

Title of the contribution:

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

Authors' names and affiliations:

Flavia Riccardo¹, Maria Grazia Dente¹, Chiara Somaruga², Claudio Colosio², Dolores Forgione³, Sergio Babudieri³, Laura Elena Pacifici⁴, Lorenza Ferrara⁵, Alba Carola Finarelli⁶, Maria Grazia Pascucci⁶, Lorenzo Antonio Surace⁷, Cinzia Germinario⁸, Aldo Palumbo⁹, Gloria Nacca¹, Silvia Declich¹

1. Istituto Superiore di Sanità (ISS National Institute of Health), National Centre for Epidemiology, Surveillance and Health Promotion. Rome, Italy
2. Department of Occupational and Environmental Health of the University of Milan, S. Paolo Hospital Unit and International Centre for Rural Health. Milan, Italy
3. Università degli Studi di Sassari, Istituto di Malattie Infettive. Sassari, Italy
4. Italian Red Cross Health Department, Rome, Italy
5. Servizio di riferimento Regionale di Epidemiologia per la sorveglianza, la prevenzione e il controllo delle Malattie Infettive (SeREMI) - ASL AL. Alessandria, Italy
6. Servizio Sanità Pubblica - Assessorato Politiche per la Salute - Regione Emilia-Romagna. Bologna, Italy
7. Coordinatore Centro Medicina del Viaggiatore e delle Migrazioni - ASP di Catanzaro. Catanzaro, Italy
8. DIMO Università degli Studi di Bari. Osservatorio Epidemiologico Regionale – Puglia. Bari, Italy
9. Unità Organizzativa Governo della Prevenzione e Tutela Sanitaria, Regione Lombardia. Milan, Italy

Contact person: Dr Flavia Riccardo - National Institute of Health, Unit of Communicable Disease Epidemiology Via Regina Elena, 299, 99161 Rome (Italy). Telephone 0039 06 4990 4322; Mobile 0039 329 345 6662 email flavia.riccardo@iss.it

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Like in other European countries, migrants in Italy are a very diverse population comprising regular economic migrants, asylum seekers/refugees and irregular migrants.

The number of foreigners regularly residing in Italy has been increasing steadily over the years. As of the beginning of January 2011, there were over 4.5 million regular migrants in the country (7.5% of total residents)¹ mostly concentrated in the northern and central Regions². As a consequence of the North Africa Crisis of 2011, Italy has also experienced a sharp increase in the number of asylum claims, making it the 8th country of asylum in the world³. The number of foreigners irregularly present in Italy is uncertain, with recent estimates ranging between 500.000 and 800.000 nation-wide^{4,5}.

The concept of health as a fundamental individual right is enshrined in Article 32 of the Italian constitution⁶. Consequently, any foreigner present in Italy, regardless of his or her status, is entitled to access public health services⁷. This entitlement is implemented through numerous regional and local regulations⁸. Nevertheless, health services provided to migrants mostly adopt an assimilation model rather than a multicultural or multi-ethnic one⁹. This means that migrants are generally expected to autonomously use national health services. Specific programmes facilitating access and acceptability are therefore 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^{10, 11}. Particularly affected areas are health promotion and preventive care.

Migrants in Italy reside either alongside local communities (regular migrants and irregular migrants that have eluded border controls) or in dedicated migration centres (asylum seekers and irregular migrants pending repatriation).

At community level, migrants' difficulties in accessing public health services have been identified as due to bureaucratic, cultural and information barriers¹². This translates in a greater use of emergency hospital services among migrants compared with the Italian population¹³. This health care utilization profile is a source of concern as it suggests that migrants might not access prevention and promotion services and lack treatment continuity.

Internal self-managed outpatient services are provided in migration centres. This health care supply has been described as generally insufficient and reactive. Critical areas include poor contacts with the National Health System and the absence of homogeneous criteria for systematic health data collection and for monitoring/evaluation¹⁴. The overall picture suggests an underestimation of the relevance of follow-up treatments, health education and preventive care.

In the absence of a common health policy approach to the provision of health care services based on multicultural and multi-ethnic models, particularly in the field of prevention, local grass-root initiatives have emerged across Italy both at community and migration centre levels. However, successful strategies adopted to improve access to public health services have little visibility outside the context in which they have developed. In addition, assessing such experiences proves difficult owing to the absence of a systematic monitoring and evaluation system.

Against this background, the identification of access-enabling best practices could prove extremely useful. Health authorities could select existing initiatives liable to be successful in other local contexts or to be extended at regional or multiregional level, thus streamlining available resources.

This abstract presents a survey of emerging local access-enabling strategies at community level in Italy specifically focussing on primary prevention. The aim of this preliminary analysis is to explore grass-root initiatives that have emerged in Italy as a starting point to develop monitoring and evaluation tools.

Methods and procedures:

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.

Sources of reference: Italian regional public health authorities, published data.

Data used with particular regard to quality: a standardized data collection form was sent to all Italian Regions and Autonomous Provinces to survey relevant access-enabling initiatives targeting migrants. If data were available from

literature, data forms were compiled based on available publications and, when possible, compared with the authors of the papers/reports.

Results obtained:

As shown in Table 1, 21 initiatives were collected from nine Italian Regions. All the initiatives collected were community-based except two. The first described a catch-up vaccination campaign among residents of an asylum seeker centre in Apulia and the second presented a management model for health care delivery within an asylum seeker centre¹⁵ integrating curative health services and primary prevention with the National Health System.

Among type-1 initiatives, three focused only on vaccination. The rest also facilitated a broader access to public health services. Eighty-three per cent took place within local health units, the others in hospitals. Three out of four type-2 initiatives were *ad hoc* vaccination campaigns (involving residents in Roma-Sinti camps, seasonal workers and asylum seekers). The fourth was a dedicated health centre with mobilization activities in Roma-Sinti communities. Five activities focussed on bridging the gap between public health services and beneficiaries, all except one were community-based.

Table 1 – Access-enabling local initiatives by type of intervention

Type of intervention	N.	Location	Translated information materials (guides/leaflets)	Temporary actions	Cultural mediation 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%)
<i>Ad hoc</i> 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%)

As shown in Figure 1, type-1 initiatives were aimed at increasing the access of migrant populations to public vaccination services while operating within those services. The main access enabling strategy used relied on the production and dissemination of multicultural and multi-ethnic information supported by word-of-mouth communication within migrant communities that was expected to act as an action-amplifier. Type-2 and type-3 initiatives were implemented outside those services within foreign communities, in external structures or in dedicated offices inside local health units. One type-3 initiative was conducted also in a hospital maternity unit to inform new mothers on when and how childhood vaccinations could be accessed.

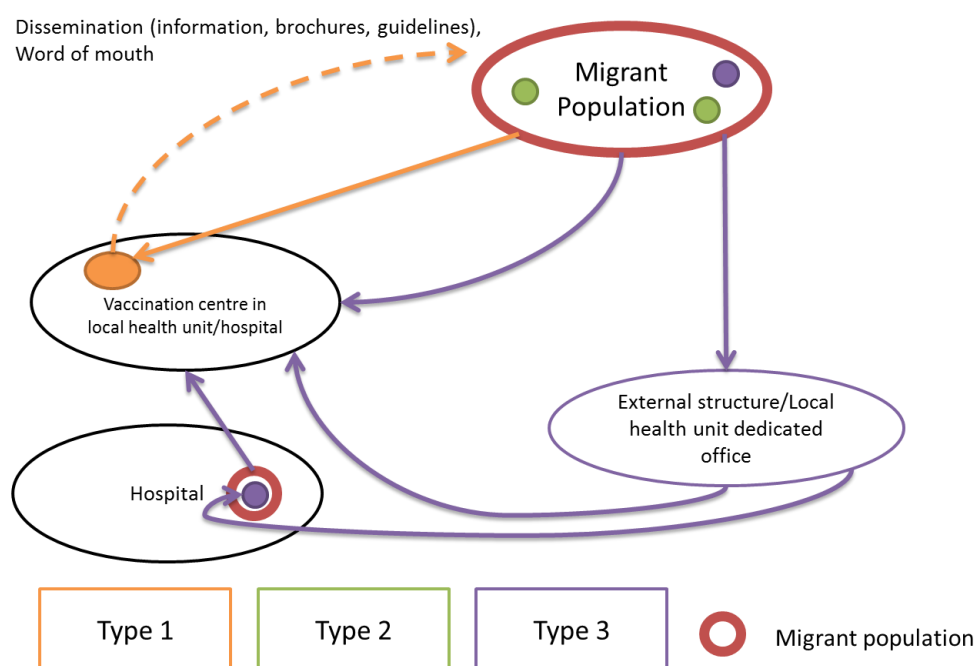


Figure 1 – Models of intervention by type of initiative

Conclusions:

The range and diversity of the initiatives identified, outline marked local health and social mobilization. Interestingly, two thirds of all initiatives were continuous rather than temporary actions. The fact that, albeit fragmented, most initiatives 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. The current low visibility of such actions may lead to funding new activities liable to duplicate efforts aimed at the production of translated leaflets and guidelines in other local or regional contexts. Products elaborated so far need to be shared among local health units

and Regions, so they may be adjusted and reproduced. Websites such as EpiCentro¹⁶ – developed by the National Institute of Health – may act as national hubs to host experiences and materials that local operators may be willing to share.

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 and shared in order to fill this gap. In collaboration with stakeholders, the next step to be taken entails defining and testing quality criteria to identify the most effective access-enabling strategies and models that could be replicated in comparable local contexts.

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