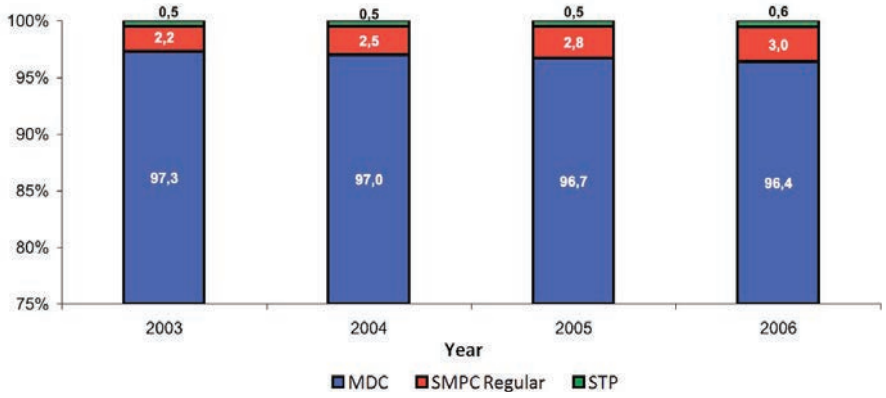
With regard to the above-described factors related to the collective temporal dimension of the migration process (assimilation of western models of behavior), recent data showed that chronic, degenerative diseases traditionally associated with native populations such as hypertension, diabetes and obesity are steadily acquiring epidemiological importance for migrants too. In Italy, in the last few years, the increase in migrant family members rejoining the family, the aging of the migrant population and the existence of second generation migrants have helped to modify the demographic structure and the health profile of migrants, and have generally weakened the healthy migrant effect.

5. DEMAND AND ACCESS TO HEALTH CARE

Migrant populations' demand for health care in Italy can be assessed through inpatients' hospital discharge data. Data on access to outpatient's services are not available by origin of patients at the national-level. Data derived from inpatients' hospital discharge forms are considered a good proxy to assess migrant health. They indicate that less migrants are admitted to hospital as compared to Italian subjects. The 2008 *Osservasalute* report shows that admission rates were lower in migrants as compared to Italians. A variety of factors might explain the lower admission rate observed for migrants. The main reason is the different age distribution of the two populations. Migrants are a younger population with fewer healthcare needs than the Italian population. Other factors underlying the lower use of hospital services by migrants are legal, logistical, language and cultural barriers as well as poor knowledge about the right to healthcare services.

SMPCs represent 3% of the total hospital admissions. The highest percentage is registered in Emilia-Romagna (4.7%) with peaks in some provincial situations (6.4% in Reggio Emilia). In Lazio, SMPCs admissions account for 4.4% of total hospital admissions, in Piedmont 3.9%, in the Marche 3.5% and in Liguria 3.3%. In southern Italy, the percentages are lower than the national average (0.8% in Puglia). In interpreting these data, the lower percentage of documented migrants in Southern regions in comparison to the national average should be taken into account. Hospital admissions for undocumented migrants account for 1% of total admissions (0.9% in Piedmont, 1.3% in Liguria, 0.9% in Emilia-Romagna).

Proportion of admissions by nationality, Italy, 2003 – 2006.



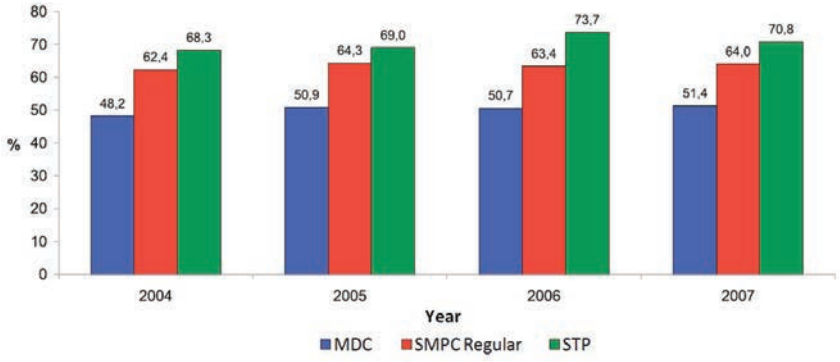
Source: Data base HDD Italy, Ministry of Labour, of Health and of Social Policy, 2003-2006 (processing Age.nas)
MDCs = Italians and other More Developed Country citizens
Regular SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Females account for the greatest share of hospital admission in the SMPCs both at the national and regional level (females represent 66% of total hospital admission in migrants in Italy). The most represented age groups in SMPCs' hospital admissions is the 18-34 years age band for the for the male population and the 35-49 years age band for the female population. The most frequent causes of hospital admission for male SMPCs are injuries followed by respiratory and digestive tract diseases. For females, the most frequent causes of hospital admission are related to pregnancy, labour, delivery and puerperium, followed by urogenital and gastrointestinal diseases.

Emergency room and Day Hospital admissions

National-level data show that Emergency Room (ER) admission rate is relatively high for migrants: migrants tend to go primarily to ER departments, considered the most easily accessible healthcare service. This is more obvious in undocumented migrants for whom it is the only way to access health care. These figures holds for both genders and for all age groups except for extreme age groups (aged under 1 and over 65). In 2006 in Italy, ER admissions accounted for 65% of SMPC admissions and 75% of undocumented migrant admissions. This patterns are the results of both the type of health problem for which migrants seek hath care for (eg injuries) but also highlight the limited use other available healthcare services by migrants such as primary care and general practice services.

Proportion urgent hospital admissions, per nationality and migrant status. Marche Region: 2004-2007.



Source: HDD Data base, *Marche* Regional Authority, 2004 - 2007.
MDCs = Italians + other More Developed Country citizens
Documented SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

'Day Hospital' admissions are lower in the SMPCs as compared to the Italian and MDCs. SMPCs account for 25% of all 'Day Hospital' admissions. In SMPC women, 'Day Hospital' admissions are higher than in males and the difference is stronger in the undocumented population. The main cause of 'Day Hospital' admission for females is termination of pregnancy (TOP). In 2006, TOP accounted for 39% of total 'Day Hospital' admissions in Italy (42% in Piedmont, 47% in the Marche, 48% in Emilia-Romagna, 43% in Lazio, 41% in Puglia). In the male population, 'Day Hospital' admissions al lower as compared to the female population for all age groups.

6. MAIN AREAS OF CONCERN

Aim of this section is to present data on the main areas of concern in migrant health and to assess migrant's health status in Italy.

Maternal health

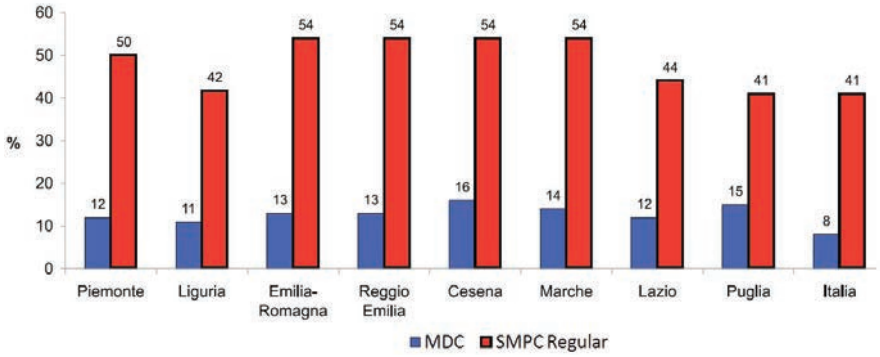
According to data from the *Dossier statistico immigrazione Caritas/ Migrantes 2011*, in Italy, in 2010 there were 2 million 300 thousand resident women with foreign nationality, accounting for 51.8% of the total female population; at the beginning of the 1990s there were around 300 thousands. Female immigration, with some differences according to country of origin, is related to both family members' rejoining and to independent migration (especially from countries such as Romania and Moldova) as well as to human trafficking and prostitution. The female migrant population comprise mostly women of child-bearing age and their presence impact on the overall birthrate in Italy. In 2010 in Italy, migrants accounted for around 2 births in 10, and, in the northern part of Italy where migrants are more numerous and more integrated in social and working life, migrants accounted for 30% of total births. With an average of 2.13 children per woman of child-bearing age, migrant women make a considerable contribution to birthrate in Italy.

The difficulties that migrant women face in accessing health care services, due in part to still inadequate policies of integration, make

maternal health one of the most critical clinical areas in migrant health. The existence of barriers to health care for migrant women of child-bearing age are confirmed by the worse results obtained by migrant women in relation to indicators of good care performance, such as: rate of outpatients' services admissions, time of first ante-natal consultation, and rate of CT scans and pre-labour invasive procedures. Data related to reproductive health in Italy for the last decade highlight how migrant women continue to be disadvantaged in comparison to Italian women.

Analysis of hospital admissions in Italy for the year 2006 show that the main reasons for hospital admission for migrant women, unlike Italian women, are related to obstetric causes, the younger age of migrant women as compared to Italian women being the main explanation for such trend.

Proportion of hospital admissions for obstetric causes out of total hospital admissions in females population, by nationality. Italy: 2006.



Source: HDD data base Regions 2006 and HDD data base Italy, Ministry of Labour, of Health and of Social Policy, 2005 (processing Age.nas)
MDCs = Italians + other More Developed Countries
Documented SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

With regard to obstetric causes for hospital admission, the proportion of admissions per birth is greater in Italian women and MDCs, for whom labour and delivery accounts for around half of obstetrics admissions. In addition, the younger age of delivery of migrant women, and the influence of cultural factors against the strong medicalisation of childbirth might partly explains the lower proportion of cesarean sections in migrants as compared to Italian women.

Absolute numbers and proportion of obstetric hospital admissions in women in child-bearing age (15-49), by nationality. Italy: 2006

	MDCs		SMPCs, Regular		STP	
Cause of Admission	**n.**	**%**	**n.**	**%**	**n.**	**%**
Childbirth	480.968	49	67.718	40	8.014	20
TOP	98.006	10	29.487	18	11.436	29
Miscarriage	76.583	8	11.097	7	2.593	7
Other	326.776	33	60.150	36	17.721	45
Tot. Obstetric Causes	**982.333**	**100**	**168.452**	**100**	**39.764**	**100**

Source: HDD data base Regions 2006 and HDD data base Italy, Ministry of Labour, of Health and of Social Policy, 2005 (processing Age.nas)
MDCs = Italians + other More Developed Countries
Documented SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

One of the most important problems in maternal health in the migrant population is the high rate of terminations of pregnancy (TOP). Data supplied by the Ministry of Labour, Health and Social Policy for the year 2006 confirmed that the proportion of admissions for TOP was higher in migrant women as compared to MDC and Italian women; nearly double in SPMC women and three times higher in undocumented migrant women. For Italian women a steady decrease in number of TOPs was observed for the same study period. Factors hypnotized to be associated with the higher rate of TOP in migrants are: fear of losing job (and therefore permit of stay), lower health education and contraceptives use as well as socio-economic instability and prostitution. Data provided by ISTAT for 2006 make it possible to evaluate some qualitative aspects of the phenomenon and draw a profile of migrant women undergoing TOPs. Documented SMPC women who resort to TOP are younger than MDC women, have lower education, are more often married and have more often undergone two or more previous TOP procedures (the latter being more prominent for undocumented migrants often forced to work in prostitution). The relative longer time interval that migrant women wait between TOP authorization and its implementation shows how access to healthcare services is still a problem for migrant populations.

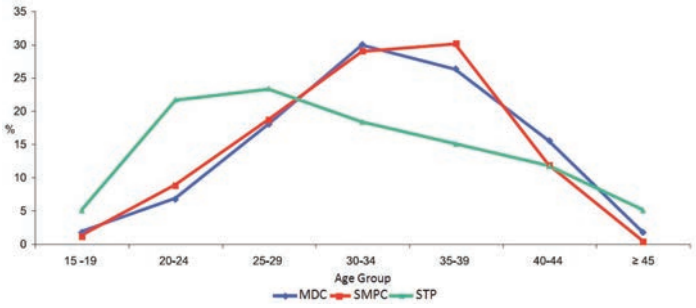
Terminations of Pregnancy (TOP) in MDC, SMPC and undocumented migrant women (STP), Italy: 2006.

Indicators	MDCs	SMPCs, Regular	STP
n. TOP (a)	88.076	29.577	7.065
% of the total TOP number (b)	70	23,5	5,6
Average age	30,0	29,2	27,7
% TOP <18 years	3,8	1,4	1,6
% high level of education (c)	7,4	5,3	4,3
% medium level of education (c)	86,6	81,5	79,9
% low level of education (c)	4,0	13,3	15,8
% single	49,0	40,6	52,6
% married	43,7	53,3	41,3
% other (d)	7,3	6,1	6,1
% employed	47,9	45,2	36,0
% unemployed	52,2	54,8	64,0
% 0 previous TOP	78,5	62,5	57,4
% 1 previous TOP	16,1	24,6	24,6
% 2+ previous TOP	5,4	14,2	18
% duration of the pregnancy <90gg	96,9	98,7	92,2
% duration of the pregnancy 90+ gg	3,1	1,3	0,8
% waiting time <14 gg	59,8	53,2	52,3
% waiting time 14+ gg	40,2	46,9	47,7
% family planning clinic certificate	30,6	51,7	51,9
% medical certificate	32,4	18,9	13,4
% hospital certificate	35,1	27,2	31,3
% other health service	1,9	2,2	3,4
% no certificate due to life risk	0,01	0,01	0,02

Source: Istat, Pregnancy Terminations
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Data from the region Puglia for the year 2006 suggests that miscarriage is not a particularly serious problem among migrant women. The young age where most miscarriage occurs in SMPCs and undocumented migrant women suggests that migration-related stress and undocumented status may constitute a risk factor for miscarriage.

Distribution of miscarriage by age and nationality. Puglia Region: 2006.



Source: HDD data base Regione Puglia 2006
MDCs = Italians + other More Developed Countries citizens
Documented SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

A project coordinated by the *CCM*, or *Centro Nazionale per la Prevenzione ed il Controllo delle Malattie* (National Centre for the Prevention and Control of Diseases), titled "Prevention of TOP in migrant women" coordinated by the *Toscana* Region, involving the technical and scientific public body of the Italian National Health Service and La Sapienza University of Rome, is studying the strategies of empowerment and active policies and services aimed at social integration of migrant women and at improving the area prevention in the field of reproductive health in this population.

Infectious diseases

At the time of the first migratory flows to Italy some infectious diseases defined as "tropical" and "imported" provided the main grounds for scientific and medical interest in the field of migrant health. As immigration has stabilised in host countries, it has emerged how migrants' often precarious living conditions facilitate diseases linked to physical and psychological debilitation as well as a greater vulnerability to infection, especially of the respiratory and digestive tracts; these illnesses are often the main cause of hospital admission for infectious diseases in this population.

Inpatients' hospital discharges by cause, gender and nationality. Italy: 2005.

Description	MALES				FEMALES			
	n. SMPC	% SMPC	Incidence SMPC	Incidence residents	n. SMPC	% SMPC	Incidence SMPC	Incidence residents
Certain infectious and parasitic diseases	4.071	5,5	4,2	2,2	2.597	1,6	2,9	1,6
Neoplasm	3.147	4,3	12,0	17,1	7.827	4,8	12,9	14,1
Endocrine, nutritional and metabolic diseases	1.268	1,7	2,7	2,7	1.645	1,0	3,5	4,1
Diseases of the blood and blood-forming organs	477	0,6	1,0	1,1	822	0,5	1,3	1,2
Mental and behavioural disorders	3.346	4,5	3,0	4,5	3.310	2,0	3,3	4,4
Diseases of the nervous system	3,538	4,8	6,7	8,0	3.148	1,9	5,9	7,6
Diseases of the circulatory system	7.316	9,9	28,9	36,8	5.263	3,2	19,3	22,9
Diseases of the respiratory system	6.369	8,6	12,9	14,1	3.960	2,4	8,6	7,9
Diseases of the digestive system	10.245	13,9	15,6	17,8	10.064	6,1	14,4	12,9
Diseases of the genitourinary system	3.298	4,5	7,8	9.8	12.055	7,1	12,1	10,8
Pregnancy, childbirth and the puerperium					93.618	56,9	57,5	32,1
Diseases of the skin and subcutaneous tissue	1.094	1,5	1,3	1,9	804	0,5	1,2	1,4
Diseases of the musculoskeletal system and connective tissue	4.513	6,1	6,3	10,1	3.601	2,2	7,1	11,2
Congenital malformations, deformations and chromosomal abnormalities	560	0,5	0,5	0,8	666	0,4	0,6	0,8
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	4.095	5,6	6,8	7,8	5.001	3,0	7,4	6,1
Injury, poisoning and certain other consequences of external causes	18.006	24,5	16,7	14,4	6.690	4,1	10,6	11,3
Factors influencing health status and contact with health services	2.295	3,1	4,2	7,2	3.360	2,0	5,6	7,0
Total	73.638	100	138,7	156,2	164.451	100	174,3	157,4

Source: ISTAT, data by Ministry of Labour, of Health and of Social Policy. Year 2008.
Documented SMPCs = documented/resident migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – *Marche* Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

The data above show that hospital admission rates for infectious diseases, in the various categories, are almost double for the migrant population in comparison to the resident Italian population. Factors that contribute to migrants' higher vulnerability to infectious diseases are: poor sanitation, overcrowded housing, difficulty accessing health services, and scant attention to preventive measures. Nevertheless, the comparison between the two populations should not distract attention from the fact that for both populations (Italian and migrant), absolute rates of admissions for infectious diseases are not particularly high in comparison to other causes of admission, and that infectious diseases are not, in terms of burden, the major health problem for the migrant population.

Infectious diseases notifications, by nationality. Italy: 2005.

Diagnosis	% / tot reported ADC	% / tot reported SMPC	% ND
Non-salmonella diarrheal diseases	97,5	1,8	0,7
Hepatitis A	92,3	6,7	0,9
Hepatitis B	90,7	8,8	0,5
Hepatitis non A non B	92,7	6,7	0,5
Typhoid fever 94,4 4,7 0,9	94,4	4,7	0,9
Legionellosis	98,1	1,7	0,2
Acute viral Meningitis and Encephalitis	96,1	3,0	0,9
Meningococcal encephalitis	96,7	3,0	0,3
Measles	91,6	6,5	1,9
Mumps	95,9	3,1	1,0
Salmonellosis (Non-Typhoid)	98,1	1,5	0,5
Scarlet fever	98,7	1,0	0,3
Syphilis	82,1	9,5	8,4
Pulmonary tuberculosis (a)	56,0	43,2	0,8
Extra-pulmonary diseases (a)	56,2	42,1	1,6
Disseminated tuberculosis (a)	47,1	51,6	1,3
Chicken pox	97,6	1,9	0,5
Other	78,4	11,9	9,6

ND: nationality not indicated or not specified
Source: ISTAT data base, 2005
MDCs = Italians and other More Developed Country citizens
Documented SMPCs = resident/documented migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Tuberculosis

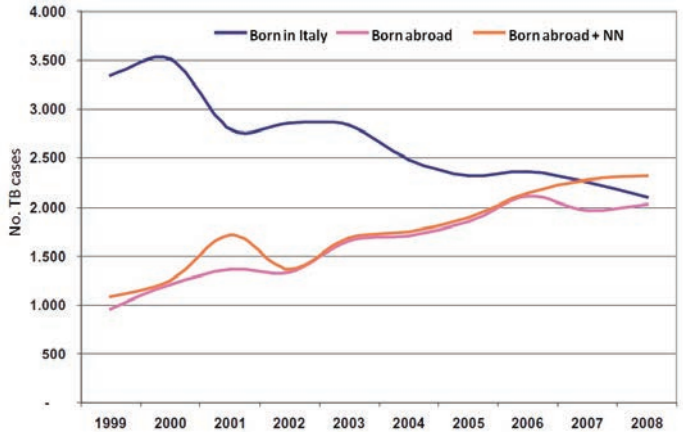
Tuberculosis (TB) is an area of public health concern for migrant populations in Italy. In recent years, the number of TB cases among the migrant population has risen significantly. Analysis of the most recent epidemiological data shows a steady reduction in TB cases in the host population and at the same time a rise in TB cases of foreign origin. This increase is clearly linked to increasing migration flows; in fact tuberculosis incidence rates among migrants have remained stable.

According to the data published in "Tuberculosis in Italy – 2008", a publication arising from a joint project involving the Health Ministry, the technical and scientific public body of the Italian National Health Service and the *Emilia-Romagna* Region Health and Social Agency, between 1999 and 2008 TB cases registered in "citizens born abroad" have accounted overall for 36.5% of total cases reported in Italy. In the period examined, this proportion increased steadily (from 22% in 1999 to 46% in 2008). In terms of absolute numbers, in 2008, 2026 notified TB cases where non-Italy born and 2012 were Italian citizens. TB incidence rates in the migrant populations in the migrant populations are decreasing but still higher than those registered for Italians. Incidence rates are also subject to distortion due to unknown quantity of undocumented migrants, making it difficult to derive real figures.

60% of foreign-born TB cases are migrants. Foreign-born TB cases are younger as compared to Italy-born TB cases. In 2008, both for the 25-64 and the 15-24 age groups, the number of TB cases in migrants was higher

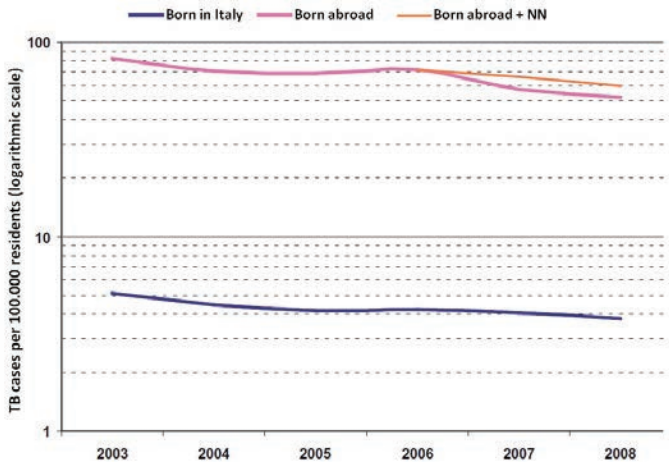
than for Italians. For those aged 65 and over, conversely, more than 90% of cases notified were Italian. Among foreign-born TB cases, the most represented continent of birth is Africa, accounting for nearly 35% of cases reported over the decade; Europe and Asia follow. However, although the number of TB cases of foreign origin is increasing, the proportion of cases in African citizens is decreasing, while the proportion in European citizens among TB cases is constantly increasing (immigration from eastern European countries). In 2008, the majority of foreign-born TB cases were from Europe and the most represented countries of birth were Romania (505 cases), followed by Morocco, Senegal, Peru, Pakistan and India.

TB cases by country of birth. Italy: 1999 to 2008.



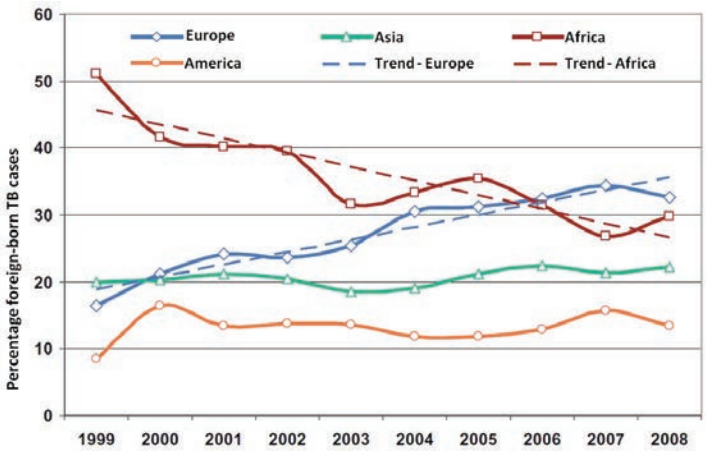
Source: Ministry of Health – General Directorate of Healthcare Prevention, Office V. Data and graphics from: Ministry of Health. Higher Institute of Health. Emilia-Romagna Regional Healthcare Agency. Tuberculosis in Italy. 2011. Translation by Author.

TB incidence by country of birth. Italy: 2003-2008.



Source: Ministry of Health – General Directorate of Healthcare Prevention, Office V. Data a graphics from: Ministry of Health. Higher Institute of Health. Emilia-Romagna Regional Healthcare Agency. Tuberculosis in Italy. 2011. Translation by Author.

Percentage foreign-born TB cases by continent of origin.



Source: Ministry of Health – General Directorate of Healthcare Prevention, Office V. Data and graphics from: Ministry of Health. Higher Institute of Health. Emilia-Romagna Regional Healthcare Agency. Tuberculosis in Italy. 2011. Translation by Author.

Evidence shows that migrants are at higher risk of tuberculosis as compared to native populations. A study published in *Osservasalute 2007* estimated that migrants have between 25 and 28 times the risk of TB as compared to Italians (accounting for two different possible scenarios of irregular presence - 20% and 10%, respectively). It is important to explore the possible factors associated with such patterns. This process needs to take into account the dynamics of the overall migratory process. The demographic and clinical characteristics of foreign-born TB cases in Italy are:

– age: as previously pointed out, the majority of TB cases in young adults are of foreign-origin;

– occurrence of TB disease in relation to year of arrival in host country: various studies have investigated the relation between the year of TB diagnosis and the year of arrival in the host country. In Italy, infectious disease notification data indicate that TB diagnosis in non-Italian citizens occurs between the first and second year after arrival in a third of cases. In the 1999-2006 period, 12% of TB cases in migrants were notified in the first year after arrival, while around 32% between the first and the second year.

– TB type: among foreign-born TB cases, a higher percentage of extra-pulmonary TB is reported as compared to native TB cases.

– multi-drug-resistant TB (MDR-TB and XDR-TB): the incidence and prevalence of MDR-TB and XDR-TB in low endemicity areas seems to be associated with migrant populations from high MDR-TB incidence countries, in particular ex Soviet Union states.

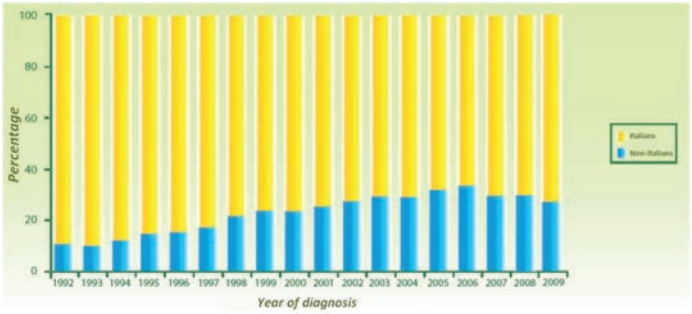
Subject from high TB burden countries are exposed to a greater risk of developing TB. Reactivation of latent infection is facilitated by conditions which weaken the immune system. HIV infection is a major risk factor for TB reactivation; however it has not been shown that HIV is associated with an increased risk of TB reactivation in migrants as compared to native subjects. The precarious living conditions in which migrants often live in

the host countries are a risk factor for tuberculosis. Indeed, malnutrition, overcrowded and badly aired spaces, poor hygiene and limited access to healthcare can facilitate both the transmission of tubercular infection as well as its reactivation. As a matter of fact, undocumented, temporary, or seasonal migrants, and homeless people, who suffer more from economic and social marginalisation, are more exposed to the risk of tuberculosis.

HIV-AIDS

Risk factors for HIV associated with migrant status include: coming from a high HIV incidence country, being young and sexually active, low health education and uptake of preventive measures, sex work and other risky behaviours. In Italy, in comparison to the early 1980s, the majority of HIV infected subjects are adults (average age of diagnosis 42 for men and 40 for women), infected through sexual contact. According to data from the AIDS Operative Centre of the technical and scientific public body of the Italian National Health Service (*COA/ISS*), infection is decreasing among drug addicts (from 47.9% in 1998 to 22.3% in 2008) and sexual transmission is increasing: from 25.3% in 1998 to 44.4% for heterosexual relations, and from 17.3% to 23.7% for bisexual and homosexual relations). In Italy, around 62,000 cases of AIDS were reported overall in the period 1982 (first year of the epidemic) – 2009; of these, nearly 25% are women. As shown by the *COA/ISS* study, HIV incidence decreased from 1995 to 2001 and has remained stable from 2002 until today. It is estimated that in 2008 around 1,400 subjects had HIV-AIDS, in line with 2007 data. The proportion of foreign-born subjects on total HIV-AIDS cases grew from 11% in 1992 to 32.9% in 2006, and then decreased; in 2009, migrants accounted for 27.2% of total cases of HIV-AIDS. The most common way of transmission is heterosexual sex contact (24.6% in 1992, reaching 70.0% in 2009).

Percentage distribution of new HIV cases by year and nationality.



Source: Istituto Superiore di Sanità, 2011

Istituto Superiore di Sanità. Notiziario dell'Istituto Superiore di Sanità 201, Volume 24, no. 5 May 2011, supplement 1, 2011. Translation by Author.

Work-related injuries

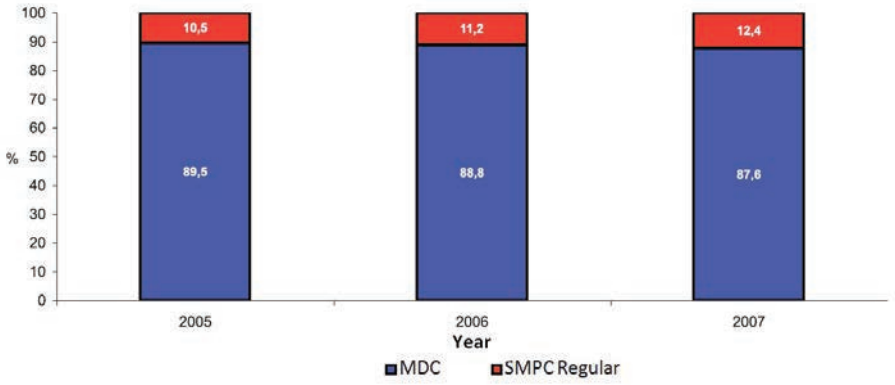
Work-related injuries in foreign-born subjects in Italy are an area of great concern. Data provided by the National Institute for Insurance Against Work-related Injuries (INAIL) for the period 2005-2007 revealed that while overall there has been a 7.8% decrease in work-related injuries in all economic sectors, injuries in SMPC workers as compared to Italian and MDC workers increased. SMPC workers accounted for 12.4% of total reported injuries in 2007, a higher percentage compared to the period 2005-2006. The increase in work-related injuries in SMPC workers was

more prominent for the female population. Among female SMPC workers an 18.3% increase in work-related injuries was observed for the period 2005-2007. However, work-related injuries incidence rate is higher in SMPC males (34.8 per thousand) as compared to SMPC females (14.5 per thousand).

Risk factors associated with higher rates of work-related injuries in migrant as compared to Italian workers include:

– employment in low-profile jobs;
– long hour shifts without appropriate protection against physical harm;
– inadequate professional training;
– unofficial employment and related lack of trade union protection.

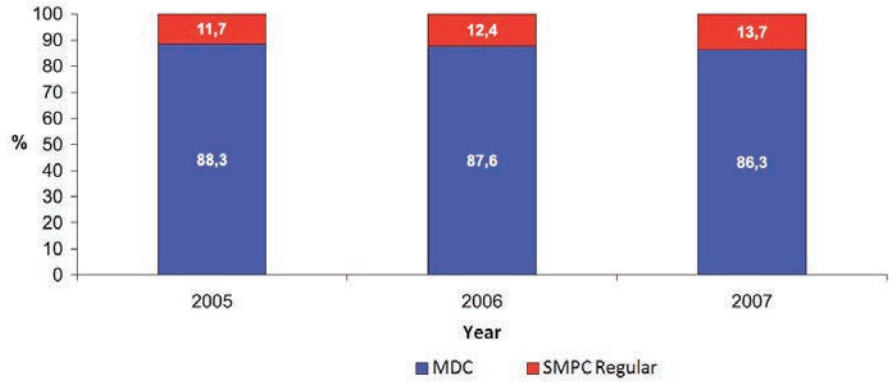
Proportion of work-related injuries recorded by INAIL, by country of birth. Italy: 2005-2007.



Source : INAIL, 2005-2007 (updated 30 April 2008)
MDC = Italians and other More Developed Country residents
Regular SMPCs = resident/documented migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Manufacturing and services is the sector with the highest rate of reported work-related injuries in SMPCs. Workers from Morocco, Albania and Romania accounted for 43% of total work-related injuries in SMPC. Young adult (18-34 years old) are the most affected category.

Proportion of injuries recorded by INAIL in the manufacturing and services sector, by country of birth. Italy: 2005-2007.



Source : *INAIL*, 2005-2007 (updated 30 April 2008)
MDC = Italians and other More Developed Country residents
Regular SMPCs = resident/documented migrants
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Data provided by *INAIL* for the period 2005- 2007 enable us to evaluate some qualitative aspects of the phenomenon and to draw a profile for SMPC workers at higher risk of work-related injuries. Women are most exposed to injury in the service sector (including real estate and cleaning businesses health, hotels and restaurants, domestic service and work as careers) The rate of female injuries is highest in the health sector and in domestic services. Men working in industry are most exposed to injury, with the greatest number in the construction industry, in metal-working industries, and in transport. In particular, the rate of injuries for males at work exceeds 90% in the oil, mechanical, metal-working and construction industries where figures almost reach 100%.

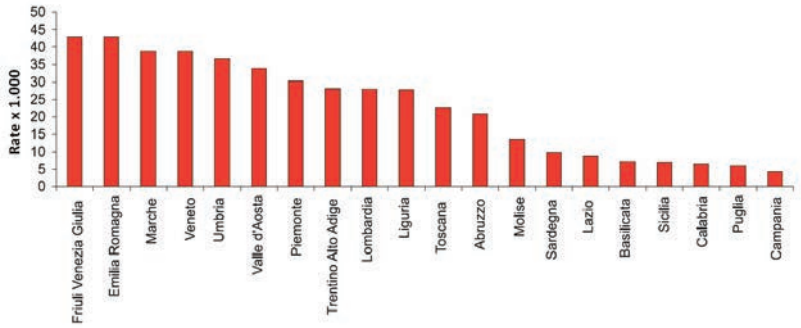
Work-related injuries (industry and services) recorded by INAIL, in SPMC workers, by economic sector (ateco-2002) and gender. Italy: 2005 – 2007.

Economic Activity	Males	Female	Total	% males/ males total	% females/ females total	% males/ total	% females/ total
A Agriculture	2.513	1.225	3.738	0,7	1,0	67,2	32,8
B Fishing	320	17	337	0,1	0,0	95,0	5,0
C Mining	1.199	50	1.249	0,3	0,0	96,0	4,0
DA Food Products	9.108	3.876	12.984	2,6	3,1	70,1	29,9
DB Textile and Clothing	3.404	3.338	6.742	1,0	2,7	50,5	49,5
DC Leather and Leather Products	1.291	934	2.225	0,4	0,8	58,0	42,0
DD Wood and Wood Products	6.329	479	6.808	1,8	0,4	93,0	7,0
DE Paper	5.343	1.247	6.590	1,5	1,0	81,1	18,9
DF Refined Petroleum	283	11	294	0,1	0,0	96,3	3,7
DG Chemicals	3.320	939	4.259	0,9	0,8	78,0	22,0
DH Rubber and Plastic Products	6.691	1.206	7.897	1,9	1,0	84,7	15,3
DI Non-metallic Mineral Products	9.403	1.011	10.414	2,7	0,8	90,3	9,7
DJ Basic Metals and Fabricated Metal Products	36.890	2.183	39.073	10,4	1,8	94,4	5,6
DK Machinery	20.214	1.927	22.141	5,7	1,6	91,3	8,7
DL Electrical Equipment	6.717	1.758	8.475	1,9	1,4	79,3	20,7
DM Transport	10.597	1.274	11.871	3,0	1,0	89,3	10,7
DN Other Manufacturing	7.531	1.386	8.917	2,1	1,1	84,5	15,5
E Electricity, Gas, Water	3.320	523	3.843	0,9	0,4	86,4	13,6
F Construction	65.478	1.020	66.498	18,5	0,8	98,5	1,5
G Wholesale and Retail Trade	39.920	18.317	58.237	11,3	14,8	68,5	31,5
H Accommodation and Food Service	9.982	11.934	21.916	2,8	9,7	45,5	54,5
I Transportation and Communication	39.524	9.670	49.194	11,2	7,8	80,3	19,7
J Financial Activities	2.108	2.226	4.334	0,6	1,8	48,6	51,4
K Real Estate and Support Service	19.816	14.713	34.529	5,6	11,9	57,4	42,6
L Public Administration	8.270	9.956	18.226	2,3	8,1	45,4	54,6
M Education	1.763	2.159	3.922	0,5	1,7	45,0	55,0
N Health and Social Work	6.232	17.206	23.438	1,8	13,9	26,6	73,4
O Other Public Services	15.167	7.536	22.730	4,3	6,1	66,7	33,3
P Households Employers	43	622	665	0,0	0,5	6,5	93,5
X Non Determined	11.653	4.819	16.472	3,3	3,9	70,7	29,3
Total	**354.429**	**123.589**	**478.018**	**100**	**100**	**74,1**	**25,9**

Source : INAIL, 2005-2007
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

The regions in the north and center of Italy, in particular Friuli-Venezia-Giulia, Emilia Romagna, followed by the Marche, the Veneto and Umbria, are the regions with the highest rate of work-related injuries in SMPC workers. However, it should be remembered that injury rates in different regions are calculated on the basis of those reported by *INAIL*, and thus exclude undocumented workers who are more numerous in the centre and south of Italy. The *INAIL* data considerably underestimate work-related injuries for migrants in the southern regions of Italy, where there are more undocumented workers than in the north.

Work-related injuries incidence (per 1000) in SMPC workers per region. 2007.



Source : INAIL, 2005-2007
Data and graphics from: Migrant Population Health: Methodology of analysis. Project: Promotion of migrant population health in Italy. Ministry of Health / CCM Agreement – Marche Regional Authority (Health Care Prevention General Directorate, Office I, n. DG/PREV/I 3488/P/F3 ad, 2007). Translation by Author.

Work-related injuries' mortality remained stable in the period 2005-2007, with a small increase observed for SMPC women, partly influenced by the increase in the same period of the percentage of migrant women insured by INAIL (around 30%).

Skin diseases

Skin diseases account for a considerable proportion of medical problems suffered by migrants, second only to problems related to the respiratory and digestive tracts. Skin diseases and symptoms associated with migrant status might include: expression, through cutaneous manifestations, of distress related to adaptation and transculturation, dermatosis related to skin colour, infectious diseases related to specific socio-economic risk factors (poor hygiene, overcrowding), skin disorders due chemical agents used in the work environment. In the early 1980s, the presence of itchiness in the absence of other clinical or laboratory signs was frequently associated with scabies or other parasitic forms with consequent stigmatization and repercussions on the social and working lives of individuals. In many cases, after a more detailed dermatological examination, it emerged scabies was not the correct diagnosis and that the itchiness was rather the expression

of cultural distress and adaptation to new living conditions. According to Frighi: "Our society concerns itself very little with the cultural requirements of migrants, and we too, as physicians, often run the risk, with patients from different cultures, of just looking at the somatic expression of health problems, without perceiving the deep psychosocial reasons behind claimed symptoms" A further element which dermatologists are required to deal with in the area of migrant health is different skin colour. Although there are no specific medical conditions for black skin, health practitioners need to pay particular attention, both to diagnosis and treatment. In terms of infectious diseases, scabies is the second most notified infectious disease in migrants after Tuberculosis. In most cases, it is transmitted through direct contact between humans and, like TB, it is related to economic and social distress. As reported by the Observatory on Immigration of the Province of Modena, sporadic cases of scabies in the migrant population grew rapidly between 2000 and 2007, with a peak in 2005 and a gradual decrease in the following years. In 2007, migrants accounted for about 40% of the total reported cases of scabies, of whom the majority came from Africa and Asia. According to *INAIL*; in the work sector, from 2001 to 2005, skin diseases accounted for 26% of illness among working migrants. Like other work-related illnesses and injuries, the risk of dermatitis from exposure to chemical agents is higher when migrant workers work in unsafe conditions.

Mental health

The increase of migration flows in Europe requires to pay greater attention to the problems suffered by migrants not only with regard to physical health, but also mental health. Dealing with mental health in people from different countries and cultures implies, for practitioners, questioning categories of reference such as healthy/sick, organic/functional, and somatic/psychic. Alongside with cultural, social and demographic differences, language barriers make it difficult to correctly assess and diagnose mental disorders in migrants. Diagnostic uncertainty is also associated to differences in symptoms and clinical manifestations in foreign-born subjects as compared to native populations. From the 1960s, the field of *ethno-psychiatry* has made a great contribution on such issues. The term 'Ethno-Psychiatry' was first used by Georges Devereux with the meaning of "...therapeutic technique that gives equal importance to the cultural dimension of a disorder and its manifestation on one side and to the analysis of the functioning of the mind, on the other". The challenge was and still is today to "develop a new multidisciplinary and multicultural knowledge that comes from seeing from above, and in parallel, various cultural systems and hence the various anthropological models and therapeutic know-how, including, but not on the same level, those produced in the western world. We need a know-how that is able to respect and contain differences and particular features and to mediate conflict between the different approaches" (Coppo P.)

Studies carried out on migrants' mental disorders highlight some interesting data, especially when comparing the first generation of migrants settling in host countries and their children (second generation-migrants). It would be logical to expect a higher frequency of mental disorders in members of the first generation of migrants who experience stress associated to the migration process (including, in many cases, traumatic events that involve risking life or physical safety, separation from the family, and a sensation of failure in leaving one's country). However, the data show that second generation migrants report higher rates of mental disorders as compared to first-generation migrants (relative risk around

4.5). In particular, a higher rate of serious psychotic disorders is reported in second-generation migrants; the most plausible hypothesis for the latter, although not confirmed, seems to relate to the tendency to find partners and have children within the close migrant community where there might be higher probability of mixing with other people at higher risk of psychotic disorders.

Another relevant aspect is the relation between migrants' mental health profile and timing of the migration process. Recent studies have showed a greater risk of functional psychic disorders, and anxiety-depression symptoms in individuals who had recently immigrated, while having lived for many years in the host country, as an effect of acculturation and adaptation, was associated with greater ability to express psychic suffering according to the traditional canons of western culture.

An Italian study analyzed the demand for psychiatric treatment in the Lazio region for the year 2002; the study showed that migrants' demand for mental health services accounted for around 2% of total demand for mental health services in an area where the migrant population accounted for 6% of the total population. The difficulties described in previous sections to identify migrants in official statistics and the barriers to health care access faced by the migrant population should be taken into account while interpreting these figures. In the period 2000-2002 demand for psychiatric services almost doubled in the Lazio region, as did the migrant population at the time.

To respond better to the demand for psychiatric care by migrant citizens, greater cultural competence is required in medical and healthcare practitioners and institutions, so that the main social, demographic, and cultural differences of the various migrant communities can be dealt with.

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APPENDIX 3. INTERVIEW GUIDELINES FOR SEMI-STRUCTURED INTERVIEWS

GENERAL INTERVIEW GUIDELINES

General information of the Interviewee
Personal Information (M/F, age, years interviewee has worked for the organization)
Profession/role in the organization?
From what angle can the interviewee contribute to out investigation?

1. Describe the structure/work of the organization and, if applicable, the services it provides
Description of service users (user profiles) and problems commonly experienced by them
How do they get in contact with users?
Quantification of users

2. How is the organization staffed? (i.e. salaried staff, volunteers etc.) Educational background/professional training of staff.

3. Interaction with institutional actors/healthcare providers (vertical level)?
Interaction with other actors (horizontal level)?
Interaction with networks/network membership

4. Describe the key obstacles that hinder the provision of the services under scrutiny. Describe the nature of such obstacles (Structural, legal, financial, cultural, bureaucratic, psychological...)

Specify whether the obstacles listed above apply to the users of the services or the providers of the services.

This part of the interview will be conducted with a view to identifying, more specifically, barriers to healthcare by migrants and homeless persons.

Explore whether such barriers are pre-existing or of recent origin. Have efforts to overcome these barriers been made? If so, are such measures adequate/effective?

From the interviewee's viewpoint, what kind of efforts/measure are required in order to eradicate/mitigate the highlighted problems? (Legislative/organizational/practical measures)? Who should be entrusted with the task of adopting such measures?

1. Are there particular issues/focus areas that warrant further investigation from the interviewee's viewpoint? (i.e. themes or areas which have not been explored in detail so far, but are nonetheless topical)

2. Can the interviewee identify existing good practices? (In different contexts: within the organization itself, other organizations in Italy or abroad)

3. Overall, how does the interviewee evaluate the quality of the service provided? Are there particular achievements which are worthy of note?

4. Data/research/reports which may be useful for our investigation

5. Can the interviewee suggest any contacts?

INTERVIEW GUIDELINES - MEDICAL FIELD

– Identification
– Current occupation: clinical activity (which level)/management (hospital/local health authority)/research activity/ academy (university/other)
– Sector: public (National Health service)/private/NGOs

Clinical activity (i.e. migrants outpatient clinics, infectious diseases departments, health care services for homeless persons etc..)

1. Target population
2. Most frequent diseases
3. Major barriers to heath care ACCESS - in your opinion
4. Major barriers to heath care UTILIZATION - in your opinion
5. Major health education messages which need to be addressed? Are there any differences among different subgroups
6. Are there any communication problems with patients (language/mediation)
7. How is your service integrated with the other regional health care services?
8. Would you agree to share some of your data with us?

MANAGEMENT ACTIVITY (HOSPITAL/LOCAL HEALTH AUTHORITY)/

1. Are there specific services for vulnerable groups? (i.e. migrant population)?
2. Are there specific ongoing activities/campaigns for vulnerable groups? (i.e. migrant population)?
3. How many people are involved in such activities?
4. Budget for such activities
5. For how long have those activities been in existence? Future planning?
6. How is your service integrated with the other regional healthcare services?
7. What would you consider to be major organizational problems?
   What problems can be foreseen for the future?
8. Would you agree to share some of your data with us?

RESEARCH ACTIVITY

1. Which kind of research organization do you work for? (University/local health authority/hospital/private sector)
2. Which are your key research fields? (scientific background)
3. From what sources d you obtain your data? (Surveillance data/ regional registers...)
4. Do you collaborate with public institutions? (regional/local health authorities)
5. Do you collaborate with other research institutions? (multicenter studies)
6. Dissemination and use of your results
7. Would you be interested in collaborating with LDF?

ACADEMIC ACTIVITY (UNIVERSITY/OTHER)

1. Which institution/department do you belong to? (University/ local health authority/hospital/private sector)
2. Do you participate in activities (courses/training/workshops/ seminars) related to LDF's fields of research? (i.e. migration medicine, medical anthropology...)
3. How are those activities organized (i.e. degree courses/masters programmes/conferences/lectures/workshops etc...)
4. How were those activities designed and developed?
5. Target student/participants
6. Funding (sponsors/grants)
7. Educational goals/objectives

APPENDIX 4. MAP OF CITY DISTRICTS IN TURIN[1]

1. **Centro - Crocetta**
2. **Santa Rita – Mirafiori Nord**
3. **San Paolo – Cenisia – Pozzo Strada Cit Turin – Borgata Lesna**
4. **San Donato – Campidoglio - Parella**
5. **Borgo Vittoria – Madonna di Campagna Lucento - Vallette**
6. **Barriera di Milano – Regio Parco – Barca Bertolla – Falchera – Rebaudengo - Villaretto**
7. **Aurora – Vanchiglia – Sassi – Madonna del Pilone**
8. **San Salvario – Cavoretto – Borgo Po**
9. **Nizza Millefonti – Lingotto - Filadelfia**
10. **Mirafiori Sud**

Source: www.comune.torino.it/decentr/