Access to health and how to do it inclusively

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with the support of the Departments n. 3 and n. 9 of the General Directorate for Health Prevention, Italian Ministry of Health
MigFacts: International Migration

244 million international migrants globally in 2015

As the world population grows so does the number of international migrants: there are three times more international migrants in 2015 than in 1970

The international migrant population has remained relatively stable over the last few decades: 2.2 to 3.3 per cent of the world’s population

257.7 M in 2017

3.4% in 2017

https://www.iom.int/
The importance of South-South migration

37% of all international migrants moved between countries in the **Global South**

- North - North: 55.2m
- South - North: 85.3m
- North - South: 13.6m
- South - South: 90.2m
Central America Route

Southeast Asian Route

Mediterranean sea Route

SOURCES: Missing Migrants Project, IOM

SOURCES: Missing Migrants Project, IOM

SOURCES: Missing Migrants Project, IOM; UNHCR; i-Map; Regional Mixed Migration Secretariat

https://migrationdataportal.org/?i=stock_abs &t=2017
Fig. 1. International migrants by region of residence, 2015

68.5 million forcibly displaced people worldwide

Internally Displaced People
40 million

Refugees
25.4 million
10.0 million under UNHCR mandate
5.1 million Palestinian refugees registered by UNRWA

Asylum-seekers
3.1 million

Where the world’s displaced people are being hosted

85% of the world’s displaced people are in developing countries

57% of refugees worldwide came from three countries

South Sudan 2.4m
Afghanistan 2.6m
Syria 6.3m

Top refugee-hosting countries

Islamic Republic of Iran 979,400
Lebanon 1.0m
Pakistan 1.4m
Uganda 1.4m
Turkey 3.5m

10 million stateless people

102,800 Refugees resettled

44,400 people a day forced to flee their homes because of conflict and persecution

We are funded almost entirely by voluntary contributions, with 87 per cent from governments and the European Union and 10 per cent from private donors

11,517 staff
UNHCR employs 11,517 staff (as of 31 May 2018)

128 countries
We work in 128 countries (as of 31 May 2018)
Complex drivers of migration: macro-, meso- and micro-factors

- **Political**
  - Conflict, insecurity
  - Discrimination
  - Persecution

- **Environmental**
  - Exposure to hazard
  - Food/water security
  - Energy security
  - Land productivity

- **Demographic**
  - Population density
  - Population structure
  - Diseases prevalence

- **Social**
  - Seeking education
  - Family obligations

- **Economic**
  - Job opportunities
  - Income
  - Producer/consumer prices

- **Obstacles/facilitators**
  - Political/legal framework
  - Social networks/diasporic links
  - Cost of moving
  - Technology

- **Individual characteristics**
  - Age, sex, ethnicity
  - Education, wealth
  - Marital status
  - Religion, language

Objectives of the talk

• Review the Italian response to the migrant surge over the past few years

• Describe the Italian model of provision of health care to new migrants
Previous refugee crises in Italy

Brindisi, 1991

Lampedusa, 2011
The Dublin Treaty

• The **Dublin III Regulation** (No. 604/2013) was approved in June 2013, replacing the Dublin II Regulation, and applies to all member states except Denmark. It came into force on 19 July 2013. It is based on the same principle as the previous two i.e. that the first Member State where finger prints are stored or an asylum claim is lodged is responsible for a person's asylum claim.

• In July 2017, the **European Court of Justice** upheld the Dublin Regulation declaring it still stands despite the high influx of 2015, giving EU member states the right to **deport** migrants to the first country of entry to the EU.
Migrants’ relocation to other European Countries

- From Italy: 12,614
- From Greece: 63,302

Pledged: 34,953
Done (as at April 2018): 21,999

Dati: Commissione europea.

ISPI Fact Checking - Migrazioni 2018
Current migrant crisis: 2014-2018

Sea arrivals in 2018

6,163
Last updated 29 Mar 2018

Most common nationalities of sea arrivals (since 1 January 2017)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Source</th>
<th>Data date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>15.6%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Guinea</td>
<td>8.3%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>8.2%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>7.6%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Eritrea</td>
<td>7.0%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Mali</td>
<td>6.1%</td>
<td>28 Feb 2018</td>
</tr>
<tr>
<td>Tunisia</td>
<td>6.1%</td>
<td>28 Feb 2018</td>
</tr>
</tbody>
</table>

Sea arrivals by month

1. Change in Italian policy towards migrants
2. Degradating political situation in Libya

Italian Ministry of Interior, data at 31st August 2018
Unaccompanied children

Italian Ministry of Interior, data at 31st August 2018
Asylum request

Expulsion

Repatriation In 7 days
2014: the first contingency plan in Sicily

Sicily presents the first contingency plan in the European Region to address the public health needs of large immigration

29-05-2014

Sicily has become the pioneer in the WHO European Region in the development of an operational strategy to respond to the public health implications of sudden and large arrivals of immigrants. This document has been produced by the regional health authorities of Sicily, with the technical assistance of the WHO/Europe project Public Health Aspects of Migration in Europe. During its launch, the Councillor of Health of Sicily, Lucia Borsellino, described the contingency plan as the region’s response to the “ethical duty to take care of migrants’ health, just as we do with the health of the rest of our citizens”.
Contingency plan in Sicily: medical triage

On board (NGOs, Italian Navy Ships)

1) Mandatory Medical report

Prior to landing (USMAF: maritime, air and border health office)

2) Authorization for landing

8.5.1. Medical triage.

Upon arrival at the port or, at the most, immediately after entry to the Hotspot, all medical triage activities should be performed in order to identify the persons who require specific medical care or are already obviously vulnerable in this first phase.

Medical staff are present on board rescue boats. In agreement with the USMAF (Maritime, Air and Border Health Office), it is mandatory to send the medical report to the health authorities before the rescue boat arrival in the designated port.

A rapid check of the presence of infective diseases is performed at the place of landing, and the suitability of disembarked persons for going ashore is verified. Only after such verification, individuals are allowed to leave the boat. Following this preliminary medical screening, priority in disembarkation is given to persons with specific needs.

In any case, a rapid medical screening should be performed prior to arrival if: a) they board a vehicle to the Hotspot; b) they enter the Hotspot.

In any case, the presence of medical personnel is guaranteed in the Hotspot 24 hours a day, 7 days a week.
GUIDED SCREENING

DATA COLLECTION: 17 screening items, with questions and answers (YES/NO) with free text note pad if YES

PERSONAL DATA

Name
Last name
Date of Birth
Country of Origin
Gender
Married
Age
Height
Weight
State condition

PATOLOGIE

Disease/Pathology

Apparato respiratorio
Breathing Apparatus

Apparato digerente
Digestive System

Apparato cardiocirculatorio
Cardiovascular System

Sistema nervoso e degli organi di senso
Central Nervous System

Apparato osteoarticolare
Skeletal System

Apparato urogenitale
Urogenital System

Sistema endocrino - Diabete Mellito
Endocrine System

Patologie psichiche
Psychological Illnesses
DATA ACCURACY IMPROVEMENT

INJURIES AND CUTANEOUS MANIFESTATIONS

- Hurt
- Fracture
- Burn
- Lacerations/Abrasions
- Cutaneous Manifestations
- Amputation

CANCEL

TAKE A PICTURE

SAVE
Contingency plan in Sicily: medical triage

On board (NGOs, Italian Navy Ships)

1) Mandatory Medical report

Prior to landing (USMAF: maritime, air and border health office)

2) Authorization for landing

3) At the port (Local Health Service, IRC: Italian Red Cross)

4) Transfer (hospital or reception centres)

B.5.1. Medical triage.

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In any case, a rapid medical screening should be performed prior to arrival if: a) they board a vehicle to the Hotspot; b) they enter the Hotspot.

In any case, the presence of medical personnel is guaranteed in the Hotspot 24 hours a day, 7 days a week.

## Medical screening at landing

**AUGUST 2013 – DECEMBER 2017**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Numero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scabies</td>
<td>43.800</td>
</tr>
<tr>
<td>Obstetric-gynaecological problems</td>
<td>4.210</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>2.865</td>
</tr>
<tr>
<td>Traumas and wounds</td>
<td>1.771</td>
</tr>
<tr>
<td>Dispneas of unknown origin</td>
<td>929</td>
</tr>
<tr>
<td>Fever of unknown origin</td>
<td>719</td>
</tr>
<tr>
<td>Ortopedical conditions</td>
<td>500</td>
</tr>
<tr>
<td>Dermatological conditions</td>
<td>469</td>
</tr>
<tr>
<td>Infections</td>
<td>442</td>
</tr>
<tr>
<td>Dehydration</td>
<td>418</td>
</tr>
<tr>
<td>Pediatric illnesses</td>
<td>144</td>
</tr>
<tr>
<td>Neurological conditions</td>
<td>86</td>
</tr>
<tr>
<td>Surgical emergencies</td>
<td>67</td>
</tr>
<tr>
<td>Other</td>
<td>63</td>
</tr>
<tr>
<td><strong>TOTALE</strong></td>
<td><strong>56.483</strong></td>
</tr>
</tbody>
</table>
## Death in the sea

**Dead bodies found on boats**

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>N. bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>10th August 2013 – 31st December 2017</td>
<td>1,035</td>
</tr>
</tbody>
</table>

*Attività di sorveglianza sanitaria sui flussi migratori, Ufficio 3, DG Prevenzione Sanitaria, dati al 31/12/2017*
The arrival by sea
Regional relocation of migrants in Italy

Tot.: 155,619

Italian Ministry of Interior, data at 31st August 2018
Asylum request:

- Refugee status
- International protection
- Humanitarian permits

Asylum request:

- Expulsion
- Repatriation (In 7 days)
Syndromic surveillance in (first) reception centres

Ministero della Salute
DIPARTIMENTO DELLA COMUNICAZIONE E PREVENZIONE
DIREZIONE GENERALE DELLA PREVENZIONE SANITARIA
UFFICIO V

Oggetto: Protocollo operativo per la sorveglianza sindromica e la profilassi immunitaria in relazione alla emergenza immigrati dall’Africa settentrionale.
The surveillance system started operating on 11 April 2011. A total of 13 syndromes were defined as potentially indicative of infectious diseases and/or unusual adverse health events. Aimed at ensuring uniform and timely epidemiological surveillance: notification to be sent within 24 hours (10:00 A.M. of the day after the evaluation). This syndromic surveillance system complements, but does not substitute for, the existing mandatory infectious disease notification system. A total of 13 syndromes were defined as potentially indicative of infectious diseases and/or unusual adverse health events. The surveillance system started operating on 11 April 2011.
### Syndromes

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Case definition</th>
</tr>
</thead>
</table>
| Respiratory tract disease | Fever (≥38 °C) and at least one of the following:  
- cough  
- sore throat  
- pharyngitis  
- bronchitis  
- pneumonia  
- bronchiolitis  
- chest rales  
- breathing difficulties  
- bloody sputum  
- lung infiltrates on X-ray |
| Tuberculosis (suspected) | Productive cough lasting more than 3 weeks  
- Low-grade evening fever  
- Night sweats  
- Weakness, AN  
- Weight loss in the last 3 months |
| Bloody diarrhoea | Blood in stool and at least one of the following:  
- Frequent diarrhoea (at least 3 loose stools a day)  
- Mucus or purulent material in the stool  
- Abdominal pain  
- Gastroenteritis with vomiting |
| Watery diarrhoea | At least one of the following:  
- Frequent watery diarrhoea (at least 3 loose stools a day)  
- Abdominal pain  
- Gastroenteritis  
- Vomiting |
| Rash and fever | Fever (≥38 °C) OR Clinical diagnosis of measles, rubella, varicella, erythema infectiousum (fifth disease) OR exanthema subitum (sixth disease, roseola infantum) |
| Measles, encephalitis or encephalopathy/delirium | Fever (≥38 °C) and at least one of the following:  
- Meningitis  
- Encephalitis  
- OR one of the following:  
- Confusion  
- Delirium  
- Altered consciousness |
| Lymphadenitis with fever | Fever (≥38 °C) and at least one of the following:  
- Enlarged lymph nodes  
- Lymphadenopathy  
- Lymphadenitis |
| Botulism-like illness | Absence of known chronic conditions causing the syndrome (e.g., myasthenia gravis, multiple sclerosis) and at least one of the following:  
- Paralysis or paresis of cranial nerves  
- Ptosis  
- Blurred vision  
- Double vision (diplopia)  
- Speech impediments (dysphonia, dysarthria, dysphagia)  
- Descending paralysis  
- OR  
- Diagnosed or suspected botulism |
| Sepsis (with or without shock) or unexplained shock | At least one of the following:  
- Sepsis  
- Septic shock  
- Severe hypotension unresponsive to medical treatment  
- AND absence of the following conditions: congestive heart failure, acute myocardial infarction or trauma causing the syndrome |
| Haemorrhagic illness | Fever (≥38 °C) and at least one of the following:  
- Haemorrhagic rash  
- Haemorrhagic exanthema |
| Acute jaundice | - Jaundice  
- Fever (≥38 °C)  
- Headache  
- Malaise  
- Myalgia  
- Enlarged liver (hepatomegaly) with or without rash, AN  
- Exclusion of chronic or alcoholic liver disease |
| Parasitic skin infection | Skin lesions caused by scratching  
- Papules, vesicles or small linear burrow tracks, AN  
- Presence of parasites |
| Unexplained death | Death of unknown cause |

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A Lasting more than 3 weeks but less than one month  
B Cases presenting with primary gastrointestinal bleeding, for example due to an ulcer, should be excluded  
C Cases do acute leukaemia should be excluded

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Ministry’s Circular n. DGPRE.V/8636 7th April 2011  
Syndromic surveillance: working principles

For each syndrome, the Observed Daily Incidence (ODI) is calculated by dividing the n. of daily cases observed in the reporting immigration centres by the n. of migrants present that same day.

The moving average of the previous 7 days incidence is used to define each syndromes’ Expected Daily Incidence (EDI).

The EDI of each syndrome is measured against a threshold set at 99% confidence interval (99% CI) of the ODI using a Poisson distribution.

A statistical alert is automatically triggered when the EDI falls outside this threshold. Statistical alerts are considered valid only when the EDI falls below the ODI (i.e., when the observed incidence was higher than expected).

A statistical alarm is issued whenever valid statistical alerts are triggered on the same syndrome for at least two consecutive days.

Asylum request

Expulsion

Repatriation
In 7 days

Refugee status: ~ 7%
International protection: ~ 15%
Humanitarian permits: ~ 25%

CAS = Centri di Accoglienza Straordinaria
Centres for Extraordinary Hospitality

SPRAR = Sistema di Protezione per Richiedenti Asilo e Rifugiati
Protection System for Refugees and Asylum Seekers
A progressive approach according to the specific stage of reception: initial evaluation on arrival, followed by a medical examination in the first reception facility, and a full taking in charge of the individual and their pathologies at the second reception level.

Consider both communicable and non communicable diseases, as well as non pathological conditions (pregnancy) and vaccination.

Infectious diseases evaluated: tuberculosis, malaria, hepatitis B and C, HIV, sexually transmitted diseases, intestinal parasites.
Vaccine-preventable diseases

Immunization has to be administered after psychological and physical stabilization (minimum 8 days after landing), or even later, following clinical decision

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unvaccinated</td>
<td>Administer vaccines per age following current Italian National Immunisation Program</td>
</tr>
<tr>
<td>Documented immunization in country of origin</td>
<td>Complete immunization schedule following current Italian National Immunization Program</td>
</tr>
<tr>
<td>Unknown or doubt</td>
<td>Follow current Italian Immunization Program avoiding to exceed the established maximum number of doses for tetanus</td>
</tr>
</tbody>
</table>

*In case of expected long term resettlement vaccine administration is to be completed*

Vaccine-preventable diseases:
Poliomyelitis

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown or doubt Poliovirus</td>
<td>Immunization with at least one dose</td>
</tr>
<tr>
<td>immunization</td>
<td></td>
</tr>
<tr>
<td>Unvaccinated against poliomyelitis</td>
<td>Complete immunization schedule (two doses)</td>
</tr>
</tbody>
</table>

Environmental surveillance aimed at the possible identification of poliovirus in the sewage discharges of the major reception centers for migrants in the Sicilian territory
## Screening for tuberculosis

**Active disease finding should start early, since landing, and should continue at each reception stage (GRADE A)**

- Provide migrant-friendly sanitary education on TB symptoms and way of transmission since the first medical contact, avoiding language and cultural barriers (GRADE A)
- Guarantee a rapid, free-of-charge treatment, and continuity of care in all confirmed TB cases, even in case of transfer (GRADE A)
- Screening using chest X ray and/or microbiological screening in asymptomatic migrants is not recommended (GRADE B)
- If cough > 2 weeks is present provide chest X ray; if not available provide molecular rapid test and isolation (GRADE B)

http://www.salute.gov.it/imgs/C_17_pubblicazioni_2624_allegato.pdf
Screening for active TB by Chest X ray: cost-effectiveness

The yield of detecting active TB through CXR screening of migrants was heterogeneous, but consistently increased with higher TB incidence in the country of origin.

- CXR is a sensitive screening tool to detect active TB but must be confirmed with a sputum culture.

- Limited evidence on screening migrants for active TB suggests that it is cost-effective to screen high-risk groups and migrants originating from counties with intermediate (>60/100,000) and high (>100/100,000) TB incidence.

<table>
<thead>
<tr>
<th>TB prevalence at country of origin/100,000</th>
<th>Yield of culture confirmed active TB /100,000*</th>
<th>95%CI</th>
<th>NNS</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-149</td>
<td>19.7</td>
<td>10.3-31.6</td>
<td>5076</td>
<td>3175-9709</td>
</tr>
<tr>
<td>150-249</td>
<td>166.2</td>
<td>140-194</td>
<td>602</td>
<td>514-714</td>
</tr>
<tr>
<td>250-349</td>
<td>133.5</td>
<td>111-158</td>
<td>749</td>
<td>631-903</td>
</tr>
<tr>
<td>&gt;350</td>
<td>335.9</td>
<td>283-393</td>
<td>298</td>
<td>254-353</td>
</tr>
</tbody>
</table>

*The yield of active TB detection in pre-arrival CXR screening programmes for migrants by TB incidence in country of origin from Aldridge et al

## Screening for LTBI

Screening by TST or IGRA (particularly in people previously vaccinated) is recommended in migrants coming from countries with estimated TB incidence >100/100,000 if a long resettlement (minimum 6 months) is expected (GRADE A)

<table>
<thead>
<tr>
<th>In children under 5 years TST is recommended (GRADE A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If TST &gt; 10 mm or IGRA positivity exclude active TB by chest X ray (and other diagnostic tools); consider TST &gt; 5 mm in severe malnutrition or HIV positivity (GRADE A)</td>
</tr>
<tr>
<td>Offer treatment for LTBI to all positive subjects (GRADE A)</td>
</tr>
</tbody>
</table>

http://www.salute.gov.it/imgs/C_17_pubblicazioni_2624_allegato.pdf
Screening for HIV, HBV and HCV

- Screening in asymptomatic migrants for HIV (age ≥ 16 years), HBV and HCV is recommended according to the estimated prevalence in country of origin (HIV>1%, HBsAg>2% and HCV>3%) (GRADE A)

- During pregnancy (HIV-HBV) or if presence of risk factors (HBV-HCV and HIV, including age <16 years) (GRADE A)

- Guarantee adequate counselling for HIV and AIDS (avoiding language and cultural barriers by the presence of mediators) to all migrants (GRADE A)

- Refer all subjects with confirmed infection to specialized centre (GRADE A)
Screening for malaria

- Pro-active evaluation of signs/symptoms suggestive in migrants coming from or crossing endemic countries (GRADE A);

- Provide tempestively emoscopy or (if not available) rapid diagnostic test in symptomatic migrants since landing or first reception centres (GRADE A);

- Refer to specialized centres confirmed cases of malaria, especially in case of *P. falciparum* (GRADE A)

- Evaluate the presence of splenomegaly and/or thrombocytopenia in asymptomatic migrants (GRADE B)
### Table 1: Summary of country of origin, number of cases included, 18S NASBA positive cases and gametocyte carriers

<table>
<thead>
<tr>
<th>Country</th>
<th>Total number of cases included in the study</th>
<th>Total number of 18S NASBA positive cases from the respective country</th>
<th>Gametocyte carriers as assessed by Pfs25 NASBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ivory Coast – West Africa</td>
<td>14</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Togo – West Africa</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guinea – West Africa</td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Somalia – East Africa</td>
<td>37</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia – East Africa</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eritrea – East Africa</td>
<td>63</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Ghana – West Africa</td>
<td>20</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Nigeria – Central Africa</td>
<td>17</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Burkina Faso – West Africa</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mali – West Africa</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cameroon – Central Africa</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liberia – West Africa</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Gambia – West Africa</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Chad – Central Africa</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senegal – West Africa</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sudan – East Africa</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Congo – Central Africa</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195</strong></td>
<td><strong>62</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>
Asylum request

Expulsion

Repatriation
In 7 days

Refugee status: ~ 7%
International protection: ~ 15%
Humanitarian permits: ~ 25%

Same health care rights as Italian nationals → NHS

Asylum is granted

Asylum is denied

Repatriation
Undocumented
“The Republic protects health as a fundamental right of the individual and in the interest of the community, and guarantees free care to the poor”
Undocumented migrants

- a) the social protection of *pregnancy and motherhood*, at the same level of Italian female citizens;
- b) the protection of *children’s health*, as for the Declaration of the Rights of the Child. They must be registered at the Italian NHS;
- c) outpatient and inpatient *urgent or «essential» care*, even long-term, needed because of disease or accident;
- d) Preventive care for the protection of individual and community health:
  - Inclusion in vaccine programmes
  - prophylaxis, diagnosis and *cure for infectious diseases*
  - cure, prevention and rehabilitation of *drug addiction*

**STP code**

STP = temporarily present foreigner
Special issues

1) Unaccompanied Minors
Demographic of Arrivals, Including Accompanied, Unaccompanied and Separated Children

Greece
- Women: 41%
- Men: 37%
- Children: 13%
- UASC: 87%
- Accompanied: 1,458

Italy
- Women: 74%
- Men: 15%
- Children: 11%
- UASC: 91%
- Accompanied: 15,779

Spain
- Women: 77%
- Men: 23%
- Children: 14%
- UASC: 63%
- Accompanied: 2,426

Bulgaria
- Women: 59%
- Men: 31%
- Children: 24%
- UASC: 73%
- Accompanied: 195

Gender Breakdown of All Children by Country of Arrival

Overall, the proportion of boys compared to girls among arrivals remains higher (on average 4 boys for every 1 girl).

Greece
- Boys: 58%
- Girls: 42%

Italy
- Boys: 93%
- Girls: 7%

Spain
- Boys: 82%
- Girls: 18%

Bulgaria
- Boys: 67%
- Girls: 33%

Source: UNHCR, UNICEF, TOM, Ministry of Interior, Bulgarian State Agency for Refugees, Bulgarian Labour and Social Policy Ministry, Spanish Ministry of Interior
Italy - Unaccompanied and Separated Children (UASC) Dashboard

Between 1 January and 31 March 2018, 1,163 children arrived in Italy by sea, of whom 927 were unaccompanied and separated children (UASC). UASC arrival numbers in the first three months of 2018 dropped by 73%, compared to the same period last year. So far in 2018, UASC represent 15% of all sea arrivals.

UASC and accompanied children sea arrivals trend, 2017 and 2018

UASC and accompanied children: sea arrivals to Italy

Most common nationalities in 2016
What is Italy doing to help the Unaccompanied Minor Refugees?

Fundamental rights:

1. **need for protection** from abuse, exploitation and neglect;
2. importance of the **physical and intellectual development** of the child;
3. **role of the family** in providing care to the child;
4. special protection needs of children deprived of their family environment and those of asylum-seeking and refugee children.

*UN Declaration on the Rights of the Child - New York 1989*
The first national Law passed in Europe regarding UAMs

Provisions on measures to protect unaccompanied foreign minors.
Pillars of Law 47/2017

- Definition of UAM;
- Prohibition of refoulement at the border;
- Organic system of connection between first and second reception facilities;
- Identification and age assessment in case of uncertainty;
- Social folder and right of being listened to;
- Registers of i) voluntary tutors and 2) families available for foster care;
- Right to education, health and legal assistance
Social interview and folder (Art. 5 & 9)

• Following the social interview, the qualified staff of the reception facility (social services and cultural mediator) fills out a specific social folder, highlighting elements useful towards the determination of the best long-term solution taking into consideration UAM’s best interest. The folder is then sent to the social services belonging to the Municipality of destination and to the Public Prosecutor's Office at the Juvenile Court.
Age assessment in case of uncertainty (art. 5)

Multidisciplinary procedure:
1. social interview
2. psychological or neuropsychiatric evaluation
3. auxological assessment
Voluntary Tutors (art. 11)

He/She is "the person who, freely and voluntarily, not only wants to and is able to legally represent an unaccompanied foreign minor, but is also a motivated and sensitive person, attentive to the relationship with the child, capable of understanding their needs and problems”

As at April 6th 2018, as many as 4,000 Italian citizens have voluntarily applied to act as Tutors (60% women, aged 40-50 yrs, mainly holding a university degree)
Special issues

2) Torture victims
DECRETO 3 aprile 2017.

Linee guida per la programmazione degli interventi di assistenza e riabilitazione nonché per il trattamento dei disturbi psichici dei titolari dello status di rifugiato e dello status di protezione sussidiaria che hanno subito torture, stupri o altre forme gravi di violenza psicologica, fisica o sessuale.
Three levels for an early identification

1. **Level 1)** participation of non-healthcare personnel to support the identification, based on what has come to light spontaneously, through analysis or through active and organized listening.

2. **Level 2)**: conversation with psychological health personnel of hosting structure, also with specific instruments to evaluate the level of vulnerability.

3. **Level 3)**: NHS personnel with specialized proficiency in multidisciplinary integrated paths, that allow an accurate clinical-diagnostic evaluation and an adequate taking charge.
Next steps

1. The SAVE Project - Support Actions for Vulnerability emergence – at hotspots

2. The FOOTPRINTS Project – Training of Regional Plan Managers (Capacity building)

3. The I-CARE Project (Integration and Community Care for Asylum and Refugees in Emergency)
“... when you, doctors, consult us in your hospitals ... do you see only our body or our souls too?”

“... you doctors hear us, but you do not listen to us. It is different....”

Birame, 25 yrs old, Senegal

BRIEF COMMUNICATIONS

Dead Blood under My Skin

Issa El-Hamad, MD, a Carmelo Scarcella, MD, b Maria Chiara Pezzoli, MD, PhD, c Antonella Ricci, MD, c and Francesco Castelli, MD, c for the Migration Health Committee of the ISTM

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The diagnostic attitude of western physicians toward migrants' complains is often an unstable balance between the obstinate search for exotic tropical diseases and the overappreciation of the cultural dimensions of symptoms. Such attitude may divert attention from organic diseases. The careful assessment of all levels of possible misunderstandings (prelinguistic, linguistic, interlinguistic, cultural, and intercultural) may help the physician to discriminate between illness and disease. The long and difficult itinerary leading to the correct diagnosis of congenital myopathy in a migrant from Senegal is described, together with the barriers encountered by the caring staff.
• Health is a **fundamental right** of each person
• Italy recognizes the **right of asylum**
• Regular migrants, asylum seekers, refugees and international protection holders are **registered with the NHS** (L.142/2015).
• Non-documentated migrants are entitled to **access preventive, urgent and essential treatments as well as treatment for public health reasons** (*STP code*).
• MoH operates **during SAR operations at sea** on Coastguard and Navy vessels and on arrival general triage, syndromic screening, medical assessment and referral to LHA second level services are performed.
• **Minors and non accompanied minors** are entitled to special assistance and protection.
Health care for migrants in Italy: the critical issues

• Conflict with NGO rescue vessels operating outside territorial waters
• Heterogenous implementation of national laws by Regions
• Bureaucratic and administrative barriers to access to care
• Cultural and religious peculiarities of migrants’ communities
• Linguistic barriers
• Poor knowledge of their rights by migrants
• Poor social network
• Possible discrimination at access to care
• New stricter legislation coming soon ...

Refugee status: ~ 7%
International protection: ~ 15%
Humanitarian permits: ~ 25%
Conclusions

• Italy, together with Greece, has beared the highest burden of migrants entering Europe in the last 5 years

• Good news:
  • The health system was capable to offer health care to migrants (Art. 32 Constitution)
  • No epidemics occurred
  • No introduction of diseases was noted

• Bad news
  • Policy → implementation gap
  • Screening for non communicable diseases has been advocated only recently
  • The health information system still needs amelioration (E-detect)
  • A large proportion of migrants who were denied asylum disappear from the system
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