Barriers to Health Care Services Among Migrants in Italy and Grass-Root Access-Enabling Initiatives

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Introduction

The concept of health as a fundamental individual right is enshrined in Article 32 of the Italian constitution. Consequently, any foreigner present in Italy, regardless of his or her status, is entitled to access public health services.

This entitlement is implemented through numerous regional and local regulations. Nevertheless, health services provided to migrants mostly adopt an assimilation model rather than a multicultural or multi-ethnic one. This means that migrants are generally expected to autonomously use national health services with programmes facilitating access and acceptability implemented on an *ad hoc* basis. This approach has caused formal (administrative) and informal (linguistic, cultural, psychological) access barriers to community-level health services in Italy.

Methods

Between 1st April and 13th June 2011, all Italian Regions and Autonomous Provinces were asked to submit a list of successful access-enabling experiences in the field of primary prevention addressing migrants. Experiences were also collected through scientific databases (namely PubMED) and grey literature. The following inclusion criteria were adopted: initiatives had to be implemented at the local level, had to target medium/long term resident foreigners in Italy (regardless of status) and had to be aimed at enhancing access to vaccination services. The initiatives have been classified into three categories: 1. activities to improve access to existing public health services, 2. ad hoc actions targeting vulnerable populations and 3. complementary activities aimed at bridging the gap between beneficiaries and public health services.

Table: – Access-enabling local initiatives by type of intervention

TYPE OF INTERVENTION	N.	LOCATION	TRANSLATED INFORMATION MATERIALS	TEMPORARY ACTIONS	CULTURAL MEDIAT. SERVICES	TRAINING	MONITORING
Activities to improve access to existing public health services	12	7 different regions: - 4 North - 1 Centre - 2 South and Islands	12 (100%) – up to 18 languages.	2 (17%)	6 (50%)	7 (58%)	3 (25%)
Ad hoc actions targeting vulnerable populations	4	4 different regions: - 0 North - 1 Centre - 3 South and Islands	2 (50%)	3 (75%)	4 (100%)	1 (25%)	1 (25%)
Complementary activities aimed at bridging the gap between beneficiaries and public health services	5	3 different regions: - 1 North - 1 Centre - 1 South and Islands	5 (100%)	2 (40%)	4 (80%)	1 (20%)	2 (40%)
Total	21	9 different regions: - 4 North - 2 Centre - 3 South and Islands	19 (90%)	7 (33%)	14 (67%)	9 (43%)	6 (29%)

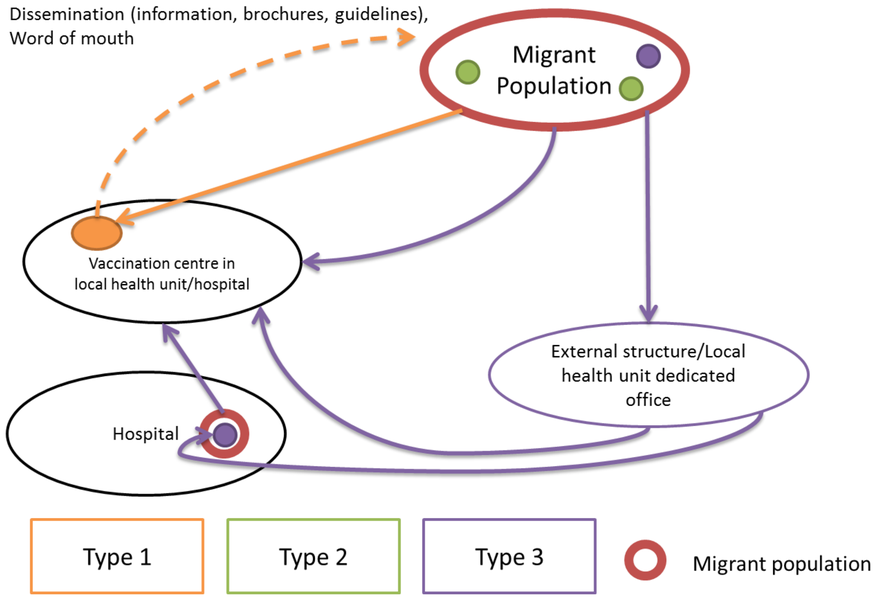

Figure: – Models of intervention by type of initiative

Results

Twenty-one initiatives were collected from nine Italian Regions (Table). All the initiatives were community-based except two that involved residents of asylum seeker centres.

Three type-1 initiatives focused only on vaccination, the rest facilitated a broader access to public health services. Eighty-three per cent took place within local health units, the rest were based in hospitals. Type-2 and type-3 initiatives were implemented within foreign communities, in external structures or in dedicated offices inside local health units. Most type-2 initiatives were *ad hoc* vaccination campaigns while type three activities focussed on bridging the gap between public health services and beneficiaries (Figure).

Conclusions

The range and diversity of the initiatives identified, outline marked local health and social mobilization. Interestingly, most initiatives were continuous rather than temporary actions. The fact that, albeit fragmented, they mostly took place within the public health sector probably explains their apparent sustainability. Most initiatives focussed on the production of translated information materials (90%) and the provision of mediation services (67%), whereas embedded training initiatives proved less common. This study provided a preliminary outline of the types of initiatives taking place at the local level in Italian Regions to promote access of migrants to primary prevention services. It also confirmed a general lack of monitoring in this field. Quality evaluation frameworks need to be developed in order to fill this gap and identify the most effective access-enabling strategies and models that could be replicated in comparable local contexts.

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FACTS BEYOND FIGURES
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