

GEORGETOWN UNIVERSITY

**“THE HEALTH STATUSES OF ARAB MUSLIM
IMMIGRANTS IN ITALY AND THEIR PROBLEMS
WITH ACCESSING HEALTH CARE”**

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Foto di Francesco Cocco



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Immigrants being examined by members from Doctors Without Borders after arriving in Italian territory in Lampedusa.

المهاجرون و صحتهم في إيطاليا

<http://www.msf.it/msfinforma/galleria/index.shtml#>

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ABBREVIATIONS

AI	Amnesty International
ASL	<i>azienda sanitaria locale</i> (local health clinic)
CPT	<i>centro di permanenza temporanea</i> (center of temporary detainment)
CVD	cardiovascular disease
EEC	European Economic Community
ER	emergency room
EU	European Union
FGM	female genital mutilation
GRIS	<i>Gruppo Regionale Immigrazione e Salute</i> (Regional Group of Immigration and Health)
HIV/AIDS	human immunodeficiency virus / acquired immune deficiency syndrome
ICMH	International Centre for Migration and Health
IOM	International Organization of Migration
MOH	(Italian) Ministry of Health
MSF	<i>Médecins Sans Frontières</i> (Doctors Without Borders)
NGO	non-governmental organization
OECD	Organization for Economic Cooperation and Development
SSN	<i>servizio sanitario nazionale</i> (National Health Service)
STP	<i>straniero temporaneamente presente</i> (foreigner temporarily present), abbreviation refers to an Italian legal document, not literal meaning
STI/STD	sexually transmitted infection/disease

TB	tuberculosis
UN	United Nations
UNAR	<i>Ufficio Nazionale Antidiscriminazioni Razziali</i> (National Office for Racial Antidiscrimination)
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

GLOSSARY

badante. Caretakers in Italy, typically for elderly Italians.

extracomunitari. An “extra-community person” signifies one who holds citizenship from a country outside of the European Union.

immigrazione irregolare. Irregular immigration means illegal immigration.

immigrazione regolare. Regular immigration refers to legal immigration.

medico di base. Basic medicine refers to the basic services and shared doctors, for which immigrants with STP documentation are eligible.

permesso di soggiorno. A resident permit, or the documentation allowing non-EU residents to remain in Italy.

ABSTRACT

Italy is a new country of migration. The increasing presence of immigrant families from North Africa and the Middle East presents challenges to the health care system in Italy. Based on a review of Italian migration and health literature and on field interviews, the thesis finds that immigrants face serious health threats in their immediate environments, mainly resulting from poor living and working conditions. Women migrants and minors also face special health problems, including reproductive health issues and exploitation. Lack of information about available health services impedes immigrants from adequately dealing with these problems, even though they are legally authorized to receive health services. The political interest exists in Italy to address these problems, as seen with the establishment of an official Commission in December 2006 on the health of Italy's immigrants. To correct the identified problems, Italy should improve cultural competency training by continuing to fund cultural mediators and by establishing diversity offices in each local health clinic. Immigrant access to health care services would benefit from an informational campaign with involvement from government Ministries. The Italian health system also should promote immigrant empowerment through advocacy outreach. The thesis further identifies the need for additional research on different immigrant communities to examine the potential for long-term health disparities in health outcomes.

INTRODUCTION

Imagine, as a poor farmhand, or as a handyman, or as a construction worker, having saved up enough money to travel from somewhere in Egypt or Morocco to the Tunisian or Libyan coast. When you get there, you hand over more money to someone who is going to pack you in a boat because he promises it will make it to the Italian coast. You decided long ago that migrating to Europe was a good decision, despite all the traveling difficulties and insecurities that awaited you. You readily hand over the money.

Fast-forward five months. You have traveled to four different cities in the past five months and had just as many jobs that did not last for one reason or another. You are returning to the south of Italy because you have a contact there working on the farms. You get to the fields and the work is hard and you have a terrible cough. You visit a free mobile clinic that is town for a day the next week. They tell you that you have tuberculosis, probably due to the crowded living spaces you have been living in. They tell you what kind of therapy you need, but not where the nearest permanent clinic is, nor that you can get medical services without the state learning that you are without papers. All you can think of is that this decision to migrate, so far, has produced very little of the benefits you were expecting. In fact, you might as well be doing the same work in Egypt.

Research Questions

This thesis will focus on the health status and problems of Arab Muslim immigrants in Italy. It explores the following questions: (i) What is the health status of these immigrants upon arriving in Italy? (ii) What is the health status of these immigrants after having spent some time

in Italy? (iii) What are the factors influencing changes in the health statuses of immigrants in Italy? (iv) How are these changes in health status seen as disparities, in comparison with the average Italian population? (v) How do immigrants access health care services to resolve their health problems in Italy? (vi) What are the barriers to accessing health care services for immigrants in Italy? And finally, (vii) How does the health status of Arab Muslim immigrants in Italy affect their integration into the Italian health system?

Purpose

Significance to Current Societal Issues

Like the majority of the world's 185 million migrants, most migrants into Europe, and into Italy, come voluntarily; that is, people from all over the world have chosen to come to Italy, despite many obstacles, in search of better opportunities and better economic fortune.¹ Others, however, are forced to migrate. They come to Italy seeking asylum as refugees due to political or social situations in their home countries, or because contacts in their countries of origin promised them a job and they ended up being trafficked to work in the sex trade. Forced or voluntary, because of the physical and mental strain it involves, migration affects the health of all those participating.

Italy is a relatively new country of migration, but it already hosts immigrants from all over the world. The country's declining birth rate necessitates the manpower economic migration brings. The powerful Italian organization representing small landowners and agriculturalists

¹ Grant, Stephanie, "Migrants' Human Rights: From the Margins to the Mainstream," *Migration Information Source* (1 March 2005), <http://www.migrationinformation.org/Feature/display.cfm?ID=291> (accessed December 29, 2006).

Coldiretti has publically acknowledged, for example, the importance of migrant workers for the Italian agricultural sector and the continued success of its “Made in Italy” fame.² The issues that this phenomenon has brought to the country include many about the problems of integration. This report will help address one means of integration – finding suitable ways of dealing with health problems in a host country. As we can see from the introductory story, making the effort to migrate to a different country for better opportunities and then finding oneself sick, on top of the necessity to continue hard labor, can lead to disillusionment. This attitude precludes integration because the host country has already disappointed you.

Health problems also prevent one from advancing economically. If a worker is so sick that staying home is a must, the worker loses not only wages for that week, but possibly their whole job. Alternatively, if wages and free time have to be spent on medical attention, the migrant worker will have a more difficult time sending remittances home or saving up for an investment in the host country, like making time for language classes. Had my Tunisian friend in Rome ever gotten seriously sick or injured, he could not have held down his job as a mechanic. He could not have joined a soccer league in the suburbs with other migrants and Italians. He could not have saved up, after six years in Italy, to start taking computer courses. He would have found it more difficult to do all the things he is doing now, which make him more accepted in the Italian culture and also more in contact with a wider range of Italians.

Lastly, health problems inhibit integration because their very prevalence among the immigrant population in Italy signifies (along with concrete statistics) that migrants are not accessing the health structures to get many of these health problems resolved. Thus, despite the possibilities migrants have for accessing the Italian health care system free from fear and

² “Stranieri nei campi, Coldiretti: L'immigrazione legale è una risorsa per il Made in Italy,” *Stranieri in Italia* (18 July 2006), <http://www.stranieriinitalia.it/news/coldiretti18lug2006.htm> (accessed February 22, 2007).

financial burden (as will be explained in the accessing health services section of the thesis), they are not doing so. Why are they not being integrated into the health care system? The second part of the thesis on immigrants accessing the Italian health care system seeks to answer this important question about the possibility, yet lack of integration of migrants within an important part of the Italian state system – health care.

Producing Outcomes

By looking at the challenges Arab Muslim families in Italy face regarding their health status and their access to Italian health services, this study evaluates the success of Italy's attempt to provide for immigrant health needs, suggests ways to diminish health disparities between Italians and Arab Muslims after an intersectional analysis on Arab Muslim immigrant health, and proposes possible avenues of policy development to better increase the health of immigrants, especially Arab Muslims, living and working in Italy.

While Arab Muslim immigrant families in Italy might arrive on Italian soil relatively healthy, subsequent experiences in their living, working, and social environments create health problems. These problems are compounded by the afflictions faced by migrants in accessing Italian health services. Improving immigrant integration and preventing larger public health problems from emerging in the country require new approaches.

Relevance

Not only do health problems and accessing health services affect the integration of migrants into the host society, but immigrant pathologies can also become public health problems, because some sectors of the Italian economy depend on these workers for their success, and because programs and initiatives targeting immigrants in the Italian health sector must not be sufficient or efficient.

Integration of immigrants into a health system, and therefore, in some way, into a host society can have very serious affects on the receiving country. The unrest among third and fourth generation North African Muslim immigrants in France, for example, shows that unsuccessful integration or feelings of disillusionment regarding integration creates a community of unhappy third or fourth generation young immigrants. Their unhappiness, as we have seen, can result in cultural separation and eventually explode into riots and civil unrest.

“Policies, or the lack of policies, that impose unnecessary stress on migrants are also in danger of contributing to psychosocial problems, poor social insertion and adjustment, and in many cases to social deviance... In a world in which social and political instability quickly translates from a personal to a more group level, the policies and programs of host countries would do well to encourage and facilitate social insertion.”³

While successfully integrating first generation immigrants in Italy now into the health care system might not equate to full societal integration (because surely most of the persons of North African descent now in France do enjoy state health care as French citizens), it is one avenue of bringing Italians and immigrants into contact outside of the work place. If immigrants are in good health and have a least one outlet of the state they can trust when in need, integration is facilitated.

On the other hand, as will be explained in the literature review, integration (as shown by changes in lifestyle) has been shown to cause increased mortality rates among initially healthy

³, Manuel Carballo and Mourtala Mboup, “International migration and health,” International Centre for Migration and Health (2005): 14, <http://www.gcim.org/attachements/TP13.pdf> (accessed 17 February 2007).

immigrants, so it is important to identify the kind of integration we seek through extending health services. Because this study notices this contradiction in pro-integration arguments, which usually only see the benefits of immigrant integration (because such arguments typically do not consider health issues), it will provide unique insight on how to best integrate Arab Muslim immigrants into the Italian health care system.

Many Italians worry that immigrants are bringing diseases from the third world into their country. The contrary, however, usually occurs. Immigrants get sick with diseases like tuberculosis (TB) after living in Italy for sometime because they are living in overcrowded and unhygienic conditions. While the average Italian might still not be at risk of catching TB from migrants, the fact that Italian health care providers may not be trained to deal with such a disease, and the fact that it is not being adequately controlled among the immigrant population, presents a public health problem for cities and the country. Any efforts to eradicate TB in industrialized countries need to take the circumstances of immigrant living and working conditions into account. The International Centre for Migration and Health (ICMH) notes that as the “ecological space” traveled by migrants increases, the problem of dealing with their health problems might lead to more complications for receiving countries, since most developed countries are no longer well prepared to deal with many tropical and parasitic diseases.⁴

As will be apparent from a later overview of migrant health problems, “programs and initiatives targeting immigrants in the Italian health sector [are clearly not] sufficient or efficient.” More research is needed in this area. As we will see, Italy has tried to do this through a wide range of mechanisms to open access to health services to immigrants, for example, through different legal processes for enrolling in the health system and the employment of “cultural mediators” (a type of translator). What we will also see is that despite these

⁴ Ibid., 13-14.

mechanisms, many immigrants remain without any type of health insurance in a country with a socialized health care system open to immigrants. Thus, we need to look at why this is so, why efforts to cater to immigrants are not working yet on a grand scale. The ICMH notes that countries have to figure out how to absorb newcomers into their increasingly costly health care systems.⁵

Health and Migration in the Technical Literature

Theories of Migration

For the purpose of this study on health migration, it is useful to focus on the literature dealing with the causes of the initiation and the persistence of migration. As briefly noted in the timeline above, in the past 30 years, the source and destination countries of international migration have changed significantly. In addition to traditional host countries like Australia, Canada, and the United States, others in Europe, in the Middle East, and middle-income countries everywhere have joined the group. Furthermore, immigrants are no longer just coming from Europe, fleeing economic hardship and war, but now people depart from developing countries in Africa, Asia, the Caribbean, and the Middle East. Southern European countries like Italy, Spain, and Portugal began recruiting workers from Africa, Asia, and the Middle East.

These increasingly diverse flows of migration have made the societies of many developed countries more multiethnic.⁶ Given this history and the rich literature on the causes of migration,

⁵ Ibid.,14.

⁶ Douglas S. Massey, Joaquin Arango, Graeme Hugo, Ali Kouaouci, Adela Pellegrino, and J. Edward Taylor, "Theories of International Migration: A Review and Appraisal," *Population and Development Review* 19, no. 3 (September 1993): 431.

we can give a brief theoretical overview of why presently more migrants from the South are choosing to migrate to industrialized countries like Italy. These motivations are enlightening to this study because the choice to migrate must outweigh the known and unknown health risks of migration.

First of all, it is important to note that a debate exists in migration literature on how to study these motivations or causes of migration. Divides in the migration literature include debates over whether sources of migration should be studied in individual or structural terms and over whether it is more appropriate empirically to analyze migration from the individual, household/family, community, region, or even nation-wide point of view.⁷ One prominent researcher, Douglas Massey, in a study with other contributors, evaluated different theories of migration, identifying each more or less as either explaining macro (structural) motivations of migrants to initiate movement, or more micro (individual or household) motivations. We will briefly go over these theories here, as they are important to understanding the migration phenomenon. We will pay particular attention to the micro theories here, as this study focuses on the health of migrant families in Italy; summaries of the macro theories can be found in Appendix B.

The first of two theories that explain more micro causes of migration is the macro neoclassical economics' corresponding micro component. This theory explains how individuals make a cost-benefit analysis that leads them to expect a positive net return from migration. People expect higher wages in return for providing greater labor productivity; they weigh the initial investments in the costs of traveling, in looking for work upon arrival, in learning a new culture and language, and the probability of finding work against the perceived earnings.

⁷ Douglas S Massey, "Social Structure, Household Strategies, and the Cumulative Causation of Migration," *Population Index* 56, no. 1 (Spring 1990): 3-4.

Perceived earnings are then compared to probable earnings in the individual's current country for a period of time. The implications of this model differ somewhat from its macro conception in that movement is not only based on wage differentials, but also employment rates, probability of employment, and "individual characteristics" that might lower migration costs (thus not everyone from one origin country might face the same impetus to migrate as the macro theory assumes). Migration stops in this model when expected earnings are equalized internationally. The micro level theory, however, still revolves around solely the labor market.⁸

The new economics of migration theory focuses not on individuals, but on families or households. According to this theory, these groups make decisions as a whole to migrate or for one member to migrate, in order to maximize expected income, or to minimize risks of market failures, not limited to the labor market. This results in a "diversification of labor" among the group members and provides economic tools in the form of remittances to hedge against market risks. Massey notes that migration is used to bet against these risks because often instruments like private insurance markets, governmental programs, or access to low cost credit are weak or nonexistent in the source countries. This theory also argues that individuals migrate not only to increase absolute household income, but also to increase income relative to other households (decrease relative deprivation); such an opportunity might be restricted in the local economy. The implications of this theory differ from the neoclassical theory importantly in that wage differentials do not have to exist to influence migration because of the conception of risk diversification, and because migration does not exclude the continuance of local opportunities.⁹

Before evaluating the significance of the different theories, which all identify different push factors and markets affecting the initiation of migration, to the current study at hand on

⁸ Ibid., 434-436.

⁹ Ibid., 436-440.

migration and health in Italy, looking at one relevant theory of migration that focuses on the causes for the persistence of migration gives us a fuller view of the theoretical arguments behind migration causes; the rest of these persistence theories can also be found in Appendix B.

The network theory identifies “migrant networks [as] sets of interpersonal ties that connect migrants, former migrants, and non-migrants in origin and destination areas through ties of kinship, friendship, and shared community origin.” These networks lower the physical and psychological costs of migration and increase expected net returns to migration; this “social capital,” therefore, increases movement. This theory of migration is conceived on the micro-level of individuals and households. Its implications are that the persistence of migration is not influenced so much by wage differentials as it is by the perceived lowered costs and risks due to the networks; migration reflects the sending society as whole; and, governments can do little to control the migration flow.¹⁰

Massey et. al. conclude that migration can be influenced at various levels, meaning that none of the above theories are inherently wrong, or wholly correct.¹¹ For this thesis, the most relevant theories to draw conclusions on are the new economics theory that proposed reasons for migration initiation on a family level and the network theory, which explains the persistence of migration through an accumulation of social capital. The new economics theory states that members in a family migrate to hedge market, labor or otherwise, risks by diversifying income sources. What happens to this strategy once someone in the migrated family or the sole person that migrated from the family falls ill? What if he/she is only minimally ill? How does this perception of risk diversification change, if at all? While this thesis will briefly address these questions, it seeks more to provide answers on how the question actually can be avoided by

¹⁰ Ibid., 448-450.

¹¹ Ibid., 454-63.

improving immigrant health in Italy. Secondly, the network theory is important to remember later in the literature review and in the thesis as it has also been expanded and used to explain other methods immigrants use to achieve goals once in the host countries, for example, utilizing network information to access health care.

Health and Migration

The International Organization of Migration (IOM) has defined several challenges for governments concerning migration and health. These challenges include the concerns that population mobility could threaten public health through disparities in disease prevalence and through globalizing communicable diseases, and that the different cultural, linguistic, economic, and other differences between immigrants and their host country might cause health problems and disparities.¹² The ICMH also notes that the

“speed of contemporary migration, the numbers of people involved, the fact that people are often moving from parts of the world with very distinct health conditions and disease profiles... and [increasingly varied] mixes of cultures, languages, and views on how people from different parts of the world perceive health and health protection”

are all important characteristics of modern migration that each have various implications on the field of international migration and health.¹³ Current Italian literature on migration and health voices the concerns outlined in the IOM’s first challenge and the research here shows that the concerns expressed in their other challenge are present in Italy.¹⁴

¹² Five challenges were presented in total at a 2004 IOM conference on migration and health. “Migration and Health,” 2007, International Organization for Migration, <http://iom.int/jahia/page1169.html> (accessed February 2, 2007).

¹³ Carballo and Mboup, “International migration and health,” 2.

¹⁴ “Migration and Health,” 2007, International Organization for Migration, <http://iom.int/jahia/page1169.html> (accessed February 2, 2007).

Going into more detail, the ICMH lists the following background, or pre-migration factors that influence migrant health: the “socio-economic and cultural background of migrants, their previous health history, and the nature and quality of the health care situation they had access to prior to moving.” The ICMH goes on to note that migrant health is also influenced by migration itself and the “social and health characteristics of re-settlement” including the type of work migrants find, available housing conditions, access to health and social services, continued contact with family, language skills, and familiarity with the host culture.¹⁵ This thesis will address all of the above factors mentioned by the ICMH as they pertain to Arab Muslim immigrants in Italy.

Health Policies Towards Migrants

A good proportion of the literature dealing with migration and health focuses on the policies of host countries towards migrants. The ICMH notes that lately most policies towards migration are restrictive, and that many might create social or economic environments detrimental to migrant health. More specific policies of many countries have historically screened out unhealthy immigrants, screening for tuberculosis being especially common. As of 2004, Italy along with Spain, Austria, and Hungary did not have a specific screening policy. Other countries like Denmark, England, Norway, Germany, the Netherlands, France, and Belgium screen immigrants coming from areas with certain prevalence thresholds. The ICMH notes that countries with “strong tradition[s] of public health and social solidarity” often provide health care to legal and clandestine immigrants, whereas countries with more privatized systems tend to exclude immigrants from services. Seasonal and/or clandestine migrants might face

¹⁵ Carballo and Mboup, “International migration and health,” 4.

challenges in both systems.¹⁶ We will see that while Italy is in the former “socialized” category, problems still exist for immigrants in trying to access health care services.

Australia illustrates a different, yet interesting approach to immigrant health. The history of Australian policy approaches to immigrants has, at different times, been based on assimilation, integration and multiculturalism; these overall approaches have carried through to the health policy level. In the early 1980s, Australian health programs used ethno-specific workers, which received high community acceptance and showed effective outcomes in health knowledge and service delivery. In the 1990s, however, “attitudes to migrants, immigration and the services which cater to their needs changed considerably” due to the fact that immigration had been labeled as the cause for Australia’s drained resources and high unemployment. Subsequently, the “conflict between the depiction of migration as a social and economic cost to Australia and the previous embracing multicultural stance has led to inconsistencies in statements and policy development by the government.”¹⁷ These inconsistencies in Australian policy have parallels in Italian policy.

Kelagher and Manderson’s study of the Australian case identifies four main models of health education and health services provision in Australia. The bicultural health worker model uses a worker of a particular ethnicity to reach out mostly to women members of the same ethnicity about specific health problems, like HIV; it has been determined to meet a low range of health needs and to have a low probability for sustainability. The multi-cultural health worker model addresses a broader range of health issues, is usually part of a permanent health service program, and uses translators or mediators to address women of various ethnicities; it has been judged by the authors to cover a high range of health needs and to be moderately sustainable.

¹⁶ Ibid., 3-4.

¹⁷ Margaret Kelagher and Lenore Manderson, “Migration and mainstreaming: matching health services to immigrants’ needs in Australia,” *Health Policy* 54, no. 1 (2000): 1-11.

The Mainstream cross-cultural training model involved training mainstream health care workers in cultural sensitivity and in how to use interpreters; it has been determined by Kelaher and Manderson to meet a moderate range of needs and to be highly sustainable. The Mainstream model uses typical health services that have not attempted to address cultural barriers in providing health services, but workers in this model can access interpreters through a national phone line; the mainstream model has been determined to meet a high range of needs and to also be highly sustainable.¹⁸ These different health provider models are beginning to be seen, without such formal definitions, in the Italian health system. The analysis of their effectiveness and sustainability will be useful when evaluating Italian attempts at culturally competent care.

Health Problems of Migrants

Migration and health literature tends to classify migrant health problems into the categories of psychosocial health problems, physical problems, disease-specific problems, accidents, and then problems specific to women, described as reproductive health problems. The literature also commonly identifies two problems not dealt with in this thesis, but we will mention them briefly here due to their importance in the larger field of migration and health.

The possible psychosocial health problems mentioned in the literature that migrants face start with an individual's fear of all that is unknown about migrating. The ICMH notes the "decision to move, for example, is often replete with fear of the unknown, anxiety about those being left behind, and a sense of impending loss. Some observers have termed it a type of cultural death..."¹⁹

¹⁸ Ibid., 1-11.

¹⁹ Carballo and Mboup, "International migration and health," 4.

Psychosocial problems then continue at the family level. The labor demands on either men or women have led to many family break-ups, affecting greatly the psychosocial health of many family units. Partners will find new relationships abroad, or idealize their familial relations they remember from home; many host countries have seen higher divorce rates in migrant families. Families left behind by the migrant can also experience psychosocial problems, especially if the migrant was the head of the household, and therefore, a figure of protection and economic security. The psychosocial health of migrants' children is also affected: parents' work hours might keep them away from home during non-school hours, or language gaps and culture conflicts may arise as the children more readily adapt to the host culture. All this "intra-familial stress and parent-child conflict" might lead to "low self-esteem, feelings of guilt, and psychosocial morbidity among the children of migrants."²⁰

Furthermore, poorly paid and highly risky jobs with low security, especially for illegal migrants, also add to a migrant's stress. Anxiety and homesickness can lead to depression and psychosomatic disorders like stomach ulcers, migraines, and back pain. Dependence on alcohol, tobacco, or prostitution can also become problems due to this stress. In a Belgian study, Moroccan immigrants experienced five times as many peptic ulcers as Belgian nationals; a study in the Netherlands showed that their immigrants have been experiencing much higher rates of chronic tension headaches; other studies have shown that stress related ulcers are common among migrants in Germany and headaches among migrants in Switzerland. Other studies have shown that higher suicide rates among migrants in the EU can be attributable to migration.²¹

The literature discussion of physical health usually begins with host countries' greatest fear: an onslaught of diseases. Many economically motivated migrants carry with them "health

²⁰ Ibid., 4-6.

²¹ Ibid., 5-6.

profiles associated with poverty,” meaning that many of them have brought increased levels of TB to Europe. As I have mentioned, not only do some migrants “carry” TB with them across borders, but the living conditions immigrants find themselves in further breed TB among them in the host country. Migrants, for example, make up large percentages of the homeless populations in many EU countries. Both human rights and public health arguments have been used to denounce the makeshift and uninhabitable dwellings many migrants are forced to live in. In Italy, researchers claim that this problem, in addition to poor access to public health services, has led to chronic and drug resistant strains of TB.²² This discussion will be expanded upon greatly in the context of Italy’s migrants later in the thesis.

Besides TB, sexually transmitted infections (STIs) are also a common problem among migrants, often attributable to the social and environmental conditions of migration. A study carried out between 1997-2001 showed that 66 percent of all new HIV cases in the European Union were diagnosed in individuals coming from countries of high HIV prevalence. Other studies have shown in various EU countries that STIs are also more common among immigrants.

Non-communicable diseases are generally linked to lifestyle choices. One of the most prevalent and dangerous diseases is cardiovascular disease (CVD). According to the ICMH, the “migrant contribution to the CVD load reflects the role of factors such as ethnic pre-disposition, diet, lifestyle and stress.” Studies have shown that South Asians and other Asian migrant populations have shown higher rates of CVD than country nationals in several host countries.²³

The prevalence of genetic diseases follows many migrants. Sickle-cell anemia and thalassemia, for example, follow migrants from “Africa, the Caribbean and Mediterranean region

²² Ibid., 6-7.

²³ Ibid., 7-8.

where these diseases are more common.”²⁴ The prevalence of thalassemia and sickle-cell anemia in migrants in the European Union has brought up questions like the need for “diagnostic and special counseling services that are not always available.”²⁵

Another area of concern in migration health is occupational accidents. One study has shown that occupational accidents are twice as high among immigrant workers in Europe. Work in the agricultural sector, with its exposure to pesticides and other chemicals, has been associated with “high incidences of depression, headaches, neurological disorders and in the case of women, miscarriage,” in addition to muscular diseases, dehydration, parasite infections, respiratory problems, and heart complications.²⁶ Industrial accidents are also common among migrant workers due to poor safety measures; they sometimes lead to higher disability rates for migrants than for national workers. Because immigrant children might have to spend more time alone due their parents’ long or erratic working hours, studies have shown that immigrant children face higher rates of of higher rates of traffic accidents and of domestic accidents (poisoning, lead or otherwise, and burns), which are exacerbated by poor housing conditions.²⁷ These issues will also be further explored later in the thesis as they have been considerably researched in Italy.

Concerning the reproductive health of migrants, it has been noted in the literature that “in many EU countries, pregnancy-related morbidity is higher among migrants than local women.” Lower birth weights, premature births, neo-natal or peri-natal mortality, and delivery complications are common problems. Studies in Spain have shown that migrant knowledge of

²⁴ Ibid., 8.

²⁵ Ibid., 8.

²⁶ Ibid., 8-9.

²⁷ Ibid., 8-9.

contraceptive services is often a problem, leading to much higher rates of abortion than for Spanish women.²⁸ We will see that these issues are very concerning also in Italy.

Many country studies on migration and health merely repeat the problems noted here by the ICMH in their own domestic context. An article on the health of Hispanic and Latino immigrants to the United States, for example, lists many of the issues outlined above by the ICMH, and elaborates on other health issues. The article notes, for example, that studies have shown that disparities exist along epidemiological trends and along utilization of health care between the Hispanic/Latino populations and that of the rest of the United States.²⁹

Other host country studies have been instrumental not only in making migrant health problems known, but by clarifying the difference between ethnicity and immigration status causality. A study on the social determinants of health in Canada's immigrant population, for example, notes that past studies on immigration and health in Canada are problematic in that they sometimes confuse race with immigration status and because they sometimes reduce different health outcomes to genetic or biological factors. Past studies, furthermore, did not address how an immigrant's health status relates to "employment, income, occupations, education family structures, living conditions, of immigrants as a whole, or immigrant sub-groups (e.g. refugees, low-income, or by country of origin)."³⁰ We will see that such studies have been done in Italy already, despite its relatively new status as a host country. We will also see that although this thesis focuses on a particular ethnic and religious sub-group of migrants, it will distinguish between ethnicity and immigration as factors in migrant health status.

²⁸ Ibid., 10.

²⁹ Elena Bastida, "Hispanic Health: Persistent Disparities and Promising Developments," *Ethnicity and Disease* 12 (2002): 456-457, <http://www.ishib.org/ED/journal/ethn-12-04-456.pdf> (accessed February 17, 2007).

³⁰ James R. Dunn and Isabel Dyck, "Social determinants of health in Canada's immigrant population: results from the National Population Health Survey," *Social Science and Medicine* 51, no. 11 (Dec. 2000).

The two issues not dealt with further in this thesis, because they do not involve Arab migrants in Italy, but are nonetheless important components of migration health studies are the international tourist movement's relation to health and the international migration of health professionals. Brief information on these topics can be found in Appendix C.

While the above review on migration and health provides us with the range of issues dealt with in the literature, it is also useful to look at other migration and health studies completed by or about host country situations because the goal of this thesis is to do the same task for Italy.

Healthy Migrant Paradox

Past studies on immigrant health also in Canada display the “healthy immigrant” syndrome, in which immigrants have fewer chronic diseases and disabilities relative to other Canadians; this has been attributed to the screening process in Canadian immigration policies. This has become known as a paradox, given that immigrants have relatively lower socioeconomic status, which generally results in worse health outcomes and higher mortality in typical public health studies. Over time, however, immigrant health measures begin to converge with those of the Canadian population (and the paradox then becomes less of a paradox). “Declining health status with greater length of residence is not unique to Canadian immigrants, as a similar relationship has been shown in Australia and in the United States” ... and as we will see, in Italy. In fact, why the “healthy migrant” becomes sick in Italy is a key question of this study. Studies on the “immigration experience” in Canada have shown that “sudden dietary changes, exposure to local pathogens, catastrophic stress leading to depression, anger, anxiety

and psychosomatic symptoms, post-traumatic stress disorder, poverty, inter-racial conflict, inter-generational conflict, and communication difficulties” lead to changes in immigrant health.³¹

Early studies of Turkish migrants in Germany also exhibit the healthy migrant phenomenon. One study, for example, found that Turkish residents, both male and female, experienced lower mortality rates than Germans, sometimes half, throughout the 1980s. These findings also remained true for second-generation Turkish migrants. The study also states that little evidence exists to suggest that chronically ill Turks return, but an “un-healthy remigration effect” might partially explain their findings.³² Later studies in Germany, however, report that while Turkish men were still less likely to die of cancer than German men, stomach cancer rates in general are increasing among Turkish male residents and breast cancer rates in Turkish female residents. The author of the study noted “broadly it seems that the [Turkish] population is increasingly integrating, to the extent that traditional diets and lifestyles are being abandoned in favor of 'industrialized' habits, along with the accompanying cancers.”³³

The same kind of contradictory studies exist in the United States on Hispanic migrants. One article, for example, notes that Latino health profiles in the United States contradict the “minority health disparity” model because while Latinos experience greater risk factors than non-Latinos with lower incomes, lower educational attainments, and less access to care, they show strong health profiles. In a 2002 study, compared to non-Hispanic Whites, Californian Hispanics have 35 percent lower mortality due to heart disease, 43 percent lower mortality due to cancers, and 25 percent lower mortality due to stroke. Latinos also experience a longer life

³¹ Ibid.

³² Oliver Razzum, Hajo Zeeb, H. Seval Akgün, and Selma Yilmaz, “Low overall mortality of Turkish residents in Germany persists and extends into a second generation: merely a healthy migrant effect?” *Tropical Medicine and International Health* 3, no. 4 (April 1998), <http://www.blackwell-synergy.com/doi/pdf/10.1046/j.1365-3156.1998.00233.x> (accessed February 17, 2007).

³³ “Cancer rates increasing in Germany’s Turkish migrants,” *European Journal of Cancer* (2002), <http://www.oncolink.com/resources/article.cfm?c=3&s=8&ss=23&id=8310&month=04&year=2002> (accessed February 17, 2007).

expectancy (on average, 4.1 more years) than non-Hispanic Whites. Medical research cannot yet explain these outcomes, other than hypothesizing that Hispanic culture offers some “protective factor.” The author concludes that more scientific research is not being done on this “paradox” because of the scarcity of Hispanics in health care professions.³⁴

Later studies again, however, show how, with time, Hispanic health outcomes start to resemble those typical to the host country. One study, for example, notes that Latinos typically have lower mortality rates than non-Hispanic Whites and African Americans, and similar infant mortality rates as non-Hispanic Whites, but then the study shows that Hispanics’ acculturation into American culture has been associated with worse health outcomes, behaviors, or perceptions. The study finds that “although not absolute, the strongest evidence points toward a negative effect of acculturation on health behaviors overall—substance abuse, diet, and birth outcomes (low birthweight and prematurity)—among Latinos living in the United States. More acculturated Latinos are more likely to engage in substance abuse and undesirable dietary behaviors and experience worse birth outcomes compared with their less acculturated counterparts.” On the positive side, changed health care use and self-perceptions of health due to acculturation have led to positive health outcomes.³⁵ Despite these many studies noting the “healthy migrant paradox” and the long-term worsening of migrant health, it should be noted that this assimilation of health profiles of migrants to the those typical of the host country still does not fully explain the paradox, it only shows that with time (and according to these country

³⁴ David E. Hayes-Bautista, “Hispanic Health: How Healthy is the Fastest Growing Population of the United States?” *Ethnicity and Disease* 12. (2002): 459, <http://www.ishib.org/ED/journal/ethn-12-04-459.pdf> (accessed February 17, 2007).

³⁵ Marielena Lara, Cristina Gamboa, M. Iya Kahramanian, Leo S. Morales, and David E. Hayes-Bautista, “Acculturation and Latino Health in the United States: A Review of the Literature and its Sociopolitical Context,” *Annual Review of Public Health* 26 (April 2005).

studies, integration) the paradox disappears. I will examine whether or not the healthy migrant paradox exists in Italy or not, and how Italy might differ from the above mentioned countries.

Immigrants' Social Resources and Their Health

Returning to Canada, a small number of studies also exist that investigate the “relationship between immigrants’ social support and health status.” Some studies, for example, have shown that “social and psychological resources, especially ethnic social support, tend to ameliorate the effects of stressors and their outcome as psychological distress,” while other studies have demonstrated the “adverse mental health impacts of immigrating to a region where there is no ethno-cultural community of one’s own culture.”³⁶

Another Canadian study further explores how immigrant social networks affect immigrant health services utilization in Canada. It notes that immigrant networks can “provide information on institutional details of the health care system, [reduce] the search costs of locating an appropriate health care provider, [and can] even alter the demand for services by affecting the perceived efficacy or desirability of the available services.” The study showed that being surround by an extensive “network” either resulted in over or under utilization in comparison to the immigrant mean, depending on how much the community knew or trusted the Canadian health system. The study also showed that immigrant utilization of health care resources increases with the number of doctors that speak their language in their neighborhood.³⁷ We will see later how certain networks affect immigrant knowledge and perceptions of Italian health care services. The above two studies are also instrumental in considering how immigrant social

³⁶ Dunn and Dyck, “Social determinants of health in Canada’s immigrant population.”

³⁷ Catherine Deri, “Social Networks and Health Service Utilization in Canada,” (job market paper, University of Toronto, 2002): 1, 14-15, <http://socserv.socsci.mcmaster.ca/rdc2003/Deri.pdf> (accessed February 17, 2007).

capital can be used to successful health system integration policies.

In conclusion to the review of the literature on health and migration, it is important to note that the ICMH noted that the health of migrants, with the exception of refugees and other migrants due to political conflict, has been a neglected field of study. The increasing pace of migration, the reluctance to claim liability and responsibility for migrants (and thus absorb additional health care costs), and the belief that migration always ends well for everyone have been offered as reasons for this negligence.³⁸ This study seeks to help bridge this negligence gap.

While I will not go into a detailed summary of the Italian literature on migration and on migrant health because it is reviewed throughout the rest of the thesis, it serves us to mention here that a great deal has been written about how migration is affecting the Italian economy, politics, and society, despite Italy's relatively new status as a host country. A lot of sensational writing, for example, has been published on the threat of "Eurabia" and Islam as a second religion. In the health realm, as previously mentioned, a lot of focused studies have been written on immigrant conditions and pathologies. Some works have even attempted summary accounts like this thesis. A non-profit organization Alisei, for example, has published the following manuals in English: "Health Care Services – A Tool Kit To Fight Discrimination Against Immigrants" (2004) and "Health for all, all in Health. European Experiences on Health Care for Migrants" (2000); and in Italian: "The Safeguarding of Health in a Multicultural Society" (1996) and "Informing Immigrants about Health" (2001, also written in English, French, and Arabic).³⁹

Significance of the problem itself

³⁸ Carballo and Mboup, "International migration and health," 13.

³⁹ "Pubblicazioni e Materiali," Alisei, <http://www.alisei.org/pubblicazioni.html> (accessed February 17, 2007).

We can see from the introduction of the thesis and from the literature review that the topic of health and migration is important both on the national and international levels. We can see that it is necessary to look at how health might affect migration motivations, how different health care policies might affect immigrant health, especially considering policies that foster integration and acculturation, how many different health problems might affect immigrants, and how immigrants' social networks might affect their health.

We can also see that the problem of immigrant health in Italy could use a broad overview, a bringing together of the sources, to address all the above issues brought up in other migration literature, which is what this report will do: to show that the health problems immigrants acquire in Italy due to various conditions, compounded by the problems of access barriers to the health system, creates troubling health outcomes for Arab Muslim immigrant families. Putting all the available information together here on immigrants' health statuses and their access problems will help to propose ways that Italy can better its management of immigrant health, with attention to particular community needs. While, as will be explained later, Italy has already done a great deal for Immigrants in their health system, social and disparity issues still trouble immigrant families.

Methodology

My research involved interviewing persons in Italy working in the health sector, in services for immigrants, in immigrant cultural associations, and in research institutions. Out of a total of 73 attempted contacts, I succeeded in contacting and interviewing 16 persons or groups in Rome (11 interviews), Milan (4), and Palermo (1). I asked a set of four to eight questions,

depending on the source interviewed, in order to define their perceptions of the problems and to identify the challenges immigrants have in Italy concerning their health, the role Italian institutions play in this issue, and the cultural differences that influence the answers of interviewees to the questions I posed. The primary research, thus, is based on the professional and personal opinions of those interviewed, not quantitative data assessments or qualitative observations.

The interviews identified problems and pointed the way to additional literature of the health problems of migrants in Italy that I was further able to research upon returning to the United States. Thus, the rest of the research for this report was drawn from various secondary sources like European Union reports, Italian migrant newspapers, Italian NGO reports, Italian migration literature, and articles from other sources of Italian migration and health literature. This study combines these reports in order to provide an over-arching picture of the health situation for immigrants (especially Arab Muslim immigrants) in Italy.

This method of conducting interviews to identify key challenges was effective given the month and a half I had to do research in Italy. Given my new entrance into the field of health and migration in Italy, the interviews were key in identifying prominent experts on the subject and in identifying research material not available in the United States nor over the internet. The interviews also helped to identify issues I had not previously considered, and that are not directly mentioned in the Italian literature, like local politics affecting health care management, or small problems, like inconsistencies in immigrant paper work leading to problems in accessing the national health care system.

My choice to focus on Arab Muslim immigrants came from my background in studying Arabic but also serves as an effective method to study immigrant health in Italy. One way of

evaluating the complete mental and physical health conditions a typical immigrant faces is to study one community – so that cautious generalizations can be made and community needs and possible interventions identified. This study will focus on Italy’s close neighbors across the Mediterranean: Arabic-speaking Muslims. While Arab Muslims come from a variety of North African and Middle Eastern countries, all speak various dialects, practice their religions differently, and might not even consider themselves Arabs, identifying and studying such a group is possible in Italy. Furthermore, despite the barriers just mentioned, most Arab Muslim individuals are able to communicate minimally with each other, either by reverting to what formal Arabic they know or to the Egyptian Arabic everyone knows from the movies; they share a sense of community through a shared religion, and unfortunately, they face similar cultural and religious discriminations in Italy.

Within the communities of Arab Muslims in Italy, this study will focus on the health of the immigrant family unit. We will see that an increasing number of immigrant families are taking root in Italian soil, not just young male workers sending home remittances. Looking at families will allow us to look at the different stressors – male and female, adult and minor – that immigrants might face, and how these factors affect their health.

Because of the short time period of this study and my quick preparation for it, I did not succeed in talking with many of the Arab and/or Muslim organizations in Italy, not least, because many people travel during the summer. Thus, one limitation of this study is the little information presented by immigrants themselves. Another limitation to keep in mind, as mentioned above, is that this report is based on expert opinion, and while some studies included in the report verify these opinions, I have no independent verification of the opinions expressed.

Roadmap

Given the background presented in this introduction on migration, on migration and health studies, and on the issues to be studied concerning migration and health in Italy, the thesis will next progress on to give a brief history of immigration and immigration laws in Italy and explain migration motivations in an Italian context. Then, I will look at the health status of Arab Muslim immigrants in Italy upon their arrival and after having spent some time in Italy; I will identify their health problems in relation to living, working, and other social conditions. Given these profiles, I will then look at the determinants of the disparities in immigrants' health, which make dealing with the aforementioned health problems doubly difficult. It will then be appropriate to look at how immigrants can and do access health services in Italy to try and remedy these problems. Then, I will analyze the problems immigrants have in trying to access these health services. Finally, the thesis will end with conclusions on the many questions raised in the introduction and with suggestions on how Italy might better manage immigrant health care policies.

CHAPTER 1

BRIEF HISTORY OF MIGRATION IN ITALY

Italy's transition

Italy has transformed from a country of emigrants, to a transition country for immigrants into the rest of Europe, and today, to a destination country for immigrants. Italy started sending immigrants in mass numbers to the Americas in the very late 19th C., starting around 1870, due to the failure of post-*Risorgimento* policies helping the peasant class, especially those in the south, to find use for their available labor and integrate into the new Italian state.⁴⁰ Italians who opposed Mussolini's fascist rule came over and added to the outward flow in the 1930s. Mass emigration from Italy generally stopped after WWII.⁴¹ Internal migration within Italy from rural to urban areas and from the south to the north has been constant as well since Italians also started leaving the peninsula. The oil crisis in 1973 also brought down the demand in other European countries for Italian guest workers and due to inflation, cheaper Italian goods became more marketable on the European market, which brought back some jobs to Italy.⁴²

This transition is important to note because it has implications for the current health status of immigrants in Italy today. Italy's relatively new status as a destination country means it is less experienced in dealing with such a diverse population and its needs in comparison to other European countries, for example, with stronger histories of colonization and therefore longer histories of immigration.

⁴⁰ Grazia Dove, *La Democrazia Italiana e l'Emigrazione in America*. (Brescia: Biblioteca di storia contemporanea, 1964).

⁴¹ "Italian Immigration," *Spartacus* (2007), <http://www.spartacus.schoolnet.co.uk/USAEItaly.htm> (accessed March 11, 2007).

⁴² Susan Martin

Italy as a Gateway to Europe

Many immigrants have used and still use Italy as a gateway country to the rest of Europe. Statistics published by EUROSTAT, for example, show that 38 percent of the 54,428 illegal immigrants apprehended in the European Community during the third quarter of 1999 had entered through Italy, followed by France (23 percent) and Spain (18 percent).⁴³ This starting occurring around the late 1970s because of the motivations explained in the various theories presented in the literature review. The reasons they use Italy as an entry country sometimes also influence them to stay in country. Immigrants come to Italy because of (i) its historically weak border control, and (ii) immigrant communities already in Italy promise contacts and assistance.

Up until recently, Italy had a more lax migration policy compared to northern European countries. Italy then had to amend its laws to conform to European policy. The changing of these policies has been termed somewhat contradictory, given Italy's and other southern European countries' need for immigrant labor and their "bureaucratic incapability" to regulate immigration efficiently.⁴⁴ Italy's questionable border security, however, is still of great importance in this debate: "Italy was viewed from many other European capitals as the unsecured door through which immigrants were accessing other European countries."⁴⁵ The Ministry of the Interior is

⁴³ Global Commission on International Migration, "Crisis in countries of origin and illegal immigration into Europe via Italy," *Global Migration Perspectives* no. 53, prepared by Maria Concetta Chiuri, Giuseppe De Arcangelis, and Giovanni Ferri, (Geneva, October 2005): 2, <http://www.gcim.org/mm/File/GMP%2053.pdf> (accessed December 29, 2006).

⁴⁴ Martin Baldwin-Edwards, "The Changing Mosaic of Mediterranean Migrations," *Mediterranean Migration Observatory* (June 1, 2004), <http://www.migrationinformation.org/Feature/display.cfm?ID=230> (accessed December 27, 2006).

⁴⁵ Kimberly Hamilton, "Italy's Southern Exposure," *Migration Policy Institute* 27 (May 2002), <http://www.migrationinformation.org/feature/display.cfm?ID=121> (accessed December 27, 2007).

responsible for border control and all the other tasks involved in controlling illegal immigration into Italy.⁴⁶

Many migrants try to make the trip from North Africa to southern Sicily each year and to discourage this, Italy uses only “soft” measures of enforcement like publicizing boat accidents. Ironically, however, migrants use boat accidents to gain access to the country; they purposefully capsize their boats upon reaching Italian coasts so that the Coast Guard will have to rescue them rather than turn them back around. “Hard” measures of immigration control like deportation were rarely exercised, according to a 2004 study. If officials catch illegal migrants, Italy gives them a few days to leave the country. Migrants hide in the underground network or move on to another EU country. The Schengen Treaty of 1985 makes moving between EU country borders relatively effortless.⁴⁷ Conflicts in the Balkans brought many immigrants into Italy as a first stopping point or final destination for many Albanians, Turks, and others.⁴⁸

Spain, another new country of immigration like Italy, likewise pulls in immigrants due to its comparatively lax regulations. Spain’s new socialist government, for example, considered offering its nearly 800,000 illegal immigrants legal status in 2004. Spain also considered legislation that would offer residence permits to migrants who reported employers that hired illegal immigrants. The EU says that “25 percent of the 500,000 unauthorized foreigners arriving

⁴⁶ Carmelita F. Ammendola, Oliviero Forti, Susanna Garavini, Franco Pittau, and Antonio Ricci, *Immigrazione Irregolare in Itali – L’approccio nazionale nei confronti dei cittadini stranieri irregolarmente soggiornati: caratteristiche e condizioni sociali* (Rome: European Migration Network Punto Nazionale di Contatto in Italia, 2005), 42.

⁴⁷ Casey Newell, “History of Italy’s Illegal Immigration Problem,” “Policy Alternatives,” “Cost / Benefit Analysis,” “Policy Recommendation,” and “Conclusion,” in *Illegal Immigration in Italy* (April 2004), <http://www-pub.naz.edu:9000/~cmnewell/history.htm> (accessed May 25, 2006).

⁴⁸ Hamilton, “Italy’s Southern Exposure.”

each year enter via Spain, and the Spanish government hopes that a new cooperative attitude with Morocco can stem unauthorized migration despite a 12 to 1 wage gap.”⁴⁹

The second reason for landing in Italy, a network of contacts, is due to the diverse nature of Italy’s immigrant population. In France, most Muslims come from Algeria, in Germany from Turkey; in Italy there is no specific group, or origin, of Muslim foreigners.⁵⁰ This diversity makes the network theory probable for a number of nationalities to enter Italy.

Entering Italy as a gateway country also has a lot to do with increased migration to Europe in general and stricter immigration legislation coming out of other EU nations. Some scholars, however, in addition to the distinctions drawn above, distinguish Italy from the rest of the European phenomenon – Italy is part of the “Mediterranean model of migration” paradigm, versus other European countries’ whose migratory patterns are more influenced by their colonial activities in the twentieth century. Spain, Greece, and Portugal also fall into this category. Italy, Spain, Greece, and Portugal all witnessed large emigration from their borders and did not become countries of migration until the 1970s.⁵¹

Destination Country

Along with many other European countries in the 1970s, Italy experienced a larger numbers of immigrants arriving on its land. Italy’s yearly and most comprehensive study on migration notes that the three factors influencing the increased immigration to Italy are: (i) its

⁴⁹ “Italy, Spain: Boat People,” *Migration News* (Oct. 2004),

http://migration.ucdavis.edu/MN/comments.php?id=3051_0_4_0 (accessed May 27, 2006).

⁵⁰ Shaykh Prof. Abdul Hadi Palazzi with the Istituto Culturale della Comunità Islamica Italiana (Cultural Institute of the Italian Islamic Community), interview with author, Rome, Italy, July 24, 2006.

⁵¹ Global Commission on International Migration, “Public policies and community services for immigrant integration: Italy and the European Union,” *Global Migration Perspectives* no. 29, prepared by Paolo Ruspini, (Geneva, September 2005): 2-3, <http://www.gcim.org/attachements/GMP%20No%2045.pdf> (accessed December 29, 2006).

geographic location, with long borders, in an area of strong migration, (ii) numerically weak and operationally ineffective planning for these influxes, and (iii) immigrants lacking *permessi di soggiorno* (residence permits) but being already inserted into the black market of work.⁵² We discussed reasons (i) and (ii) above; researching the rest of the literature shows that the probable major reason people immigrate to Italy relates to reason (iii), to fill the unmet need for labor in many Italian sectors. Other reasons exist, as explained in the theories of migration section of the introduction, but I will go on now to give a more detailed explanation of the labor situation in Italy, as many of the health problems to be discussed directly or indirectly result from this work.⁵³

Historically, Italy, facing a declining population due to its many emigrants and falling birth rates, kept its borders relatively open for work purposes. In 1986, the Italian Parliament passed legislation giving non-European Economic Community (EEC) migrants more rights and access to jobs. Non-ECC migrants in Italy subsequently have increased dramatically over the last 30 years; in the 1970s, they roughly numbered 300,000 and in 2000, 1.2 million.⁵⁴

It is said “with a 7,600-kilometer (4,720 mile) coastline to patrol and one of the world's lowest total fertility rates (1.23), it is clear that Italy will have more immigrants and fewer Italian workers in the years to come.”⁵⁵ In most European OECD member countries, populations will decrease by 10 percent in the next fifty years. The dependency ratio, or the number of persons in the population under the age of 15 and over the age of 65 divided by the number of persons in the population between the ages of 15 to 64 will double; this means a dramatically shrunken

⁵² Luca Di Scullo, “Flussi e soggiornati: 35 anni d’immigrazione in Italia” in *Immigrazione: Dossier Statistico 2005: XV Rapporto*, ed. Alberto Colaiacomo, Alessio D’Angelo, Manuella De Marco, Luca Di Scullo, Oliviero Forti, Delfina Licata, Franco Pittau, and Antonino Ricci, (Rome: Caritas/Migrantes, 2005), 70-71.

⁵³ Global Commission on International Migration, “Crisis in countries of origin and illegal immigration into Europe via Italy,” 7.

⁵⁴ Newell, *Illegal Immigration in Italy*.

⁵⁵ Hamilton, “Italy’s Southern Exposure.”

work force and an enlarged proportion of the population relying on this reduced amount of productive persons.⁵⁶

The Ministry of Work sets the quotas for immigration each year, as they are the body that surveys the needs of the Italian workforce.⁵⁷ They did this given the restrictive laws passed to reduce increasing irregular immigration in an attempt to reexamine measures concerning border security. The decision to set quotas of workers, however, was insufficient because the estimated need of workers continues to fall short of actual need; the number of irregular immigrants that enter fill this gap.⁵⁸ Law no. 40 passed in 1998 was the first to set quotas. The fact that these numbers remain insufficient leaves open a “back door” of illegal entry for many workers. Many legal workers were at sometime illegal and “entered into legality” during one of Italy’s legalization processes.⁵⁹ Currently, to find legal work in Italy, migrants must put their name on a list at an Italian consulate and firms will hire individuals from these lists.⁶⁰ For 2006, the Ministry of Work and Social Politics made 170,000 its quota for *extracomunitari* (non-EU) seasonal and non-seasonal workers. Within this number, Italy gave permission for 38,000 workers from various countries with whom it had drawn specific agreements permission to enter the country for non-seasonal work; of these 38,000, 3,500 could have been from Tunisia, 4,000 from Morocco, and 7,000 from Egypt. Fifty thousand could enter for seasonal work.⁶¹

⁵⁶ OECD Development Centre, “Immigrants and EU Labor Markets,” prepared by Louka T. Katseli, Migration Information Source (December 1, 2004), <http://www.migrationinformation.org/Feature/display.cfm?ID=274> (accessed December 27, 2006).

⁵⁷ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 42.

⁵⁸ *Ibid.*, 42-43.

⁵⁹ Global Commission on International Migration, “Public policies and community services for immigrant integration: Italy and the European Union,” 5-7.

⁶⁰ Newell, *Illegal Immigration in Italy*.

⁶¹ Associazione Lavoratori Emigrati del Friuli Venezia Giulia, *Decreto del Presidente del Consiglio dei Ministri 15 febbraio 2006*, (March 7, 2006), <http://www.alef-fvg.it/immigrazione/temi/flussi/2006/flussi2006.html> (accessed December 27, 2006).

Studies show that sanctions against Italian employers of illegal immigrants also fail to control the demand for cheap labor not found in the domestic market.⁶² “The combined presence of legal, illegal, semi-legal, and seasonal migrants in all sectors is fairly large—perhaps even exceeding 10 percent of the labor force.”⁶³ Work motives bring immigrants to Italy in the first few months of the year, familial reasons throughout the year, and attempts to illegally enter, regardless of motive, usually happen during the summer because of this migration’s maritime nature from the coast of North Africa.⁶⁴

A 2003 survey study concludes that the demographic and economic benefits of irregular immigration outweigh its financial costs. According to the Audit Court, fighting irregular immigration in 2004 cost Italy €320,000 a day. Integration and assistance programs completed in that year cost an additional €29 million. Expulsion and temporary residence centers add additional costs.⁶⁵ Counting all the people Italy rejects, expels, escorts to the border, and readmits each year totals around 150,000 foreigners.⁶⁶ In 1997 alone, 8,388 Moroccans were identified for expulsion or immediately turned away.⁶⁷

Where exactly is this need for labor? Over 56 percent of foreigners live in Northern Italy; this data corresponds to the higher demand for agricultural and industrial work in the North versus the South.⁶⁸ It should also be noted that

“particularly in the North-East, the arrival of immigrants is viewed as an aid to the survival of whole sectors of manufacturing, while in people-minding jobs (*badante*), the availability of foreign workers has proved not just essential but has also saved hundreds

⁶² Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 50.

⁶³ Martin, “The Changing Mosaic of Mediterranean Migrations.”

⁶⁴ Luca Bettinelli with Caritas Ambrosiana, interview by author, Milan, Italy, July 13, 2006.

⁶⁵ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 55.

⁶⁶ *Ibid.*, 42.

⁶⁷ Flavia Piperno, “Espulsione e poi? L’impatto del rimpatrio forzato in Albania e Marocco” in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 249.

⁶⁸ Global Commission on International Migration, “Public policies and community services for immigrant integration: Italy and the European Union,” 4.

of millions of euros, thanks to the lower number of admissions to hospitals, nursing homes and other institutions.”⁶⁹

Statistics show that 7.7 percent of *extracomunitari* immigrants in Italy work in the agriculture or fishing sector, 23.4 percent in the industry sector (10.3 percent in construction, 3.1 percent in metals, 2.0 percent in the food industry, 1.8 percent in the textile industry, 1.0 percent in the mechanics industry, 4.9 percent and more in other industries like tobacco, rubber, wood, auto repair, electrics, transportation, paper, mineral extraction, and chemicals), 28.2 percent in the service sector (10.1 percent in hotels and restaurants, 5.7 percent furniture, 3.8 percent in transportation, 2.4 percent in commercial retail, 2.2 percent in commercial wholesaling, 1.4 percent in public services, 1.3 percent in health, 0.3 percent in intermediary financing, 0.2 percent in teaching, 0.2 percent in public administration) and 40.7 percent in “non-determinable activities.”⁷⁰

For temporary, or seasonal, workers, industry work employs 72 percent of them, commerce 7 percent, services 6.3 percent, and tourism and hotels 4.3 percent. Only 0.1 percent of the employees officially work in the agriculture sector. More than 30 percent of the employed workers work in the metal and mechanics industries; 10 percent in the petrochemical industry and 6 percent in the food industry.⁷¹

Over half of the immigrants in Italy send home remittances, but only 21.4 percent of these individuals send them regularly. More remittances are sent from the central and southern regions of Italy and from irregular immigrants in general.⁷² For most of the respondents in a

⁶⁹ Ibid., 10.

⁷⁰ Oliviero Forti, “Le assunzioni e il lavoro interinale per territorio e settori,” in *Immigrazione: Dossier Statistico 2005: XV Rapporto*, ed. Alberto Colaiacomo, Alessio D’Angelo, Manuela De Marco, Luca Di Scullo, Oliviero Forti, Delfina Licata, Franco Pittau, and Antonio Ricci, (Rome: Caritas/Migrantes, 2005), 266-267.

⁷¹ Ibid., 264.

⁷² Natale Losi, Rose Helena Ippolito, and Bruno Mazzara, *Gente in Movimento: Migranti, Progetti Migratori, Rapporto con il Sistema Italia nella Percezione di Immigrati e Operatori di Servizi Pubblici*, (Rome: International Organization of Migration, 2002), 55.

2003 survey, social and financial reasons motivated migration rather than environmental disasters, famines, or epidemics. Only 25 percent of them had been previously employed in their home countries despite the fact that most of them had had a considerable amount of schooling.⁷³

While the need for labor helps immigrants in their search for fortune and helps employers keep their prices down, the flow of illegal immigration into the Italian economy also creates several problems. Unstable unemployment rates and growing unrecognized economic sectors are two particularly related to the economy.⁷⁴

The two main reasons explaining the draw of Italy for many migrants, an easy entrance into Europe and the open job possibilities, show how Italy has become a European country of migration. The Caritas organization, a major producer of studies and statistics on migration in Italy, has explained how Italy is undergoing the process of structuralization with migration. This process has involved: (i) the relative number of immigrants (in regards to other European countries) and incidence of immigration growing ever closer to the European average of 5 percent, (ii) the rhythm of increase in migration accelerating in the last years in comparison to other European countries, (iii) the distribution of immigrants being throughout the country, most however, being in the north and in urban areas, (iv) the migration normalizing from a demographic point of view – equal numbers of both genders being present with increase in minors and foreign babies born in Italy each year (48,364 in 2004), (v) the tendency towards stability growing - 60 percent of foreigners have lived in Italy longer than five years, (vi) the elevated need of work also growing – 8 percent of the work force, 80 percent of domestic

⁷³ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 47-48.

⁷⁴ Newell, *Illegal Immigration in Italy*.

workers, and (vii) the non-substitutable role of migration taking hold in several sectors like domestic work.⁷⁵

Important Legislation Affecting Immigrant Health Care

Laws and their Ramifications

Before evaluating the health rights and status of immigrants in Italy, it is important to know the laws that govern their presence, movements, and actions within Italy beyond those that govern labor-specific activities, particularly those laws that govern immigrants and health care. Two major pieces of Italian legislation focus on immigrants: the 1998 Turco-Napolitano law and the 2002 Bossi-Fini Law.

Before 1998, between 1986 and 1998, Italy offered migrants several “periods of amnesty,” during which at least 700,000 illegal aliens declared themselves and applied for citizenship without punishment. Rather than diminishing the problem of an underground economy, however, these actions on the part of the Italian government actually attracted more migrants.⁷⁶

The Turco-Napolitano law, also known as the *Testo Unico* (Single Act) or law no. 286 passed in July 1998, sought to better integrate immigrants into Italian society, to reduce conflict between nationals and immigrants, to foster respect for the “personal integrity” of immigrants, to extend full rights to legal immigrants, and to establish basic rights for illegal immigrants.⁷⁷ The country, however, still had problems enforcing deportation. In 1999, for example, out of the

⁷⁵ Di Scullo, *Flussi e soggiornanti*, 73.

⁷⁶ Newell, *Illegal Immigration in Italy*.

⁷⁷ *Ibid.*

11,269 immigrants held in custody for deportation, only 3,987 of them were actually deported. In 2000, furthermore, Italy issued 64,734 deportation warrants, and only acted upon 2,867 of them.⁷⁸ The 1998 legislation also established that immigrant minors present in Italy, even those without *permessi di soggiorno*, have the right to education and medical care. It also safeguards pregnant women and those who have just given birth and guarantees them medical care.⁷⁹

Italians characterize the 1980s and the 1990s as a period of emergency in which Italy had to confront and prepare itself for the migratory phenomenon. The period following the 1998 Turco-Napolitano law Italians identify as the period of limited and contrasted *organicità* (organic unity, or organization), in which Italians attempted to confront the problems and all their complexity with innovative measures. This period, however, Caritas contends cannot last. Italy must enter a period of accepting immigration as a new structural dimension of Italy that will bring consequences. So while Italy has realized it cannot stop integration, it needs to realize that measures must be taken to move forward, to protect the future of everyone in the country.⁸⁰ This realization might have happened with the 2002 law.

In 2002, Parliament passed Law 189, or the Bossi-Fini Law. This law, as opposed to the earlier major piece of legislation, made conditions stricter for illegal immigrants. It required that they leave the country within five days of being caught and maintained that such individuals be held in custody during that period.⁸¹ The Bossi-Fini Law

“amends the 1998 Immigration Act and introduces new clauses. Some of the most significant changes include: [tighter] immigrant quotas, mandatory employer-immigrant contracts, stricter illegal immigration deportation practices, amnesty for illegal immigrants who have worked and lived in the country for over three months, and new

⁷⁸ Ibid.

⁷⁹ Giusy D’Alconzo, *Invisibili: Minori migranti detenuti all’arrivo in Italia*. (Turin: Amnesty International, Italian Section - EGA Editors, 2006), 38-39.

⁸⁰ Di Scullo, *Flussi e soggiornanti*, 74-75.

⁸¹ Newell, *Illegal Immigration in Italy*.

provincial immigration offices to help manage immigrant worker and family reunification cases.”⁸²

According to Ruspini, Italy’s later definition of immigration legislation (1998 and 2002) benefited from the weaknesses’ of other countries’ laws. The Italian legislation had two goals for integration policies: (i) low conflict interaction between nationals and immigrant minorities, and (ii) respect of immigrants’ personal integrity. In Ruspini’s point of view, these goals were addressed by “(i) safety and security measures meant to reassure Italian citizens, (ii) pluralism and communication measures meant to produce mutual respect and understanding, integrity through (iii) full rights for legal immigrants and (iv) basic rights for illegal immigrants.”⁸³

Many, however, including the newly elected (May 2006) Prime Minister Romano Prodi, find a lot of flaws in what they consider to be overbearing Italian immigration legislation. His Welfare Minister Paolo Ferraro in December 2006 promised a new law by the summer of 2007. This law should relax some of the restrictions and difficulties of getting a residency permit, double the permit from two to four years, create one asylum law, and introduce a “points-based entry system” to better manage migration. Other proposals include giving immigrants the right to vote and making acquiring citizenship easier.⁸⁴ Are these full rights to legal immigrants and basic rights to illegal immigrants enough to counter the problems of disillusionment and of the difficulty of economic advancement mentioned in the introduction? I will examine the answer to this question and the questions also presented earlier on proper integration into the health care system in the “health status of immigrants” and “access” sections later in this thesis.

⁸² Hamilton, “Italy’s Southern Exposure.”

⁸³ Global Commission on International Migration, “Public policies and community services for immigrant integration.”

⁸⁴ Ronald Ashri, “New Italian immigration law by summer,” 8 December 2006 *Italy Magazine* (December 8, 2006, <http://www.italymag.co.uk/2006/news-from-italy/new-italian-immigration-law-by-summer/> (accessed January 27, 2007)).

The Ministry of Health (MOH) has put out several decrees and other documents concerning immigration. Decrees from the MOH as far back as 1982 address the presence of foreigners in Italy. Decree 25/11/1982, for example, addresses the right to services for diseases related to unfortunate work circumstances and for other diseases and maternity conditions for Italian citizens or for foreigners. Decree 08/10/1986 determined the contribution of health assistance for foreign citizens. Laws and decrees throughout the late 1980s and early 1990s addressed combating HIV/AIDS and how immigration plays a role in controlling the disease. Any decrees addressing non-Italian workers, however, usually refer to “communal foreigners,” or workers coming from within the European Union. Decree 01/01/1996 addresses the tariffs connected with emergency hospital services consumed from the National Health Service for uninsured Italian citizens and foreigners.⁸⁵ Articles 34-36 of Legislative Decree no. 286 passed July 25, 1998 (Turco-Napolitano, *Testo Unico*) sanctioned the inclusion of immigrants, even those irregularly and clandestinely present, to the same health rights and obligations as Italians.⁸⁶ Circular no. 5 published March 24, 2000 elaborated on the health rights of immigrants, particularly on who can enroll in the National Health System, which was mentioned in the 1998 legislation and also discussed in a previous Circulars, one published, for example, April 22, 1998.⁸⁷ The 2002 Bossi-Fini law did not modify any of rights afforded in the 1998 law.

The Italian “Governing Program” for the promotion and equality of health among citizens specifically makes special reference to women immigrants, especially their reproductive and

⁸⁵ “Leggi, decreti e direttive comunitarie,” Italian Ministry of Health, <http://www.ministerosalute.it/normativa/pnRisultati.jsp?area=escludi&subarea=escludi&tipo=escludi&emanatore=escludi&numeronormahidden=&datada=1901%2F01%2F01&dataa=2101%2F01%2F01&protocollohidden=&titolohidden=&pubblicazione=escludi&numeropubhidden=&datapubda=1901%2F01%2F01&datapuba=2101%2F01%2F01&keywords=immigrati&keywordshidden=immigrati&keywordshiddenkey=immigrati&keywordshiddenTA=immigrati> (accessed January 27, 2007).

⁸⁶ P. Ghezzi, “La Tutela del Diritto alla Salute in una Società Multiculturale,” *Difesa Sociale* 6 (2003), http://www.iims.it/iims/Difesa%20Sociale/2003_Numero_6/Editoriale%20Pagg%207-11%206-03.pdf (accessed January 28, 2007).

⁸⁷ “Leggi, decreti e direttive comunitarie,” Italian Ministry of Health.

maternal health.⁸⁸ In the national health plan for 2006-2008, paragraph 5.7 recognizes the need for health interventions in migrant and other socially marginalized groups. With this focus, the plan calls for policies especially focused on young persons and minors, for research on the spread of infectious diseases, for training programs for Italian social workers (*operatori*) focused on maternal-child health, unfortunate workers, and the homeless.⁸⁹

A 2006 Decree recognizes the need to make the National Health System more capable of coordinating responses to the demands and needs of Italians and immigrants. It also recognizes that the parts relevant to immigrants in the National Health Plan and the Governing Program need to be fully realized.⁹⁰ Article 1 of the Dec. 2006 decree declares the institution of the Commission on “Health and Immigration” to promote and protect the health of foreigners in Italy. This commission will last for three years.⁹¹ Article 2 defines the objectives and tasks of the Commission, which include improving prevention and access to health services for immigrants as well as developing and monitoring interventions and campaigns for the immigrant population. The specific tasks and objectives of the Commission are laid out in Appendix D.

The rest of Italian legislation that refers to migrants deals with refugees and asylum seekers. In 1954, Italy ratified the 1951 the Convention of Geneva on the status of refugees, which guarantees those asking for asylum food and board, medical services, and the right not to be sent back to one’s country of origin.⁹² While this thesis focuses more on voluntary migrants, Italy’s poor track record at welcoming asylum seekers is important to review as many of these individuals end up living and working with the voluntary migrants.

⁸⁸ Commissione “Salute e Immigrazione,” Italian Ministry of Health, *Decreto del Ministero della Salute* (Rome, 12 December 2006), http://www.ministerosalute.it/imgs/C_17_normativa_903_allegato.doc (accessed December 28, 2006).

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² D’Alconzo, *Invisibili*, 23-24.

The 1990 Martelli Law welcomed refugees from outside the European Union. Italy regularized large numbers of asylum seekers in 1986, 1990, 1995, and 1998. In 2000, 24,500 Asylum seekers – Kurdish Turks and Iraqis from Afghanistan and Iraq, all applied for asylum in Italy. Another 18,000 from Kosovo and 1,015 Bosnians were let into the country under other agreements of temporary residence.⁹³

Despite being party to the 1951 convention and its periods of regularization, Italy still has a poor track record in guaranteeing the rights of asylum-seekers. In 2004, as in other years, many immigrants from North Africa arrived at the Italian island of Lampedusa, off the coast of Sicily. In October 2004, Italian officials flew at least 2,600 of the migrants back to Libya without offering them asylum; this action may have violated the 1951 Geneva Refugee Convention. Italian officials returned all migrants except those from Somalia, Eritrea, and Ethiopia.⁹⁴ The UNHCR has “expressed serious doubts on the effective capacity of welcoming in Italy, on the transparency of procedures of identification, and on the aspect of minimum standards of welcoming.” Italy is regarded as a “weak country of asylum, weak in welcoming.”⁹⁵ Issues in the debate include whether immigrants landing on the southern islands who are subsequently turned away had the right to asylum and how to control illegal immigrants in cities, considering a group who committed serious crimes in June 2005.⁹⁶

General Rights

⁹³ Hamilton, “Italy’s Southern Exposure.”

⁹⁴ “Italy, Spain: Boat People.”

⁹⁵ Claudia Finotelli, “Welcomed or Sanctioned? The Asylum and the Humanitarian Protection in ‘New’ and ‘Old’ Countries of Immigration” in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 211.

⁹⁶ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 42-43.

Italy has not yet (as of Dec. 2006) ratified the 1990 Convention on the Rights of All Migrant Workers and of all their Family Members (but neither has any other European country).⁹⁷ Europeans claim to have signed to such rights in other documents like the European Convention of Human Rights.⁹⁸ This document, created in 1950, reiterates many of the rights and freedoms listed, including the prohibition of restricting the political activities of aliens and the freedom of movement, however, restricted by terms of state sovereignty. Article 14 of the Convention prohibits discrimination against many groups including language, race, ethnicity, and religion and Protocol 12 extends the protection under any legal right.⁹⁹

Other EU documents discuss the rights of migrants in Europe, like the 1977 European Convention on the Legal Status of Migrant Workers and the 2004 European Platform for Migrant Workers' Rights. The older document defines a "migrant worker," describes how forms of recruitment, medical examinations, and vocational tests can be carried out, and identifies and defines migrants' rights to exit and to admission. It also explains administrative and work contract formalities, how employers should provide maximum information on paperwork, social services, and family reunification processes, and how employers must pay the travel expenses of the migrant. The Convention goes into detail on these services including education, the right of migrant workers to equal medical assistance as nationals (Article 19), and the duty of employers to inspect working conditions.¹⁰⁰ The newer group of which Italy is a member seeks to increase advocacy on the behalf of immigrant rights, to coordinate more national campaigns and activities

⁹⁷ D'Alconzo, *Invisibili*, 23-24.

⁹⁸ Susan Martin, meeting with author, January 2007, Washington DC.

⁹⁹ Council of Europe, *The European Convention on Human Rights* (Rome, 1950), <http://www.hri.org/docs/ECHR50.html> (accessed March 14, 2007).

¹⁰⁰ Council of Europe, *European Convention on the Legal Status of Migrant Workers* (Strasbourg, 1977), <http://conventions.coe.int/Treaty/EN/Treaties/Html/093.htm> (accessed March 14, 2007).

across Europe, and to work towards EU member states' ratification of the UN Migrant Workers' Convention.¹⁰¹

Most recently on the table is the Green Paper on an EU Approach to Managing Economic Migration. This document was created to provide debate among member states on how to regulate the entry and residence of third country nationals seeking employment in the European Union. It still values individual countries' rights to govern immigration practices and raises the question of securing the rights and integration of immigrant workers, with special attention given to the questionable status of temporary workers.¹⁰²

Italian legislation does protect many rights of migrants and reflects the above conventions. Irregular immigrants are guaranteed fundamental rights, despite their legal status. If someone commits a discriminatory act against them, for example, there are avenues for recourse and compensation.¹⁰³ Everyone has a right to leave his or her country, but he or she has no right to enter another state without its permission. Even illegal migrants, however, must be afforded the protection of their basic rights without discrimination. A state has the right to deport irregular immigrants, for example, but not to whip them in the process. Unskilled workers, irregular migrants, and women are at a higher risk for human rights violations due to the nature of their new work, legal, and power-dynamic conditions.¹⁰⁴

Law 2000/43/CE calls for equal treatment of individuals regardless of race or ethnic origin. With decree number 215 on July 9, 2003 Italy created the "Office for the Promotion of the Parity of Treatment and the Removal of Discrimination Founded on Race or of Ethnic

¹⁰¹ "Portal for the Promotion and Protection of the Rights of Migrants," December 18: International Advocacy and Resource Centre on the Human Rights of Migrant Workers, <http://www.december18.net/> (accessed March 14, 2007).

¹⁰² "EU Opens Debate on Economic Migration," EuroActiv (January 12, 2005), <http://www.eurociv.com/en/justice/eu-opens-debate-economic-migration/article-134074> (accessed March 14, 2007).

¹⁰³ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*.

¹⁰⁴ Grant, "Migrants' Human Rights: From the Margins to the Mainstream."

Origin” (UNAR). The new norm calls for people to act on shows of discrimination committed by either individuals or organizations. Out of all the areas of discrimination filed, UNAR notes that 4.7 percent of the cases dealt with health.¹⁰⁵ This right against discrimination will be important in later discussions on the stress and health effects of discriminatory experiences.

Many critics, however, claim that immigrants do not hold enough rights, like the right to vote in municipal elections as specified in the European Convention on the Legal Status of Migrant Workers.¹⁰⁶ Only legal resident immigrants in Italy can participate in local politics.¹⁰⁷ A high percentage of Italian social workers (66.1 percent) think the acquisition of civil rights should also be less restrictive for immigrants.¹⁰⁸

This study, in its conclusion, will evaluate the actual presence of the health-specific protections mentioned in the EU documents and Italian legislation on migrants in the Italian health system. The information presented below will show that the Italian legislation both referring to the health of migrants and their rights might provide a good basis for keeping migrants healthy, but that certain factors make it overall lacking.

Migration from the Arab World to Italy

Recent Increase in Women Migrants

¹⁰⁵ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 39-40.

¹⁰⁶ *Ibid.*, 44.

¹⁰⁷ *Ibid.*, 53.

¹⁰⁸ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 17.

In 1970, Italy had only a little more than 140,000 immigrants residing in its borders. As of 2004, this number multiplied nearly 20 times to over 2.7 million.¹⁰⁹ What needs immediate clarification is that not every person representing one of those numbers is a male worker. The recent increase in women migrants and the increase in the number of other migrants requesting residence permits for family reunifications show that the health challenges this study will address cannot be limited to those problems only men experience in the workplace. On the contrary, this study focuses on the health of entire Arab Muslim families due to the fact that Arab Muslim communities are taking hold in Italian soil and that certain issues and problems come along with this population change.

Between 1991 and 2002, the number of (legal) women immigrants in Italy doubled from 361,000 to 726,000, increasing the proportion of women migrants from 42 percent to 48.4 percent. The 2004 census shows that women now account for over half of the immigrants in Italy, coming in at 50.5 percent; for every three resident women immigrants, one is gaining citizenship.¹¹⁰ In 2003, over 96,000 women from North Africa alone immigrated to Italy.¹¹¹ In 1991, 40.7 percent of the immigrants were married, in 2003 that number rose to 49.9 percent. In 2004, only 15 percent of the women immigrants came from some part of Africa.¹¹² One woman migrates for every six men that migrate from Algeria; the same rule applies to Egypt. One

¹⁰⁹ Franco Pittau, "35 anni di immigrazione in Italia," in *Immigrazione: Dossier Statistico 2005: XV Rapporto*, ed. Alberto Colaiacomo, Alessio D'Angelo, Manuela De Marco, Luca Di Scullo, Oliviero Forti, Delfina Licata, Franco Pittau, and Antontio Ricci, (Rome: Caritas/Migrantes, 2005), 76.

¹¹⁰ Luca Di Scullo, "Indexes of insertion for the immigrants: Immigrazione al femminile e matrimoni misti" in *Immigrazione: Dossier Statistico 2005* (Roma: Caritas/Migrantes, 2005), 132.

¹¹¹ "Italia. Incidenza donne immigrate per aree continentali (2003)," in *Immigrazione: Dossier Statistico 2005: XV Rapporto*, ed. Alberto Colaiacomo, Alessio D'Angelo, Manuela De Marco, Luca Di Scullo, Oliviero Forti, Delfina Licata, Franco Pittau, and Antontio Ricci, (Rome: Caritas/Migrantes, 2005), 504.

¹¹² Di Scullo, "Indexes of insertion for the immigrants," 132.

woman migrates for every four men that come from Tunisia, for every three men that come from Morocco, and for every four or five men that come from Jordan, Syria, or Palestine.¹¹³

Women either stay in Italy for family or work reasons – 39 percent and 50.2 percent respectively (versus 80.9 percent men for work reasons).¹¹⁴ The first reason for the recent increase in women immigrants – the desire for male workers to bring their families to Italy, results in the greater number of *permessi di soggiorno* for family reasons. This signifies an increased number of immigrants probably settling in Italy for the long term, that is, less families and men returning to their countries of origin after a period of employment.¹¹⁵ In 2003, 532,670 (out of 2,128,787) individuals obtained residence permits for “family motives.”¹¹⁶

The 1998 law gave immigrants the right to enter the country (migrate) for the purpose of family reunification.¹¹⁷ After permits for work, permits to stay in Italy due to family-related reasons are the most numerous. Certain restrictions and verifications must first be satisfied before the permits are granted.¹¹⁸ Only holders of an at least one-year renewable visa can apply for family reunification. Once in Italy, the family members do have the right to work. The Bossi-Fini law made it harder for the parents still in countries of origin to join their children in Italy. The number of people given permission to enter the country for familial reunifications is not counted in the yearly decreed quotas.¹¹⁹

¹¹³ Ibid., 133.

¹¹⁴ Ibid., 133.

¹¹⁵ Daniela Melfa, “The Muslim Communities in Sicily Between Internal Networks and the *Umma al-islamiyya* and Interaction with the Host Society” in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 153-154.

¹¹⁶ “Italia. Stima dei soggiornati stranieri per province (31 dicembre 2004),” in *Immigrazione: Dossier Statistico 2005: XV Rapporto*, ed. Alberto Colaiacomo, Alessio D’Angelo, Manuela De Marco, Luca Di Scullo, Oliviero Forti, Delfina Licata, Franco Pittau, and Antonio Ricci, (Rome: Caritas/Migrantes, 2005), 499.

¹¹⁷ Baldwin-Edwards, “The Changing Mosaic of Mediterranean Migrations.”

¹¹⁸ Di Scullo, “Indexes of insertion for the immigrants,” 93-94.

¹¹⁹ Global Commission on International Migration, “Public policies and community services for immigrant integration,” 6.

In 1991, only 14.2 percent of *permessi di soggiorno* were given to family, in 2002 that number had risen to 31.8 percent.¹²⁰ Most females that come with these permits are around the age of 30 (wives) and most of the males are between the ages of 15 to 20 (children). Women immigrants from predominantly Muslim countries request more permits for family reasons than the average (30 percent); 89.2 percent from Egypt are for familial reunification, 81.1 percent from Tunisia, 76.9 percent from Jordan, and 76.4 percent from Algeria, among others. The regions of Lombardia, Lazio, and Emilia Romagna host the most women immigrants (21.2, 16.7, and 9.6 percent respectively).¹²¹

The other reason for the recent increase in women migrants is the fact that many women themselves are seeking employment in Italy. Twenty-nine percent of the foreign workers in Italy are women, 15 percent coming from Africa and Asia (most coming from Eastern Europe).¹²² The 1998 law “[provided] for legalization of two types of irregular immigrants: those employed either as domestic workers and home-helpers or as dependent workers. These individuals may qualify for regularization, provided that they have not received a deportation order.” Many such workers are women.¹²³

As of 2004, 53,000 women (and 319,000 men) did ancillary work; Moroccan women made up 4 percent of these workers (most women came from Romania, China, and the Ukraine). Triple that amount, 147,000 women (and 42,000 men) did domestic work; Moroccans composed 2.3 percent of that total with most women again coming from Romania and the Ukraine. At least

¹²⁰ Di Sciullo, “Indexes of insertion for the immigrants,” 133.

¹²¹ Ibid., 133-135.

¹²² Forti, “Le assunzioni e il lavoro interinale per territorio e settori,” 264.

¹²³ Hamilton, “Italy’s Southern Exposure.”

121,000 women (and 19,000 men) did assistance work; Moroccans composed only 1.1 percent of that total with most women again coming from Romania and the Ukraine.¹²⁴

One can find many studies, in addition to the bare statistics, showing the increase of women immigrants in Italy. A letter from a provincial secretary in Catania to one of the major Italian trade unions sent in 2005, for example, asked that an adjustment be made considering the number of irregular immigrants, to supply female health personnel.¹²⁵ According to a study about Muslim immigrants in Sicily, “Islamic immigration” to Italy is increasingly involving more women.¹²⁶

Increasing Arab and Muslim Communities

In the same period of time mentioned above, from 1970 to 2004, in which immigrant numbers greatly increased in Italy, the number of immigrants from North Africa and the Middle East has probably increased in the same manner, although statistics showing the total number immigrants coming from each country or region for the past 30 years cannot be found. It should be noted that statistics on immigrants in Italy before 1970 are unavailable and, according to some, only those numbers after 1980 are really reliable due to changes in the monitoring of those with *permessi di soggiorno* longer for one month.¹²⁷

Looking at recent numbers of immigrants coming from key countries in the Arab world to Italy does give one an idea of the current Arab population in Italy. Most Arabs in Italy come from Morocco, Tunisia, and Egypt as shown in Table 1 According to 2004 Caritas data, 227,940

¹²⁴ Di Sciullo, “Indexes of insertion for the immigrants.”

¹²⁵ D’Alconzo, *Invisibili*, 57.

¹²⁶ Melfa, “The Muslim Communities in Sicily...”

¹²⁷ Di Sciullo, *Flussi e soggiornanti*, 69.

Moroccans officially live in Italy.¹²⁸ Morocco follows Senegal with the highest number of workers in Italy, representing 10.2 percent of foreign workers.¹²⁹ Morocco and Tunisia both rank in the top five for legal (Morocco –first, Tunisia – third) and illegal (Morocco – second, Tunisia – fifth) immigrants present in Italy.¹³⁰ Figures 1 and 2 in Appendix A show the distribution of Moroccans and Tunisians throughout Italy.

In 2004, Libya announced that at least 1.5 million people waited within its boundaries for boats to the European Union. Libya is the only North African country that has not yet signed an agreement regarding immigration with the European Union. A majority of the immigrants coming to Italy through Libya are Egyptian. These Egyptians, however, often claim to be political refugees from Palestine or Sudan so that Italy will not turn them away. Some smugglers charge Egyptians \$2,500 each for the trip.¹³¹

A significant number of Arab immigrants are minors. One study showed that most unaccompanied immigrant minors in Italy come from Romania, Moldova, and *Morocco*.¹³² The 2003 survey showed that three quarters of the illegal immigrants in Italy were between the ages of 18 and 30.¹³³

The 2003 survey identified additional figures about illegal immigrants, some of them pertaining to Arabs: 58 percent of the immigrants surveyed were refugees or asylum seekers, 30 percent were holders of an expired visa or having no visa at all, 10 percent were awaiting expulsion, and 2 percent were waiting for a rejection order and escort to the border. Of the refugees or asylum seekers, the majority came from Iraq, Sudan, and Liberia. The others came

¹²⁸ Piperno, “Expulsion and Then?” 249.

¹²⁹ *Immigrazione: Dossier Statistico 2005: XV Rapporto*.

¹³⁰ Global Commission on International Migration, “Crisis in countries of origin and illegal immigration into Europe via Italy,” 8.

¹³¹ “Italy, Spain: Boat People.”

¹³² D’Alconzo, *Invisibili*, 27.

¹³³ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 47.

mostly from Morocco, Senegal, Turkey, Pakistan, Albania, and Sierra Leone. Most were men, with the few women coming mostly from Eastern Europe.¹³⁴

Table 1. Foreign resident population born abroad by sex, year of settlement in Italy, geographic area, and country of citizenship¹³⁵

GEOGRAPHIC AREA AND COUNTRIES OF ORIGIN	Year of Settlement in Italy					Totale
	Before 1992	1992-1996	1997-1999	2000	2001	
Europa	55945	76627	67591	21651	16935	238749
Turchia	1085	695	699	300	244	3023
Africa	91212	50095	39444	12337	7970	201058
AFRICA SETTENTRIONALE	66319	33189	27327	9020	5902	141757
<i>di cui: Algeria</i>	1667	3113	1325	359	223	6687
Egitto	6454	4016	3341	816	527	15154
Marocco	42471	20997	19058	6261	3931	92718
Tunisia	14922	4914	3461	1501	1126	25924
AFRICA OCCIDENTALE	20113	14351	10269	2598	1580	48911
<i>Nigeria</i>	1665	2025	1227	356	235	5508
<i>Senegal</i>	11644	6635	5315	1081	517	25192
AFRICA ORIENTALE	3617	1622	1114	376	279	7008
<i>di cui: Eritrea</i>	696	157	147	44	38	1082
<i>Etiopia</i>	479	207	205	79	65	1035
Asia	30479	28482	22236	7523	5488	94208
ASIA OCCIDENTALE	5208	1196	1371	502	333	8610
<i>di cui: Giordania</i>	729	192	130	49	28	1128
<i>Iran</i>	2163	289	313	137	97	2999
<i>Israele</i>	449	155	146	60	48	858
<i>Libano</i>	947	176	191	57	39	1410
<i>Siria</i>	571	224	216	70	40	1121
Apolidi	184	65	53	14	8	324
TOTALE	192996	165341	139489	46493	34565	578884

While not all Arab immigrants to Italy are Muslim, as noted before, most are. Around 35.4 percent of total foreigners (legal and illegal) in Italy are Muslim; Muslims are also the

¹³⁴ Ibid., 46.

¹³⁵ “Tavola: Popolazione straniera residente nata all’estero per sesso, anno di trasferimento in Italia, area geografica e paese di cittadinanza – Italia – Censimento 2001,” Istituto Nazionale di Statistica (Rome, 2001), [http://dawinci.istat.it/daWinci/jsp/MD/dawinciMD.jsp?a1=m0GG0c0I0&a2=mG0Y8048f8&n=1UH91409OG08B2Q2S&v=1UH0D509OG000000000000](http://dawinci.istat.it/daWinci/jsp/MD/dawinciMD.jsp?a1=m0GG0c0I0&a2=mG0Y8048f8&n=1UH91409OG08B2Q2S&v=1UH0D509OG00000000000) (accessed December 29, 2007).

fastest growing religious group in Italy.¹³⁶ The growing number of Muslims in Italy makes Islam the country's second most practiced religion. Data from 2002 estimates that at least 700,000 Muslims live in Italy; while many of these Muslims, however, might come from Arabic speaking countries, many also come from countries like Malaysia, Senegal, or Albania.¹³⁷ As of 2004, at least 52,729 Muslims lived in Rome, or 16.4 percent of the city's population (9).¹³⁸ The Survey on Illegal Migration to Italy taken in 2003 identified 58 percent of the interviewees as Muslim.¹³⁹ The number of Muslims born in Italy is still very small, so most Muslims present in Italy have experienced immigration.¹⁴⁰ Muslims in Italy differ from other Muslims in Europe; they tend to come from more diverse nationalities, have a more "rapid pace of entry and settlement," and have a wider "geographical dispersion."¹⁴¹

According to a 2000 survey of Muslim immigrants, many Muslims in Italy are relatively education – 28.4 percent have graduated college, 44.3 percent have a high school degree, 78.4 percent in their countries of origin and 10.1 percent in Italy have completed some other study diploma. Over a quarter (25.9 percent) use computers and these immigrants display much lower levels of illiteracy than the means in their countries of origin (2.7 percent versus an average of 50 percent).¹⁴²

In addition to the increased presence of Muslims in Italy, believers have established a growing number of Islamic associations as well in the country. Many Muslim communities open

¹³⁶ Global Commission on International Migration, "Public policies and community services for immigrant integration: Italy and the European Union," 3.

¹³⁷ Stefano Allevi, *Islam italiano: Viaggio nella seconda religione del paese* (Turin, Einaudi, 2003), 81.

¹³⁸ Lidia Pittau, Franco Pittau, Pierpaolo Felicolo, and Michele Giuffreda, *Immigrati a Roma. Luoghi di incontro e di preghiera*. (Rome: Caritas Diocesana di Roma – Migrantes Roma e Lazio, 2004).

¹³⁹ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 47.

¹⁴⁰ Shaykh Prof. Abdul Hadi Palazzi, July 24, 2006.

¹⁴¹ Stefano Allievi, "Islam in Italy," in *Islam, Europe's Second Religion: The New Social, Cultural, and Political Landscape*, ed. Shireen Hunter, (Wesport, CT: Praeger, 2002), 77–96.

¹⁴² Italian Ministry of the Interior, "La presenza islamica in Italia," prepared by Andrea Spreafico (Rome, 2005), <http://ssai.interno.it/pubblicazioni/instrumenta/25/09%20-%20spreafico.pdf>, 191-192.

their own schools; Tunisian schools are very common, for example, in several Sicilian cities.¹⁴³ Some communities are more closed, like the Bangladeshis, and open stores all in the same area. Other communities are organized at a higher level because their countries or embassies organize something; Morocco, for example, does a lot in Italy as the country's largest Arab community. Egypt has a big cultural center to which it invites artists and other exhibitions from Egypt. Other countries, however, like Tunisia, formally provide nothing.¹⁴⁴

Through a web search, I found twenty Arab or Muslim groups in Rome, five of them Islam-focused: Unione Musulmani d'Italia (UMI), Lega Musulmana Mondiale – Italia, Associazione Musulmani Italiani (AMI), Assemblea Musulmana d'Italia - Istituto Culturale della Comunità Islamica Italiana, and Comunità Religiosa Islamica Italiana (CO.RE.IS). In Milan, I found another seven Islamic associations: Associazione Donne Musulmane in Italia (ADMI), Unione delle comunità e organizzazioni islamiche in Italia (UCOII), Comunità Religiosa Islamica Italiana (CO.RE.IS), Giovanni Musulmani d'Italia (GMI), Istituto Culturale Islamico, Islam Kültür Merkezi, and Ordine dei Jerrahi-Halveti. Many more informal groups probably exist.

According to a Caritas publication, seven different mosques – usually connected to some cultural organization are available in Rome for Muslims. This is an increase from the available five mosques included in the 2000 publishing of this pamphlet. Seven mosques out of a total 190 places of prayer for various religions makes mosques compose almost four percent of the city's places of prayer. Lebanese Maronite and Egyptian Coptic (Christian minorities in each country) places of worship even exist in Rome.¹⁴⁵

¹⁴³ Melfa, "The Muslim Communities in Sicily," 161.

¹⁴⁴ Shaykh Prof. Abdul Hadi Palazzi, July 24, 2006.

¹⁴⁵ Pittau, Pittau, Felicolo, and Giuffreda, *Immigrati a Roma*, 18, 33, 59-60, 74.

Now that we have reviewed the immigration situation in general in Italy, the increased presence of women migrants, and the significant amount of immigrants in Italy from Arab countries, we can see that on paper many safeguards exist in Italy to protect immigrants' rights and their health that the identified study group – Arab Muslim immigrant families, are a significant population in Italy.

CHAPTER 2

HEALTH STATUS OF ARAB IMMIGRANTS IN ITALY

Upon Arrival

Immigrants are Usually Healthy

Usually the foreigners that come to Italy are the healthy foreigners.¹⁴⁶ Sick individuals cannot come; the voyage is very difficult, especially for unprotected refugees, and the work opportunities sought through migration seem possible only to those in good health.¹⁴⁷ While immigrants have typically been stereotyped as the carriers of disease (a known scholar on migration and health, Salvatore Geraci along with Maurizio Marceca notes the cases of Europeans bringing plagues and of African slaves carrying yellow fever to America and the misconstrued case of Haitians carrying AIDS to America), migrants coming to work in Italy are generally in very good health conditions. Immigrants automatically select themselves for the move if they have greater possibilities for change, meaning someone who is usually healthier and physically apt.¹⁴⁸

In fact, upon arrival, 73 percent of the surveyed immigrants considered their own health status to be good.¹⁴⁹ In one study, however, 22 percent of those interviewed said that they

¹⁴⁶ Luca Bettinelli with Caritas Ambrosiana, July 13, 2006.

¹⁴⁷ Ms. Edoarda Trillò with Rome Local Health Clinic “C”, interview with author, Rome, July 24, 2006.

¹⁴⁸ Salvatore Geraci and Maurizio Marceca, “Le malattie degli immigrati” in *Migrazioni e salute in Italia*, ed. S. Geraci, M. Marceca and M. Mazzetti for the International Convention “Migrations: Scences for the 21st Century,” (Rome: Agenzia romana per la preparazione del Giubileo, July 2000), 1-2.

¹⁴⁹ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 47.

perceive their health to have worsened in respect to when they first departed from their countries of origin; nearly half of the respondents declared having needed a serious medical intervention.¹⁵⁰ According to Dr. Pani in Rome, most Italian doctors know now that immigrants actually get sick in Italy; they know that many immigrants catch respiratory diseases because they all live together, under stairs, in the humidity, etc., or that many of them develop alcohol or drug problems after arrival.¹⁵¹

As we can see, Geraci's and Marceca's acknowledgement that most immigrants coming to Italy are healthy is consistent with the healthy immigrant phenomenon presented in the introduction. As we will see in the next section on immigrant health after some time in Italy and further in the access section, many of these health migrants do not remain health for long. All data I found referred to the health problems immigrants have and referred to worse percentages in comparison to Italians (to be presented later), but I found no studies confirming the health migrant phenomenon in Italy. No studies, for example, showed that immigrants in Italy exhibited better health than Italians.

Exceptions – Boat People, Carriers of Communicable Diseases, and CPT

One exception to the rule that most immigrants arrive healthy in Italy are those who sail from North Africa to southern Italy in unsafe and unstable boats. Italian officials usually talk about the problems of domestic racism, concerns about violence, and labor availability that immigration brings to the country, but many have named the numerous immigrant deaths at sea as their true concern. For example, Interior Minister Giuseppe Pisanu said: "this umpteenth

¹⁵⁰ D'Alconzo, *Invisibili*, 45.

¹⁵¹ Cecilia Pani with Comunità di Sant'Egidio, interview with author, Rome, July 28, 2006.

tragedy at sea dramatically heightens the need to regulate migration through broad international agreements addressing countries of origin, transit, and arrival.”¹⁵² Many of those arriving in boats enter Italy suffering from overcrowded conditions, hypothermia, or starvation. In 2003, over 14,000 immigrants arrived by boat in Italy, more than the number that landed in Spain and Greece.¹⁵³ Around 80,000 total people arrived in Italy between 2001 and 2005 in boats; this number represents 10 percent of all irregular immigrants arriving in Italy.¹⁵⁴

Another exception to the healthy immigrant portrait described above, are the small numbers of immigrants that do carry communicable diseases into Italy. According to one of the managers of a free clinic that serves immigrants in Milan, some people come carrying diseases that in Italy and Europe do not exist anymore like TB, Polio, and other respiratory diseases. He also noted that often they do not get themselves treated or have never been to a doctor in their lives.¹⁵⁵ According to a doctor in Sicily, immigrants bring malaria from Sub-Saharan Africa and increasingly from India, “scabies” (mites) from Africa, and sexually transmitted like HIV/AIDS.¹⁵⁶

Geraci and Marceca note in their work, however, that when analyzing the causes of death of foreigners in Italy, the smallest percentage die from infectious diseases or parasites.¹⁵⁷ They continue to remind everyone that immigrants spread STDs just as Italians do. Most importantly, almost 80 percent of immigrant STD cases were contracted in Italy; the majority of immigrants did not bring them from their countries of origin.¹⁵⁸

¹⁵² “Italy, Spain: Boat People.”

¹⁵³ Baldwin-Edwards, “The Changing Mosaic of Mediterranean Migrations.”

¹⁵⁴ D’Alconzo, *Invisibili*, 28-29.

¹⁵⁵ Sig. Andrea with Fratelli di San Francesco, interview with author, Milan, July 20, 2006.

¹⁵⁶ Dr. Alfio Gennaro, interview with author, Palermo, August 9, 2006.

¹⁵⁷ Geraci and Marceca, “Le malattie degli immigrati,” 4.

¹⁵⁸ *Ibid.*, 21.

Another way an immigrant might not arrive healthy in Italy, or at least might not start a life in Italy feeling 100 percent healthy is if he or she had to enter Italy through a *centro di permanenza temporanea* (CPT), a center of temporary detainment. Italian legislation in 1998 determined that those who arrive in Italy irregularly should be sent back to their home countries; the CPTA (centers of temporary detainment and assistance) were created to hold such individuals.¹⁵⁹ Since then, these institutions have become a topic of great controversy due to their lack of transparency and reports about their legal questionability.

The CPT are described as *isole staccate*, or detached islands.¹⁶⁰ Others describe them and their tight control as prisons.¹⁶¹ In 2004, the Commission for Human Rights of the UN and the Italian government affirmed the commitment to provide “maximum transparency as possible” in the CPTA. Groups like Amnesty International and Doctors Without Borders (MSF), however, continue to document human rights abuses in these centers and asks Italy: “why close the doors, if everything inside is ok?”¹⁶² Not just international organizations, but Italian ones as well are repeatedly denied access to these centers, even to perform humanitarian work.¹⁶³

A variety of factors within the CPT can lead to poor mental and physical health for the arriving immigrants. Treatment interruption or denial, human rights abuses, and poor conditions generally lead to these problems. Upon arrival, treatments are needed either for conditions that immigrants had in their home countries, conditions that worsened and required treatment due to the voyage, or conditions that immigrants acquired because of the voyage.

¹⁵⁹ D’Alconzo, *Invisibili*, 31.

¹⁶⁰ Andrea Accardi with Medici Senza Frontiere (Doctors Without Borders), interview with author, Rome, July 27, 2006.

¹⁶¹ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, interview with author, Milan, July 18, 2006.

¹⁶² D’Alconzo, *Invisibili*, 20-21.

¹⁶³ Cecilia Pani with Comunità di Sant’Egidio, July 28, 2006.

An Amnesty International (AI) report introduces the story of a little boy who had had a stomach operation just before coming to Italy. He would often cry at night during his journey at sea to the Italian coast. A lawyer alerted this little boy's case to the management of the CPT he was brought to; she was assured that the boy would be brought to a hospital in Catanaro. After eight days he was still in the Center. The lawyer asked for the boy's documentation so she could get the boy a *permesso di soggiorno* for reasons of health. Although the center promised these documents, the lawyer never saw them, nor the little boy ever again, nor proof of his hospitalization the next time she returned to the center.¹⁶⁴

Andrea Accardi, head of the Italian MSF mission, noted that whatever health care workers serve in the CPT have no access to the central system and that many immigrants in need of certain therapies go without them. MSF crews start therapies when helping immigrants off boats in Lampedusa before they are detained. Lampedusa is an Italian island between Sicily and Tunisia; it is geographically part of Africa and a European immigration hot spot. While MSF is allowed to do some follow-up work in the ports of Agrigento once officials move the irregular immigrants to Sicily, often times many of the therapies they had started for numerous patients get interrupted and MSF is denied access to their patients until the lucky ones are transferred to Welcoming Centers.¹⁶⁵

The documented human rights abuses that lead to poor health in the CPT include mentally and physically harmful practices. Among other abuses, AI has received reports that in the Centers, hospital stays were not in line with the UNHCR's standards for the welcoming of refugees; these reports also raised suspicion on the "realization of personal liberty."¹⁶⁶ Possible

¹⁶⁴ Andrea Camilleri, "Preface." In *Invisibili: Minori migranti detenuti all'arrivo in Italia*, ed. Gisuy D'Alconzo (Torino: Amnesty International, Italian Section - EGA Editors, 2006), 11.

¹⁶⁵ Andrea Accardi with Medici Senza Frontiere, July 27, 2006.

¹⁶⁶ D'Alconzo, *Invisibili*, 55.

denials of personal liberty include not providing hygienic and spacious living conditions. Regarding detention conditions, the “minimum regulations” laid out in UN documents require that all places of lodging must uphold certain standards of hygiene and that there is sufficient air space (i.e. avoid suffocating situations), light, heating, and ventilation. The UNCHR also demands rights of dignity and mental and physical integrity for immigrants requesting asylum, which include the right to medical assistance.¹⁶⁷ Reports of lice in the CPT have been attributed to the Centers’ unhygienic conditions.¹⁶⁸

AI recounts a story of a mother and her 20-day year old baby, who was extremely underweight when they arrived in Italy. They were brought with other young mothers to a hospital for six days. They were all put together in a tiny room and were let out only to use the restroom; they said conditions in the hospital were worse than their trip to Italy itself. They were then made to take a 20-hour bus ride to another detention center, without food, water, or adequate heating, and had to stay in that center for another month.¹⁶⁹ AI has received numerous other reports about the conditions of transport to and from different centers of immigrants. Like the one just described, these trips often were characterized by a lack of food and water, lack of consideration of the physical limitations of babies, newborns, and pregnant women enduring such journeys, and by the lack of female personnel.¹⁷⁰

Other noted abuses of immigrants’ personal liberty in the CPT include the use of benzodiazepine to sedate people, the cultural and linguistic miscommunication over the “belief of need” for certain services,¹⁷¹ and as already alluded to, the inadequate concern for the living conditions of mothers and minors. In another story of a mother in a CPT, for example, the

¹⁶⁷ Ibid., 60-61.

¹⁶⁸ Luca Bettinelli with Caritas Ambrosiana, July 13, 2006.

¹⁶⁹ D’Alconzo, *Invisibili*, 51-52.

¹⁷⁰ Ibid., 56.

¹⁷¹ Andrea Accardi with Medici Senza Frontiere, July 27, 2006.

woman was brought to a hospital to give birth, and after delivering the baby, was shortly taken back to her “container” in the center. Due to the heat and lack of shade, her baby became full of red spots. AI suggests that nuclear families be separated from other detainees, or avoid being detained at all.¹⁷² All these issues, and the very act of being detained, lead to mental health issues for many of the migrants including depression, stress, and desperation.¹⁷³

Of special concern is the health of minor immigrants, those with less than 18 years of age, detained in the CPT. A considerable number of detained minors arrive by boat from Arab countries. From 2002 to 2005, AI received reports that showed that about at least 275 minors from North Africa and the Middle East were detained upon arrival in Italy.¹⁷⁴ According to a different source, in 2005 alone, 400 minors arrived in Lampedusa; some minors were about to be born, others were very small children, maybe 100-150 adolescents.¹⁷⁵

Two issues arise in the debate of detaining minors, primarily unaccompanied minors: (i) the legality of detaining them at all, and if so, under what conditions and (ii) minors’ rights to access services. Determining the legality of detaining minors must first start with determining whether a person is actually a minor. In Italy, a norm does not exist that clarifies which procedure should be used to verify the age of a young unaccompanied migrant. Most medical tests have proven to be, at best, probabilities or estimates. In any case, the UN says that such tests must be undertaken keeping the physical and mental integrity of the person safeguarded. Many times, even though young boys claim to be minors, officials will nonetheless, declare them older and repatriate them. In two of the stories AI recounts, one boy committed suicide after receiving this information and another started to cry and the center personnel tranquillized him.

¹⁷² D’Alconzo, *Invisibili*, 70-74.

¹⁷³ Cecilia Pani with Comunità di Sant’Egidio, July 28, 2006.

¹⁷⁴ D’Alconzo, *Invisibili*, 88.

¹⁷⁵ Sig. Andrea with Fratelli di San Francesco, interview with author, Milan, July 20, 2006.

Many boys, on the other hand, will declare themselves to be older than they actually are because they do not want to be separated from their families, not knowing they will then be expelled.¹⁷⁶

Minors that are kept in CPT, according to AI, are protected by international laws and norms, specifically by the 1989 Convention of the UN on the Rights of Infancy, which Italy became party to in 1991.¹⁷⁷ From this convention came the standard that minors should be placed in the CPT only as a last resort; they are generally placed in the centers to be identified and cannot be expelled. New norms from April 21, 2005, state that unaccompanied minors requesting asylum should not be detained at all.¹⁷⁸ AI has received numerous reports of minors being illegitimately held, however, and this could have important mental health ramifications on such individuals.¹⁷⁹ AI also says that minors should not be lodged with adults for similar mental health reasons.¹⁸⁰

When in the CPT, the European Directive on Minimum Standards of Welcoming of Seekers of Asylum guarantees that all minors who were victims of abuse, abandonment, exploitation, torture, or experienced cruel, inhumane, or degrading conditions, or suffered the consequences of an armed conflict, should have access to services of rehabilitation, medical care, and a qualified orientation. All these rights are in risk of violation in Italy due to the often-frequent detainment of minors.¹⁸¹

By putting together the migration literature on boat arrivals, communicable diseases, and the CPT, I have identified three situations (when immigrants have arrived by boat, when immigrants come from countries with high prevalence rates of communicable diseases, and when

¹⁷⁶ D'Alconzo, *Invisibili*, 91-94, 97.

¹⁷⁷ *Ibid.*, 22.

¹⁷⁸ *Ibid.*, 83.

¹⁷⁹ *Ibid.*, 41, 44-45.

¹⁸⁰ *Ibid.*, 72.

¹⁸¹ *Ibid.*, 81-82.

immigrants settle in Italy after having been detained in a CPT) in which Italian health providers should be aware of possible necessary interventions at early stages in an immigrant's arrival to the country. Dermatologist and migration health specialist Dr. Aldo Morrone agrees that the "health migrant effect" is today only partially true and that immigrants fall sick more easily than before. The immigrant's "heritage of health," his or her sole resource upon arrival, disappears as he or she faces the various psychological and physical stressors to be described.¹⁸²

Health Indicators

Despite the fact that many immigrants enter Italy in good health, we know that studies have shown that immigrants often develop health problems in their host countries. Looking at selected health indicators provided by the World Health Organization (WHO) makes this fact slightly confusing (see Table 2). One can see that when comparing Italy and the home countries of Arab Muslims immigrants, Italy comes out with higher total life expectancies for both men and women and higher healthy life expectancies. Where a larger difference can be seen is Italy's drastically lower child and infant mortality rates compared to those rates of the Arab countries and the much larger amount of money Italy spends per capita on health (over three times as much as the next highest amount that is spent in Lebanon). The child mortality rate, or under-5 mortality rate of a country is used as an indicator of overall development in a country. A large percentage of under-5 mortality is the death of infants (children under one year of age). Infant mortality rates are indicators of the health status of a population because their magnitude reflects

¹⁸² Aldo Morrone, Jana Hercogová, and Torello Lotti, *Dermatology of Human Mobile Populations* (Bologna: MNL Scientific Publishing & Communication, 2004).

factors like birth weight, nutrition, immunizations, infections, birth defects, sanitation, water supply, the education of women, and the functionality of the health care system.

Given this information, one might assume the health of immigrants should improve or at least remain stable in Italy, rather than the contrary. The socioeconomic factors that immigrants must face, however, in their living and work conditions are the actors that threaten immigrant health. In another two decades, it will be interesting to return to these health indicators and look to see how first and second generation Arab Muslim immigrants in Italy compare to Italians.

Table 2. Core health indicators – Italy and countries contributing to migration to Italy¹⁸³

Country	Life expectancy (m/f)	Healthy life expectancy (m/f)	Adult mortality rate (per 1000) (m/f)	Under-5 mortality rate (per 1000) (m/f)	Infant mortality (per 1000)	Total expenditure on health as % of GDP	Per capita total expenditure on health at int'l dollar rate	Population (in thousands) total	Per capita GDP in int'l dollars	Number of total migrants in Italy since 1992
Italy	78 / 84	70.7 / 74.7	91 / 47	5 / 4	4	8.4	2,266	58,093	27,952	---
Algeria	69 / 72	59.7 / 61.6	153 / 124	41 / 39	35	4.1	186	32,854	4,860	6,687
Egypt	66 / 70	57.8 / 60.2	239 / 158	36 / 36	26	5.8	235	74,033	3,274	15,154
Iraq	51 / 61	48.8 / 51.5	452 / 201	130 / 120	102	2.7	64	28,807	3,554	?
Jordan	69 / 73	59.7 / 62.3	187 / 119	28 / 26	23	9.4	440	5,703	4,947	1,128
Lebanon	68 / 72	59.2 / 61.6	198 / 136	35 / 26	27	10.2	730	3,577	7,336	1,410
Libya	70 / 75	62.3 / 65	186 / 109	20 / 19	18	4.1	327	5,853	7,703	?
Morocco	69 / 73	59.5 / 60.9	157 / 102	47 / 38	38	5.1	218	31,478	4,557	92,718
Palestine	?	?	?	?	?	?	?	?	?	?
Syria	70 / 74	60.4 / 63.1	186 / 125	19 / 14	15	5.1	116	19,043	2,449	1,121
Tunisia	70 / 74	61.3 / 63.6	166 / 110	29 / 22	21	5.4	409	10,102	8,162	25,924
Year data collected	2004	2002	2004	2004	2004	2003	2003	2005	2004	2001

Note: The average rate of infant mortality for the North African and Middle East countries listed here is 33.9 and the average for just Morocco, Tunisia, and Egypt (most Arab immigrants in Italy) is 28.3.

¹⁸³ WHO “Selected Indicators” Data, World Health Organization and the National Institute of Statistics (Geneva, 2006), <http://who.int/countries/en/#1> (accessed January 27, 2007).

After Living and Working in Italy for at Least Six Months

Studies show that the once health immigrants at arrival do experience a significant number of health problems, as we will see explained later in the access section, about six months to a year after being in Italy. We will see, however, that immigrants once situated in Italy for some time experience health problems different than the typical health problems of Italians. After about six months, the environments immigrants find themselves in start to take a toll on their health. Most immigrant pathologies are connected to their conditions of life and work. Common problems include: respiratory diseases, gastro-intestinal issues, muscular or skeletal issues (orthopedics), skin diseases, and other infections.¹⁸⁴ Table 3 shows that respiratory diseases among immigrants are the most common, followed by digestive (*dirigente*) or orthopedic diseases, depending on the city.¹⁸⁵

Table 3. Disease “groups” most often diagnosed among immigrant patients between 1988-1998 in Rome, Milan, Turin, Verona, Palermo, and Perugia

Disease “groups” most often diagnosed among immigrant patients between 1988-1998 in Rome, Milan, Turin, Verona, Palermo, and Perugia						
Periodo di indagine	1993-95	1993	1988-92	1993-97	1991-97	1995-98
Struttura	Caritas Roma	Naga Milano	Sermig Torino	Cesaime Verona	S. Chiara Palermo	Lidlp, Aspu Perugia
Diagnosi						
Respiratorio	16,5%	14,7%	19,3%	15,0%	20,0%	14,2%
Digerente	13,7%	13,4%	14,2%	9,0%	11,0%	13,5%
Ortopediche	12,3%	17,4%	13,5%	11,0%	14,0%	9,5%
Dermatologiche	7,5%	10,1%	11,9%	7,0%	11,0%	7,3%
Infettive	8,1%	5,9%	-	3,0%	3,0%	9,7%
Ostetriche	5,2%	6,9%	-	8,0%	1,0%	-
Genito-Urinarie	8,7%	9,1%	5,2%	2,0%	4,0%	13,3%
Psicol.-psichiatriche	2,9%	2,9%	-	2,0%	1,0%	2,0%
Altre	25,1%	19,6%	35,9%	43,0%	35,0%	30,5%

Fonte: Geraici da fonti varie, 1995-2000¹

Most common

Second most common

Third most common

¹⁸⁴ Andrea Accardi with Medici Senza Frontiere, July 27, 2006.

¹⁸⁵ “Health and Social Protection,” European Federation of National Organizations Working with the Homeless (2006), <http://www.feantsa.org/code/en/theme.asp?ID=2> (accessed January 1, 2007).

The previously noted scholars, Geraci and Marceca break down immigrant health concerns into four main critical areas of concern: (i) pathological conditions – infectious diseases (TB, STDs), skin diseases, psychiatric diseases and disorders, traumas and accidents; (ii) physiological conditions – maternity, infancy, old age; (iii) social conditions – prostitution and trafficking, abuse, and detention; and (iv) aggravations – social discomfort, forced or un-chosen immigration, legal ramifications of being illegally present, and the lack or difficulty of accessing ordinary health structures.¹⁸⁶

Geraci and Marceca define the “social-health” problems of immigrants as: (i) factors linked to their legal status (ordinary access to the National Health System, prejudices and fears of the immigrant and health workers, hidden rights), (ii) factors linked to their social marginalization (physical-environmental – risk factors for physical health, psycho-social – risk factors for psychological health), and (iii) factors linked to their cultural marginalization (difference biometric reference systems).¹⁸⁷

I will address all these issues, but re-categorize them into problems related to living conditions, work conditions, conditions affecting women and minors in particular, and social conditions.¹⁸⁸ This method of analyzing the pathologies allows one to determine the social spheres in which each health problem manifests (home, work, in society in general, or a combination of the three) and who is most affected. This in turn will help identify where disparities exist between the health status of immigrants and Italians and where and how interventions or suggestions can be made in various Italian health care, social, and government structures.

¹⁸⁶ Geraci and Marceca, “Le malattie degli immigrati,” 12.

¹⁸⁷ Ibid., 30.

¹⁸⁸ Ibid.

Problems Related to Living Conditions

While 50.4 percent of immigrants say they are very satisfied with their housing situation, 40.8 percent of them also said that their situations are decidedly worse than those in their home countries. Factors such as the cost, the size, worse sanitary and ascetic conditions fuel such opinions.¹⁸⁹ The “makeshift accommodations” many immigrants live in due to the difficulty in finding regular housing are often “uncomfortable or in poor condition and inevitably affect [the immigrants’] health.”¹⁹⁰ The majority of immigrants (63.9 percent) live in an apartment in a condominium (other situations being a single house, a Center of Welcoming, or provisional structures). Most immigrants (59.2 percent) live in spaces 46-100 square meters (495 ft² – 1076ft²) in space. Nearly 55 percent of immigrants divide an apartment with no more than three people, the majority of them living with nuclear family members.¹⁹¹

Legal exploitation

Many of the difficulties immigrants experience with housing, and the subsequent health problems discussed below, have to do with their weak and easily exploitable legal status. Legal immigrants have a right to housing, illegal, or “irregular” immigrants, however, do not. Access to housing for illegal immigrants is excluded (prohibited) except for in Centers of Primary Welcoming. These centers generally consist of 20 to 50 beds; one’s stay is limited to six months,

¹⁸⁹ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 44-45.

¹⁹⁰ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare*, 49.

¹⁹¹ Giovanna Semi, “The Return of the Bazaar Economy. Moroccan Commercial Activity in Porto Palazzo, Torino” in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 43; Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia: Storie di chi l’agricoltura la fa*, (Rome: Sinnos editrice, 2005), 23. If you divide 100 sq. meters by three for a typical immigrant apartment, each person has approximately 33 sq. meters of space, which is just over the minimum space requirements per person in refugee camps set by the UNHCR.

and the guests must pay a daily “social” fee – help with maintenance and cleaning. The centers generally contain smaller centers for social, cultural, and orientation services. In some cases, the mayor comes to help individuals enter the state legally or enter Centers of Secondary Welcoming.¹⁹²

When illegal immigrants do find housing, landlords frequently overcharge them because they know the immigrants will not question authorities due to the fear of expulsion. In many other situations, illegal immigrants refrain from contact, or practice “self-imprisonment” to avoid identification.¹⁹³

The “housing emergency” in Italy refers to the rapid increase in rents across the board; in 2000, apartment rents increased 10 to 20 percent from 1999. At least 600,000 immigrants were subsequently “excluded” from the housing market, especially in large urban centers like Rome, Milan, Naples, and Turin. Tables 4 and 5 show the numbers of homeless immigrants resulting from this emergency in 2000 by city and by religion of those affected. One study says that immigrants working in the northern industries use their first paycheck to buy a used car to sleep in.¹⁹⁴ Another study says that 56 percent of the interviewed immigrants spend up to a third of their income on housing. While this does not differ much from the general Italian population,¹⁹⁵ those immigrants making the least, however, must not be able to manage the cheapest rents even when spending over a third of their salaries on housing.

¹⁹² Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare*, 38-39.

¹⁹³ *Ibid.*, 49.

¹⁹⁴ R. Nobile, V. Lannutti, A. Cassanelli, P. Venturini, and Siddique Nure Alam, “Il Colore delle Case,” *Ares* 2000, September 2000, <http://www.ares2000.net/ricerche/colorecase/ilcoloredellecase.htm> (accessed January 1, 2007).

¹⁹⁵ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 43-44.

Table 4. Housing Emergency in the Cities¹⁹⁶

<i>City</i>	<i>Immigrants</i>	<i>Homeless</i>	<i>Sq. Meters Necessary</i>
Rome	219.368	87.747	877.470
Milan	161.746	64.638	646.380
Turin	46.345	18.538	185.380
Florence	45.120	18.048	180.480
Napoli	43.166	17.266	172.660
Bologna	34.000	13.600	136.000

Table 5. Need for houses by religious confession¹⁹⁷

RELIGION	HOMELESS	REQUIRED M²
Muslims	182.800	1.828.000
Cattolics	136.800	1.368.000
Other Christians	110.400	1.110.000
Oriental Religions	32.400	324.000
Jews	2.000	20,000
Others	36.800	368.000

Immigrants also face the following legal difficulties (besides rent) in finding housing: (i) landlords will not rent to foreigners (especially “colored” individuals or Albanians) without additional guarantees, (ii) foreigners usually have to pay additional fees and get bank contracts, (iii) often in large cities, landlords make foreigners pay by person rather than by square meter, and (iv) housing agencies also often profit in helping immigrants find housing. These “unspoken rules” exclude the weak from the housing market.¹⁹⁸ Table 6 shows the different rents, per square meter, Italians (first column) and immigrants (third column) paid in major Italian cities in 2000.

¹⁹⁶ Nobile, Lannutti, Cassanelli, Venturini, and Alam, “Il Colore delle Case.”

¹⁹⁷ Ibid.

¹⁹⁸ Ibid.

Table 6. Average housing standards in the semi-central zone (per m²) in lira¹⁹⁹

City	Fixed standard (Italians)	Free standard	Special standard for immigrants
ROME	10.000	14.000	17.000
VENICE	9.800	13.800	16.800
FLORENCE	9.616	13.500	15.500
GENOA	8.250	12.500	14.800
TURIN	7.750	11.500	13.800
NAPOLI	6.875	10.600	13.200
MILAN	6.460	10.400	13.100

Overcrowding

As a result of the “housing emergency” the simple problem of overcrowding in immigrant homes is constantly noted in the literature; overcrowding leads to many health problems. The area Borgo Dora around the Moroccan market where the immigrant community lives in Turin, for example, is in a state of decline. The houses are all “heterogeneous and full of conflict” with foreigners and also many southern Italians practically living on top of each other. Young illegal immigrants crowd under ceilings and in cellars. In this Turin study, contrary to the authors’ expectations, overcrowding was mentioned more often than discrimination as causing situations of discomfort for the immigrants.²⁰⁰

“The shortage of hygiene services and running water is frequent in some such cases and is simultaneous with the reduced space in general. In the hotter months, people use public bath houses, pools, or apartments of other acquaintances to make normal hygienic practices possible.”²⁰¹

¹⁹⁹ Ibid.

²⁰⁰ Semi, “The Return of the Bazaar Economy,” 94, 45.

²⁰¹ Ibid., 94.

The tiny space available to the foreigners forces them to live more in the surrounding streets, piazzas, and cafes, making the “young Moroccan” presence very public.²⁰² We can see that the first health problem overcrowded conditions lead to is poor hygiene. The manager of a Milan clinic noted that hygiene troubles, particularly concerning water, lead to bad teeth and dirty clothing, which makes lice and other skin diseases common among immigrants.²⁰³ Another major cause of death for immigrants coming from outside the European Union is digestive tract problems relayed to poor hygiene and lack of clean water.²⁰⁴

Overcrowding also greatly facilitates the creation of environments ripe with respiratory diseases and of the conditions for their spreading. Immigrants, therefore, among the elderly, drug addicts, HIV positive persons, and the homeless are one of the risk groups for contracting tuberculosis (TB). The overcrowded and narrow rooms immigrants often live in with limited air exchange are the environmental factors that contribute to the continuance and spread of this problem in immigrant communities. Close living conditions in unhealthy environments act to increase the risk of first infection and external re-infection for other immigrants.²⁰⁵

In Italy, one fifth of all pulmonary TB cases and one third of contagious cases are manifested in immigrants. Most of the affected immigrants come from the tropical regions of Asia or regions in Africa where the disease is spread. The percent of cases in the immigrant population has risen over the years (10.7 percent in 1994, 11 percent in 1995, 11.3 percent in

²⁰² Ibid., 94-95.

²⁰³ Sig. Andrea with Fratelli di San Francesco, July 20, 2006.

²⁰⁴ Aldo Morrone, Jana Hercogová, and Torello Lotti, *Dermatology of Mobile Human Populations* (Bologna: MNL Scientific Publishing and Communication, 2004). Dr. Aldo Morrone et. al. has listed the following dermatological disorders common among the “human mobile populations:” viral dermatoses, bacterial dermatoses, non-venereal treponematoses, superficial fungal infections, deep mycosis, protozoan dermatoses, helminthic dermatoses, dermatoses due to arthropods, dermatosis caused by malnutrition, pigmentary disorders, genodermatoses, eczema and dermatitis, maculo-papulo-squamous dermatoses, bullous diseases, connective tissue disorders, urticaria and drug-induced eruptions, cutaneous appendages disorders, benign cutaneous neoplasias, and malignant cutaneous neoplasias.

²⁰⁵ Geraci and Marceca, “Le malattie degli immigrati,” 13, 14, 16.

1996, and 13 percent in 1997). In a study between 1990 and 1997, of 267 TB immigrant patients, almost 76 percent of the cases occurred after the individual being in Italy longer than six months and over 56 percent of the cases after one year. TB immigrant patients in Italy are usually young (between the ages of 20-30) and mostly male (75-80 percent).²⁰⁶

Symptoms of TB are the same for Italians and immigrants alike: dry and/or persistent coughing, chest pains, bloody coughing, difficulty breathing, and toxemia (lack of energy and strength, persistent fever, night perspirations). Whereas co-infection is common among HIV/AIDS patients in Africa, this only occurs in about four percent of cases in Italy. Doctors have noted among TB immigrant patients in Italy resistance to the drug isoniazide; they suppose this has to do with the use of low quality and low cost antibacterial drugs in the immigrants' countries of origin.²⁰⁷

TB has always been considered a disease of poverty, affecting those at the lowest economic levels.

According to Geraci and Marceca: *“Come patologia della povertà e dell'emarginazione sociale potremmo provocatoriamente affermare che la tubercolosi è la malattia che meglio misura l'incapacità di un paese di accogliere degnamente gli stranieri.”*

As a pathology of poverty and of social marginalization, we can provocatively affirm that TB is the disease that best measures the incapacity of a country to worthily welcome foreigners.²⁰⁸

Geraci and Marceca even note that the “social-environmental” conditions immigrants face in Italy make their likelihood of infection and contagion higher than their co-nationals remaining in the countries of origin. Due to their irregular and clandestine status and their lack of economic resources, the normal methods and chemical treatments for controlling the disease cannot be

²⁰⁶ Ibid., 13, 15-16.

²⁰⁷ Ibid., 16.

²⁰⁸ Ibid.

adopted to many immigrants' situations. Compliance and accessing free health services, like for diagnosis and pharmaceuticals, also present obstacles to solving the problem.²⁰⁹

Immigrant patients fail to comply with drug routines for several reasons: (i) they undervalue the seriousness of their disease and stop taking the medicines when they start to feel better, (ii) they experience a difficult doctor-patient relationship (linguistic and cultural differences the inhibit mutual trust), or (iii) they have to deal with problems related to “survival,” i.e. moving around to where different work opportunities exist. Dietary imbalances, other present infections, and stress also increase the chance of “reactivation of the (TB) microbe.”²¹⁰

Despite the high prevalence of TB among Italy's immigrants, Geraci and Marceca give several reasons why their migration is not an epidemiological risk: migration is characterized by generally young and healthy individuals, host countries usually have a developed and capable health system, and because Italy (the world) does have the pharmacological ability to control the disease.²¹¹ The high prevalence of TB among immigrants, however, is a public health problem for Italy.

Overcrowded housing conditions also facilitate the spread of other communicable diseases. Because the spread of STDs has been facilitated by greater population mobility over the last decades, the role of migration in their progression must be addressed. Most of the immigrants coming into Italy are young and in the prime of their sexually active years. The natural process of urbanization everywhere for economic opportunities and increased urbanization due to immigration put people in closer and more frequent contact. The resulting

²⁰⁹ Ibid., 13-16.

²¹⁰ Ibid., 14, 16-17.

²¹¹ Ibid., 13.

unemployment and marginalization from such situations augments recourse to prostitution and promiscuity.²¹²

A survey performed by the Italian Institute of Superior Health between 1991-1995 revealed that 10 percent of total STDs cases were in foreigners, 52.2 percent of them coming from Africa (35 percent of this number was North Africans), and 71.2 percent of them men. Three quarters of the immigrants surveyed (72.2 percent) had either never used a condom or only very rarely. Nearly 80 percent said they acquired the disease in Italy, 20 percent in their countries of origin. Seventeen percent were aspecific cases of urinary tract infection, 16.9 percent specific latent syphilis, and 16.2 percent human papilloma virus (HPV). Foreigners presented three times as many cases of gonorrhea as Italians and twice as many cases of syphilis.²¹³

In treating STDs, Geraci and Marceca list the following issues as difficulties for immigrants: “accessing specialized public health services (STD centers, venereal and gynecological clinics) on top of economic difficulties guaranteeing oneself a private treatment, the fact that such individuals are invisible to institutions as targets of cures and surveillance, and lastly, the difficulty in reaching such persons for preventive measures.”²¹⁴

Geraci and Marceca note that the WHO suggests that addressing STDs needs to occur as a part of basic medicine and it needs to be adapted to various political, cultural, economic, ethnic, financial, and clinical settings. Geraci and Marceca, thus, note the importance of studying the cultural and religious backgrounds of immigrants when determining prevention plans against STDs. They note the studies of Antonietta D'Antuono done in 1994. She showed that STDs among Pakistani immigrants were relatively absent and contributed it to “religious precepts.” Her studies also showed, however, that other Muslims, like those from North Africa did exhibit more cases of STDs. These North Africans exhibited “inconsistent and rule-breaking behaviors,

²¹² Ibid., 18-19.

²¹³ Ibid., 21-22.

²¹⁴ Ibid., 19.

[and thus], lived with 'senses of fault'" and subsequently frequented prostitutes more often and failed to use condoms.²¹⁵

Only five percent of STD-infected immigrants in Italy test HIV positive, half as many as Italians. Most HIV positive immigrants come from Latin America and Sub-Saharan Africa. In one study, only 1.6 percent of cases were in North Africans. The proportion of foreigners with AIDS in Italy has increased from 3 percent in the period of 1982-1993 to 11.6 percent in 1999. The increase can be attributed not only to the increase of immigrants in Italy, but also to the poor socioeconomic conditions of immigrants.²¹⁶

Homelessness

Other aspects of the immigrant housing situation in Italy, besides overcrowding, have serious health effects. Those immigrants without a secure or stable residence, for example, have to deal with the stress of moving, and in the worst cases, homelessness. The 2006 theme of the European Federation of National Organizations Working with the Homeless is the "right to health is a human right: ensuring access to health for people who are homeless." The environment of homeless can lead to: "physical ailments, cutaneous and respiratory problems... and severe stress and isolation, which lead to mental health problems. Mental disorders include depression, schizophrenia, and personality disorders." Substance abuse and addictions to alcohol, cigarettes, or other drugs is also common; this can lead to liver and/or heart damage and a risk for HIV or other communicable diseases if intravenous drugs are used.²¹⁷

²¹⁵ Ibid., 19-20.

²¹⁶ Ibid., 22.

²¹⁷ "Health and Social Protection," European Federation of National Organizations Working with the Homeless (2006), <http://www.feantsa.org/code/en/theme.asp?ID=2> (accessed January 1, 2007).

Most of the immigrants that are firmly settled (43.1 percent) or restrictively settled (55.8 percent) are in Northern Italy. More immigrants in transit (42.9 percent), disappointed and in transit (44.2 percent), or in transit and optimistic (49.1 percent) are in Central Italy. Immigrants from North Africa or the Middle East make up a considerable percentage of the immigrants in Italy who are restrictively settled and those who are disappointed and in transit.²¹⁸

While most immigrants have spent one to two years in their current housing situation, 72 percent of immigrants claim that their current living situation is stable overall, although at least 15 percent of the immigrants studied have experienced sleeping in the streets and 10 percent have rested some time in a Center of Welcoming.²¹⁹ At least 3.3 percent of Rome Caritas clinic users in 1997 were homeless; that number decreased to 2.2 percent in 1998. In 1998, 21 percent were guests of a friend or family member, and 68 percent lived in a rented apartment, often with other co-nationals.²²⁰

Many of the *extracomunitari* immigrants in Rome sleep under the major bridges. Police blitzes sometimes find apartments rented by Italians but inhabited by dozens of immigrants.²²¹ Immigrants often sleep under bridges, in cars, in train cars, in shacks, in welcoming centers, public dormitories, administrative detention centers, in prisons, in empty warehouses, social centers, or if they are lucky, with other immigrant families.²²² On November 12, 1998 one hundred *extracomunitari* stormed the Basilica of St. Petronio in Milan, demanding the right to housing. In central Italy, an Algerian man in his 30s who had a *permesso di soggiorno* but could not find housing froze to death at night in 1998.²²³

²¹⁸ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 30-31.

²¹⁹ *Ibid.*, 43-44.

²²⁰ Geraci and Marceca, "Le malattie degli immigrati," 8.

²²¹ Nobile, Lannutti, Cassanelli, Venturini, and Alam, "Il Colore delle Case."

²²² *Ibid.*

²²³ *Ibid.*

It is supposed to be relatively easier to find housing in Rome (versus a job), whereas it is harder to find housing in Milan, and easier to find a job. This study notes that the economic growth in the North might slow down if immigrants continue to be unable to find housing.²²⁴

Seasonal Workers

The “seasonal worker circuit” describes the movements of immigrants around southern Italy during the year to pick certain agricultural products in different regions. Because of their constant mobility after immigration, these immigrants do suffer from overcrowdedness and homelessness, and thus the problems described above, but I have given them their own category and special attention due to their inherent instability of their living conditions.

Doctors Without Borders estimated that 12,000 immigrants participate in this circuit. Their survey in the south of Italy showed that over half of the interviewed immigrants did not have a *permesso di soggiorno*, but some had received *permessi* for other motives, had asylum permits, or had been given refugee or humanitarian protection status.²²⁵ Over half of them do not have a valid residence permit and others with this permit still do not have the right to work, and therefore, the right to protection. These immigrants often work 12 hours a day and earn just enough to subsist off of.²²⁶

The regions in which seasonal agricultural work takes place are Sicily, Calabria, Campania, and Puglia. The summer begins in the region of Puglia in the province of Foggia with tomato collection and then moves to the province of Andria for olive collection. The end of the season lasts from November to sometimes March in Piana di Gioia Tauro in the region of

²²⁴ Ibid.

²²⁵ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 20.

²²⁶ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 51.

Calabria for the collection of oranges. Workers in Sicily usually remain in Sicily for the entirety of this so-called “seasonal circuit.”²²⁷ The immigrants wake up at 4:30 or 5 in the morning (later in the winter) to go to recruitment offices. Most immigrants only “find” work three to four days a week. They are paid daily or by piecework. One third of the migrant workers earn 25 to 40 euro a day, 26.4 percent 25 euro, 22.7 percent less than 25 euro, and only 16.4 percent more than 40 euro a day. Half the workers send home remittances; twenty percent of total workers managed to send more than 100 euro home every month, 17 percent between 50 and 100 euro, and 10 percent less than 50 euro.²²⁸

Mostly men work in the agriculture sector (91.4 percent of the total). According to MSF 20 percent of these workers come from North Africa (mostly Moroccans and Tunisians) and 0.4 percent from the Middle East, the rest coming mostly from sub-Saharan Africa (67.1 percent) but also from Eastern Europe. Many of those coming from the more southern regions of Africa had to first cross the Sahara and then dangerously embark from the Libyan or Tunisian coasts to arrive in Italy. Ages of the workers range mostly from 18 to 45 years of age, 30.5 being the average age, and small percentages of immigrants being minors or over the age of 45.²²⁹

Because these immigrants must move around often to follow seasonal work, and because they are not paid well, they often live in very precarious living conditions. Of those interviewed, 40 percent live in abandoned houses, 37 percent in rented spaces, 9.4 percent in camps of tents managed by organizations, 5.2 percent in welcoming centers, 4.5 do not live in anything, and 3.4 percent live in houses offered to them by their employers. Many of the “abandoned houses” signify half-constructed buildings or out of use factories; rented spaces sometimes referred to garages, boats, unsafe and crumbling structures, or old warehouses. The living spaces are most

²²⁷ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 33.

²²⁸ Ibid. 29-30.

²²⁹ Ibid., 16-18.

often divided among co-nationals and are characterized by overcrowding and minimal access to water, potable water, light, gas, and restrooms. At least 36 percent of those interviewed live in spaces occupied by more than 100 people; 30 percent of interviewed immigrants declared having to share the mattress with another person; 70 percent had to divide the room in which they sleep with more than four persons.²³⁰

Over half the immigrants did not have access to running water where they lived, 30 percent did not have electric light, and 43.2 percent did not have bathrooms. Over half the immigrants (50.2 percent) had to travel over 300 meters regularly to get potable water to their residences; as explained shortly, this is double the maximum distance stipulated by the UNHCR for emergency situations. Questions remain as to whether these sources of water are really potable. Only 35.5 percent of the migrants buy their water, 15.7 get it from an “external faucet.” In many of the cases, these external faucets are connected to cisterns containing water used for irrigation. Often the migrants will use the cisterns to store their water, which is troubling given the questionable sanitary status of these cisterns.²³¹

The MSF survey shows that most of the living situations for these migrant seasonal workers in the South do not match up to the minimum standards of refugee camps established by the UNHCR. These norms include: 30 square meters of walk-able space per person, 3.5 square meters available per person inside living modules, a maximum of 20 people per latrine, 150 meters maximum to a water point, 30 meters distance between latrines and lodging, 100 meters distance between latrines and the water point, and a minimum of two meters of distance between each living module.²³²

²³⁰ Ibid., 22-24.

²³¹ Ibid., 24-25.

²³² Ibid., 23.

Within the number of chronic diagnoses among this seasonal worker population, 62.5 percent of the cases were due to a non-infective agent, whereas 37.5 percent of the cases were due to an infective agent. According to MSF, the presence of infective chronic diseases in Italy is inexcusable given the availability of antibiotics, the national system of health, and the availability of doctors. The presence of these diseases is connected with personal and environmental hygiene. In addition to the problem of accessing clean water, MSF also noted considerable percentages of workers who have troubles with personal hygiene. While 70 percent of the interviewed immigrants said they have the chance to bath themselves every day, 3.5 percent said they had a chance to do so three to five times during the weekdays, and 16 percent said they did not have the chance to bath more than three times every week. At least 78 percent were able to bath themselves where they lived, the others doing so in welcoming centers, at work, or in public places (like restaurant bathrooms or public fountains).²³³

Skin problems accounted for 23.6 percent of the chronic infective cases; the problems included cellulitis (a possibly life-threatening bacterial infection characterized by inflamed skin), impetigo (a bacterial infection characterized by boils), and other parasites that led to in some cases scabies (mites, which can be very debilitating) or filariasis. Skin diseases also signify conditions of poor hygiene (as previously explained). Skin diseases caused by parasites are also a public health problem and therefore considered “diseases of obligatory declaration.” Many of the agents of these diseases are also very hard to eliminate given the living conditions of the migrants. Genital pathologies, another condition connected to overcrowdedness and poor housing conditions, as explained above, accounted for 13.5 percent of the cases; most of the

²³³ Ibid., 48, 26.

cases were STIs (HPV, other secretions due to syphilis or gonorrhea) and one case was a urinary tract infection.²³⁴

Respiratory diseases accounted for only 14.3 percent of the cases, but this number would be higher had the study been conducted in the winter (and the numbers in connection with parasitic diseases lower). Half of the cases were tuberculosis and some of the others involved severe pulmonary pathologies. MSF noted that out of the migrants interviewed, only 33.2 percent were smokers. It is interesting to note that 60 percent of the smokers (mostly North Africans and Eastern Europeans) earned more than the non-smokers, perhaps suggesting other factors besides choice influencing the higher percentage of non-smokers. It is also interesting that non-smokers also presented more respiratory pathologies and also more severe respiratory pathologies; because these persons earn less, MSF hypothesizes that poor living conditions were actually a greater risk for disease than smoking for these migrants.²³⁵

Out of all the chronic and infective diagnoses, 15.5 percent were due to the presence of intestinal parasites. Such parasites at times cause explosive diarrhea; they can also eat away at the intestinal walls and cause malnutrition, anemia, or bring on sleeping problems. The overcrowded and often unhygienic living conditions of the seasonal workers breed such parasites and will often infect entire communities. Another 15.5 percent of the cases were oral problems like cavities, rotting teeth, or gingivitis. Mouth problems are also considered “diseases of poverty.” The difficulties of prevention are more difficult for the foreigners because sometimes they lack education on oral hygiene, but dental care or concerns also come second to more primary concerns. Unhealthy diets also contribute to these problems. While almost all the interviewed immigrants (96.3 percent) reported eating dinner regularly, 31 percent do not each

²³⁴ Ibid., 50-51.

²³⁵ Ibid., 54-55.

lunch and 51.7 percent do eat breakfast. According to MSF this eating habits bring health consequences in regards to sufficient daily caloric intake, especially for young men doing physical labor for 8-10 hours a day. Only 40 percent of the interviewed immigrants have access to a refrigerator in which they can conserve their food.²³⁶

In sum, given that employers who hire seasonal workers are supposed to arrange for housing for their workers (in addition to travel expenses home after the harvesting season) and inspect this housing, we can see thanks to MSF that this is definitely not the case for most seasonal workers in the south of Italy. The reason is that most of these workers are irregular. Because the bureaucracy and paperwork for recruiting workers from abroad is such a hassle, because of the difficulty to predict the need for labor in the agricultural sector, and because of the supply of already present illegal immigrants, much of the manpower on southern farms remains unregulated. MSF concludes that the only way to improve the living conditions (and other work conditions to be described in the next section) of these immigrants is structural change in immigration law.

Looking at how an immigrant's housing situation affects his or her health status showed that the following issues that concern housing need to be addressed: (i) conditions associated with overcrowding: unhygienic conditions and access to running water leading to skin diseases and other problems, respiratory diseases (especially TB), stress, and STDs; (ii) conditions associated with homelessness: stress, mental problems, substance abuse, respiratory and other diseases, and (iii) conditions associated with legal exploitation: stress and risk of the problems associated with overcrowding and homelessness.

Given these housing problems, immigrants seem to need: access to clean water for hygienic reasons, screening for respiratory diseases and plans to limit the spread of such

²³⁶ Ibid., 49-50 and 26-27.

diseases, education on STDs, (multilingual) outreach for the homeless so they can participate in services and care programs, and information on their legal rights. These interventions are primarily preventative; the first objective identified by Article 2 of the 2006 Decree establishing the Commission on Health and Immigration in Italy is to “promote interventions of prevention for the foreign population.” Several of the Commission’s tasks also put forth in Article 2 mention educational campaigns and interventions on several state and social levels. Therefore, these facts just described about immigrants’ housing situations that contribute to poor health outcomes should be making their way onto the Commission’s agenda and onto the agendas of local agencies dealing with the social problems of immigration. Given that the various problems mentioned, thus far, encompass a range of medical disciplines, but all manifest in some way due to living conditions, I propose that a team of disciplines come together to better the health of immigrants in their housing situations. Doing this would allow for expertise on each problem, but would also allow for an integrated approach at complete health in the homes of immigrants, and therefore, not prioritizing one problem over another, but trying to improve living conditions in a holistic manner.

Problems Related to Work Conditions

The first way in which work conditions affect migrant health in Italy is similar to problems contributing to the housing situation – shaky legal protection. As mentioned before, immigration policy in southern Europe, Italy included, is becoming more restrictive. One researcher argues that this forces many legal immigrants back into an illegal status; this results from the following factors. First, recruiting migrants from abroad legally is too bureaucratic –

employers face the burden of finding employees they have never met. Usually, the employers just recruit illegals already in Italy, then the migrants leave to get the necessary paperwork from their foreign consulates. Second, the short work contracts given to migrant workers quickly force them back into illegal status. Lastly, many of the new restrictions make the difference between legal and illegal statuses an ever-changing duality, leaving many migrant workers in insecure situations.²³⁷ Seasonal workers in Italy, for example, are supposed to receive stipends from their employers to travel back to their countries of origin, but this often does not happen as the official recruitment system that falls under the previously explained regime of quotas is inadequate.²³⁸

Additional structural and legal discrimination exists in the work force for foreigners in Italy. Structurally, the large “shadow economy” in construction, agriculture, and services demands most of the labor.²³⁹ Workers in the so-called shadow economy are poorly paid off the books.²⁴⁰ Legally, much of the work migrants performs is governed by contracted companies, so the workers do not receive the benefits other employees in the same building, for example, in civil service jobs, receive.²⁴¹ Irregular immigrants also cannot miss work as easily to take care of their health needs because they are legally exploitable.²⁴²

As the previously presented statistics show, most immigrants work in the industry, service, and agriculture sectors in Italy where their labor is most demanded. Most of this work involves some kind of manual labor. According to Geraci and Marceca, most male immigrants that die in Italy die from violent or accidental deaths related to their work conditions – accidents

²³⁷ Baldwin-Edwards, “The Changing Mosaic of Mediterranean Migrations.”

²³⁸ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*.

²³⁹ Global Commission on International Migration, “Public policies and community services for immigrant integration,” 10-11.

²⁴⁰ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*.

²⁴¹ Global Commission on International Migration, “Public policies and community services for immigrant integration,” 10-11.

²⁴² Francesca Barbieri, Margherita Sistieri and Massimiagno Copz with the Local Health Clinic D, interview with author, Rome, July 28, 2006.

at work, suicides, and homicides.²⁴³ “In 2002 alone, accidents involving immigrants in the workplace increased by 23 percent.”²⁴⁴

“The main occupational sectors to which migrant workers have access offer only unskilled, low paying and poorly protected jobs – jobs rejected by Italians. These jobs are the so-called “five-p jobs”: *pesanti, precari, pericolosi, poco pagati, penalizzati socialmente* (heavy, precarious, dangerous, poorly paid, socially penalised) (Ambrosini, 2003: 76).”²⁴⁵

To be sure, accidents happen even in risk-evaluated, top-notch international companies. When accidents happen to immigrants, or when they fall ill, however, they do not have the legal confidence to address these problems correctly, and thus, end up harming their health. Immigrants might have to live and work with a disability due to accidents at work.

An immigrant newspaper declared in June 2006 the number of deaths due to accidents at work in the fields, factories, and construction sites (40 in addition to unreported accidents, 10 of which were foreigners) a massacre. In 2005, falls, building collapses, fires, and explosions amounted to 1,2000 deaths. The newspaper notes additionally that many incidents go unreported because they involve a majority of irregular workers; it cites an accident in Rome at a construction site that even the local health center did not know about until a week later. These work accidents in Italy (involving foreigners and Italians) amount to 28 billion euro lost on social costs, like health care costs, compensations, and allocations for invalidity, in addition to over 17 million days of work lost. Table 7 demonstrates the magnitude of work incidents in 2005 for foreigners in Italy.²⁴⁶

²⁴³ Geraci and Marceca, “Le malattie degli immigrati,” 4.

²⁴⁴ Global Commission on International Migration, “Public policies and community services for immigrant integration,” 12.

²⁴⁵ Ibid., 10.

²⁴⁶ Gabriele Bonincontro, “Lavoro, la strage di giugno quaranta vittime nei cantieri,” *La Repubblica – Metropoli* 1, no. 25, July 9, 2006.

Table 7. Work incidents in 2005²⁴⁷

Accidents	940,000 total	113,553 <i>extracomunitari</i> workers
Deaths	1,2000 total	142 foreigners
Women	25 percent of total accidents	6-9 percent of total victims
Age	35-49 avg. age of men	18-34 avg. age of women
Construction	191 total deaths	36 foreigners (18.8 percent)

The previously mentioned study and outreach done by Doctors Without Borders on seasonal workers in the South, also documents many accidents occurring among immigrants working in the agricultural sector. In their diagnosis, 26 percent of the pathologies were acute and the rest were considered chronic. In a quarter of the acute pathology cases, the diagnosis was a result of “diverse reasons” like injuries to major joints like the knee, injuries to the eyes or skin like amputations or other wounds. In total, at least 24 percent of the acute cases referred to a skin problem and about the same percentage referred to joint injuries often due to large traumas but also due to repeated “micro traumas.” Around seven percent of the cases involved eye injuries.²⁴⁸

Other documented health problems by MSF in the seasonal worker circuit included violence and exposure to toxic substances. Over 30 percent of the interviewed immigrants had been mistreated in the last six months. In most of the cases, the mistreatment referred to intimidation or actually being beaten. Smaller percentages of the cases involved robbery or sexual mistreatment. In 83 percent of the cases, the aggressor was Italian. In terms of exposure to dangerous materials, MSF documented that only 56 percent of the agricultural workers declared having used protective material while working, and 92 percent of these workers got the material themselves while only 6.3 percent received them directly from their employers. Only 54 percent

²⁴⁷ Ibid.

²⁴⁸ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 45-48.

of the workers habitually wear gloves, only 12 percent wear boots, and only 1.8 percent wear masks (greenhouse workers).²⁴⁹

In analyzing the morbidity of migrant agricultural workers, MSF divided pathologies due to work into two categories: (i) acute or chronic intoxications by phyto-pharmacologic agents (which are more prevalent for workers in the greenhouses), and (ii) ergonomic pathologies (due to hard working conditions, and working in a repeated position until exhaustion and challenging one's muscular-skeletal system). MSF also includes in these pathologies physical traumas due to work like amputations, injuries, and burns. Out of the migrants MSF surveyed, 41.4 percent had a muscular-skeletal or joint pathology.²⁵⁰

The rest of the problems noted in the literature and mentioned in interviews concerning health problems related to immigrants' work deal more with access issues to the health system and will be addressed later in the section on access. Overall, the health problems identified concerning immigrants' work conditions included: (i) work accidents that result in death or disability, (ii) ergonomic muscular-skeletal issues, and (iii) violence and legal exploitation that led to stress and/or inadequate conditions for taking care of oneself. Therefore, at work, immigrants need concern from employers about preventing and dealing with accidents and compliance of employers to safety regulations and to legal norms regarding pay and working hours or when the work is illegal, knowledge of one's rights despite being *irregolare*.

Special Needs of Arab Women

²⁴⁹ Ibid., 34-36.

²⁵⁰ Ibid., 65-66.

While Arab Muslim female immigrants face the same problems in living conditions and in some cases, some of the same problems if they work, women migrants in general have to deal with other additional health needs like finding female physicians and pregnancy. Some Arab Muslim women and other African immigrants have to deal with having undergone female genital mutilation and coming to a country not accustomed to this tradition.

Many health workers in Italy that I interviewed noted Arab women's request for a female physician when visiting the doctor, and also for having their husbands present during examinations. A gynecologist Dr. Lisa Canitano noted, however, that with Italy's very historically Catholic and sexually repressed culture this request is not so complicated, given that such requests would not have seemed so strange in their own country twenty years ago. Nonetheless, many doctors feel unsure in such situations about whom to address and about whether the woman is really in charge of her own consent to health procedures.

Dr. Canitano told the following story to illustrate this point. She was following the pregnancy of a Muslim couple. At a certain point she thought that there was a complication so she suggested that the couple have an amniocentesis test and eventually abort this 5-6 month old baby. The husband wanted to do the exam and interrupt the pregnancy; the wife, however, refused the test and wanted to keep the baby in any condition. The (Catholic) doctor that performs the amniocentesis tests in Dr. Canitano's clinic said that Arab women never come for these tests, even when they agree to be put on the list. Dr. Canitano understood that between the Muslim woman and the Catholic doctor there was an understanding that she did not have with this patient as a "lay" doctor, and so in the end, she was glad the woman did what she wanted.²⁵¹

The major health challenge for women migrants is support during pregnancy. Many times, a family's first encounter with health services in Italy is due to a pregnancy. One

²⁵¹ Dr. Lisa Canitano (gynecologist) with Vitadonna.it, interview with author, Rome, July 22, 2006.

gynecologist noted of Arab women that they tend to give birth naturally (without drugs), are younger mothers than Italians, and are willing to take on the expenses of having more babies than Italians.²⁵²

Geraci and Marceca make a distinction between the birthing experience in immigrants' countries of origins (especially in the south) and in Italy. At home, pregnancy and birth involve the whole extended family and women from the community. In countries of migration, pregnancy is a condition dealt with alone; it can become an "internal illness." Geraci and Marceca use the "pathology of eradication" to describe the problems immigrant women face and the subsequently easy "psychosomatic onset of illness": a change in rhythms, of climate, of diet, and feelings of betrayal towards one's original community."²⁵³

More immigrant women have premature births, low weight babies, miscarriages, voluntary interruption of pregnancies high rates of caesarean births, and recourse to unknown or misunderstood methods of contraception. Linguistic challenges in the obstetric ward and miscommunication leading to early termination or interruption of breastfeeding also cause health problems for immigrant babies. These women also have difficulty in accessing health services and experience general social strain.²⁵⁴

All these problems that immigrant women must deal with in greater numbers than Italian women have very serious health ramifications. Premature or preterm births and their resulting complications like underdeveloped organs or low body weight are a major cause of neonatal deaths. Birth weight is the single most important predictor for infant survival, therefore, low birth weight (LBW) is a leading cause of infant mortality. This condition is prevalent in adolescent mothers or mothers with poor nutrition. Some low birth weight babies develop long-

²⁵² Dr. Lucille Labi with Ospedale Policlinico Umberto I, interview with author, Rome, July 25, 2006.

²⁵³ Geraci and Marceca, "Le malattie degli immigrati," 24.

²⁵⁴ *Ibid.*, 24.

term health problems and disabilities. Very low birth weight increases the probabilities of blindness, deafness, chronic respiratory problems, mental retardation, mental illness, and cerebral palsy. In addition, low birth weight doubles the chances that a child will later be diagnosed as having dyslexia, hyperactivity, and other cognitive disabilities.

While immigrant women have every right to voluntarily interrupt their pregnancies like Italian women, irregular immigrants are at higher risk for complications due to unsafe abortions due to their avoidance of state facilities. Complications from unsafe abortion account for approximately 13 percent of all maternal deaths. The majority of women who have an unsafe abortion (80 percent) suffer illness, injury or disability as a result.

Incorrect use of contraception can lead to poor family planning. Adequate family planning, on the other hand, can lead to the reduction of unwanted pregnancies and therefore the lifetime risk of maternal mortality and morbidity, more spacing between births and a smaller number of children and therefore larger human capital investments in individual children (i.e. allocation of resources for education and health), greater freedom from fear of unplanned pregnancy and therefore an improved sexual life, partner relations and family well-being, and lastly, where jobs are available, family planning users are more likely to take advantage of work opportunities.

Breastfeeding is also crucial to infant health because it provides the infant with antibodies, nutrients, and is much healthier than formula milk especially in places where clean water cannot be secured.

A study completed by the Lazio Epidemiological Observatory showed that babies born of immigrant mothers do in fact have higher mortality rates (see Table 8).²⁵⁵ Although we can see that the average infant mortality rate for North African and Middle Eastern babies born in Rome

²⁵⁵ Ibid., 24.

is over half as many times less the average infant mortality rate within these actual countries (recall from figure 2 the average infant mortality rate was 33.9).

Table 8. Rates of infant mortality, neo-natal mortality, and post-neonatal mortality (per 1000) in the births of non-residents in Rome, by the mother’s place of birth and time period (years 1982-1995)²⁵⁶

Mother’s place of birth	Infant mortality			Neo-natal mortality			Post-neo. mortality		
	82-86	87-91	92-95	82-86	87-91	92-95	82-86	87-91	92-95
Europa Est	-	-	7,9	29,9	14,5	2,0	30,8	-	2,0
Nord Africa/M.O.	13,7	12,7	14,3	10,4	21,5	7,2	3,5	4,4	-
Africa centrale	9,1	6,8	8,6	12,3	20,4	13,0	3,1	2,3	8,8
Estremo Oriente	4,0	3,4	4,8	8,1	8,4	9,6	-	6,8	-
America Latina	10,9	-	13,9	33,0	6,5	14,0	-	6,5	2,8
Paesi occidentali	11,2	12,4	-	28,2	12,6	-	-	4,3	5,5
Nomadi	16,6	-	6,5	16,9	12,0	15,3	12,9	2,4	4,4
Lazio	5,6	4,6	3,5	8,8	5,6	4,4	1,4	1,0	1,3

The study also showed that foreign mothers had more pregnancies at a younger age than Roman women. In all ethnic groups of immigrants, immigrants had more low birth weight babies (under 2500 grams or approximately 5lbs 8oz.) than Romans (see Table 9). Geraci and Marceca emphasize the point that none of these studies have attributed low birth weights and pre-term births to genetic or biological factors present in different races, but on the hard conditions of life and poor nutrition of immigrant mothers.²⁵⁷

A 1996 study in the Emilia Romagna region of Italy showed that 10.3 percent of immigrants versus 4.6 percent of Italians had preterm (before the 37th week) babies and that 11.5 percent of immigrants versus 7.4 percent of Italians had low birth weight babies (under 5.5lbs).²⁵⁸ Doctors sometimes accuse foreign women of not understanding that when they are pregnant, they have to undergo the exams; the doctors get mad and point at all the foreign babies

²⁵⁶ Ibid., 25.

²⁵⁷ Ibid., 25.

²⁵⁸ Ibid., 26.

born underweight.²⁵⁹ What really is happening is probably fear on the patient's part and inadequate communication between immigrant women and the health structures.

Table 9. Neo-natal weight of the children of *extracomunitari* and nomad foreigners; national study on 28 points of birth in 24 Italian cities (2,424 births, 6.1% nomadic, years 1996-1997)²⁶⁰

Peso neonatale	< 1500 (3lbs 5oz)	1501-2500	2501-4000	> 4001	
Controlli	1,2	5,7	88,0	5,1	%
Bimbi extracomunitari	1,9	7,8	84,2	6,1	%
Europa Est	3,1	7,5	83,0	6,4	%
Medio Oriente	1,4	4,2	84,5	9,9	%
Sub Cont. Indiano	2,9	12,4	82,4	2,3	%
Estremo Oriente	1,2	8,0	87,2	3,6	%
Africa Nord	1,3	6,8	82,9	9,0	%
Africa Sub Sahar.	1,2	8,3	85,9	4,6	%
America Latina	2,8	5,0	86,2	6,0	%
America Latina	1,3	11,6	86,4	0,7	%

Abortion among immigrant women in Italy is very common. A 1995 study of hospitalized women in Milan showed that the issue that often pushed women to first access health services was an abortion. Out of the women surveyed, 25 percent of immigrants versus 10.5 percent of Italians had had an abortion. A 15-year study in Emilia Romagna showed that 31 percent of foreign women patients were hospitalized for abortions versus 26.13 percent of Italians. Interesting to note is that the percentage of foreign women hospitalized for abortion remained steady over the 15 years (30.8 percent in 1980 and 30.3 percent in 1995) whereas the percentage of Italian women hospitalized for abortion nearly halved (35 percent in 1980 to 17.9 percent in 1995). Nationally since 1980, the percentage of abortions performed on foreigners

²⁵⁹ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

²⁶⁰ Ibid., 25-26.

increased from 2 percent to 10 percent in 1995.²⁶¹ All these statistics mean that immigrant women need more support or help accessing support for pregnancies and contraception services.

While not affecting the health of women so much as their children, studies have shown that immigrant mothers often breastfeed their babies for inadequate periods of time. Because immigrant women often do not have their nuclear or extended families nearby for help, and because these women have to return to work shortly after delivery, they do not have the time or resources to keep breastfeeding their babies. Their children are entrusted to relatives back in their countries' of origin or to older brothers who have to play baby sitter. A study of the Rome Caritas clinic showed that 58 percent of the 100 surveyed women's children had returned to their countries of origin, 37 percent of the children had lived far away from their mothers for at least two years (57 percent of the children ages 2-5); the children usually returned to their mothers after three to four years.²⁶² The lack of breastfeeding means that the mothers lose a natural form of birth control and are more susceptible to shorter intervals between births, which has various health effects on the mother and her next children.

This separation issue, in addition to breast feeding, makes the issue of vaccinations worrying. Geraci and Marceca note that among immigrant women, the "possibility / obligation" of vaccination is little known or avoided by the majority of immigrant women in Italy. Geraci and Marceca note the need for an intervention – for greater attention to basic pediatric care. A study done by the Italian Society of Pediatrics showed that 30 percent of young immigrant children examined had had the opportunity to be vaccinated but did not take advantage of the opportunity. What happens is that 2/3 of the children only receive care in the emergency

²⁶¹ Geraci and Marceca, "Le malattie degli immigrati," 26.

²⁶² Ibid., 27.

rooms.²⁶³ Thus, immigrant mothers need to be better informed about vaccination services, about misconceptions they might have about the necessity or side effects of vaccinations, and about their rights to access the health system for their children (access to be discussed later).

Another problem constantly mentioned in Italian migration literature is the violence many immigrant women undergo in Italy.

“Exactly on rights, overall of women immigrants, there is still much to do. Psychological and physical violence. Exploitation. Abuses. Many immigrant women, in search of a better future in Europe and in the West, have to undergo all of this, thinking that there is no way of escape, that there is no way to avoid shameful and inhumane practices. We are talking about forced marriages, genital mutilations, reductions to slavery and prostitution. Many times with thousands of minors involved.”²⁶⁴

According to the authors of this quote, in the last year more than 52 million minor girls were forced to marry, 40 thousand of which are infibulated women who live in Italy. Almost 20 thousand foreign women in Italy are prostitutes and among these women the number of women prisoners, trafficked women, and women undergoing sexual exploitation is continually increasing.²⁶⁵ According to employees I interviewed at an anti-violence center in Rome, 55 percent of their patients are foreigners. These women, however, do not just come from immigrant families, but from mixed marriage families, meaning that many of them experienced violence from Italian partners. They noted the stereotype that foreigners are more violent, reminding me that violence against women is, unfortunately, a very universal phenomenon.²⁶⁶ All such violence on women contributes to the mental and / or physical health of the victims and because of immigrants’ well document weak social status, especially women immigrants, stopping and treating the violence is very difficult.

²⁶³ Ibid., 27.

²⁶⁴ Roberta Agnelilli and Cristiana Muscardini, “Puoi dire di no!”, vademecum contro matrimoni forzati, mutilazioni genitali, riduzione in schiavitù,” Agnelilli, <http://www.angelilli.it/page.asp?VisImg=S&Art=29&Cat=1&I=91> (accessed March 17, 2007).

²⁶⁵ Ibid.

²⁶⁶ Anti-Violence Center for Women, interview with author, Rome, July 31, 2006.

Another issue falling under the topic of gender violence some immigrant women might need help with is female genital cutting, more commonly known as female genital mutilation, or FGM. Many of Italy's female immigrants have undergone one of the four types of FGM (each type differs by the degree of parts, the labia, prepuce, and clitoris, excised or in the lesser forms just cut or pricked). This practice is performed in many parts of the world and done for various motives (some attributed to religion, particularly Islam, but most to culture and tradition). It affects a woman's sexual and reproductive health her whole life.²⁶⁷

Health effects as noted by the UNFPA are affected by the health of girl, the hygienic conditions where the operation is carried out, and the type of FGM performed. FGM can immediately cause "severe pain, shock, haemorrhage, tetanus or infection, urine retention, ulceration of the genital region and injury to adjacent tissue, wound infection, urinary infection, fever and septicaemia." Later health effects include

"anemia, the formation of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction, hypersensitivity of the genital area...scar formation, difficulty in urinating, menstrual disorders, recurrent bladder and urinary tract infection, fistulae, prolonged and obstructed labor (sometimes resulting in fetal death and vesico-vaginal fistulae and/or vesico-rectal fistulae), and infertility (as a consequence of earlier infections)."

Mental health effects include "psychological stress, [which] may trigger behavioral disturbances in children, closely linked to the loss of trust and confidence in care-givers..." In the longer term, women may suffer "feelings of anxiety, depression, and frigidity. Sexual dysfunction may also be the cause for marital conflicts and eventual divorce."²⁶⁸

²⁶⁷ Geraci and Marceca, "Le malattie degli immigrati," 28.

²⁶⁸ "Frequently Asked Questions on Female Genital Mutilation/Cutting: How does FGM/FGC affect women's health?," UNFPA, <http://www.unfpa.org/gender/practices2.htm#15> (accessed March 17, 2007).

Data is hard to come by, but studies have estimated that thousands of women in Italy are genitally mutilated.²⁶⁹ Immigrants coming from countries in which FGM is widely practiced (Egypt and the Sudan) or from countries in which certain ethnic groups practice it (the United Arab Emirates, Yemen, and Saudi Arabia) would be the concern in this study, but many more immigrants from Africa and parts of Asia also are at risk of the procedure.²⁷⁰

A difference in experience exists among the Italian medical community in their exposure, and subsequently, belief in the prevalence of FGM among immigrants in Italy. One Italian doctor I interviewed in Milan, for example, noticed the procedure more in African immigrants.²⁷¹ A different clinic assistant in Milan said that when they do see Arab women, they come for “normal” gynecological problems; they never see FGM.²⁷² In Rome, one gynecologist described how after birth, some patients ask for the reclosure of the vagina (which was closed during an FGM procedure or as a procedure on its own); doctors comply. Some might remember that it happened in Italy merely 30 years ago to some women before marriage. Others sympathize with women’s tears and claims that without reclosure, they cannot return to their homes; the doctors perform the service for free. The same doctor also noted that Italian doctors will sometimes perform plastic surgery for women who have had reproductive parts cut off. The Roman doctor also noted that no statistics exist on these practices – they go unrecorded.²⁷³ Yet a different gynecologist in Rome and her colleague said they never see FGM nor get requests for vaginal reclosure – doctors would not be paid for the procedure.²⁷⁴

²⁶⁹ Geraci and Marceca, “Le malattie degli immigrati,” 28.

²⁷⁰ “Frequently Asked Questions on Female Genital Mutilation/Cutting: In which countries is FGM/FGC practiced?,” UNFPA, <http://www.unfpa.org/gender/practices2.htm#12> (accessed March 17, 2007).

²⁷¹ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

²⁷² Assistant of Signora Maria with NAGA, interview with author, Milan, July 17, 2006.

²⁷³ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

²⁷⁴ Dr. Lucille Labi with Ospedale Policlinico Umberto I, July 25, 2006.

What all these different stories translate into is that more research is needed on the prevalence of FGM in immigrant communities, in Italy and elsewhere, before plans of actions can be made. Several hot debates have already swept through Italy on abolishing the practice within and outside its borders. Usually central in the discussions is a Somali gynecologist Dr. Omar Abdulkadir who practices outside of Florence. He caters to the immigrant community there and pulls in patients from much farther away. In 2004, he proposed legalizing a “light” form of the cutting practice, painless and harmless, as a compromise between the Italian laws and its growing diverse immigrant population; his proposal did not gain any ground from Italian authorities.²⁷⁵

Italian NGOs and doctors have found it difficult to develop an education program against the practice given its sensitive cultural and anthropological origins; they do, however, denounce attempts of immigrants to perform the surgery on Italian ground. NGOs assume that it still does occur in various health structures and that immigrant families bring their children to France (because of its large Muslim immigrant population) or back to their countries of origin to have the procedure performed. Article 5 of the Civil Code and Article 50 of the Medical Code of Deontology forbid the practice from taking place in Italy; the 1998 revision of Article 50 specifically says: “it is prohibited for a doctor to practice any form of sexual female mutilation.”²⁷⁶

It is important for Italian social workers and physicians to be trained on FGM; otherwise, attitudes of horror or curiosity make patients uncomfortable or lead to inappropriate medical interventions – like performing a cesarean birth, even when the cutting was minor. It is also important that these Italians do not blame or stigmatize these women so as to make them feel

²⁷⁵ “Infibulazione, quella tradizione ‘religiosa’ che il Corano non conosce,” RAI (Rome, 2004), <http://www.rai.it/news/articolonews/0,9217,70692,00.html> (accessed March 17, 2007).

²⁷⁶ Geraci and Marceca, “Le malattie degli immigrati,” 28-29.

inferior – the goal is to bring immigrants closer to the health system, not push them away with stereotypes.²⁷⁷ Female immigrant in Italy Kalthoum Bent Amor Ben Soltane notes:

“How do we make [women] come out into the open, knowing what violence and discrimination consumes them often in private? How do we intervene? How do we convince them to save themselves respecting their will and their privacy? It is necessary to develop a strategy of approach that permits us to understand what is tangible, hiding and veiled, without creating a wider closure... We need to respect their conditions and fears. We give the time to the unheard and do it without confrontations and forcing; we stop to look at their diversity as a sign of inferiority; we go beyond the appearances and clichés; we go to discover the diversity and we live it with richness...”²⁷⁸

Preparation for accommodating husbands, dialogue with couples about who should be addressed until an Arab women’s movement / group expresses otherwise would also be helpful to Arab Muslim women migrants.

Special Needs of Minors

Another group with needs that do not fit neatly under the living, working, cultural, or women’s needs categories are immigrant minors. While their vulnerability has already been noted in the CPT, especially for unaccompanied minors, their need for protection against legal and sexual exploitation should be reiterated here.

According to an employee at an organization in Milan, at least 15,000 minor boys arrive in the city that police know about; at least another 15,000, mostly women, remain unknown to the authorities. Few Italians know that in those boats they constantly see on television landing in Sicily there are many minors. The boys enter work in the black market. They do not get paid much and are often treated very poorly. Some boys do construction work; stereotypes say that

²⁷⁷ Ibid., 29.

²⁷⁸ Italian Ministry of Interior, “Intervento di Kalthoum Bent Amor Ben Soltane, componente della Consulta per l’Islam Italiano,” (Rome, March 8, 2007) <http://www.cittadinitalia.it/news/articolo.php?idarticolo=23785> (accessed March 17, 2007).

Moroccan boys are known for selling drugs or acting as mules and that Albanians are pimps and control their trafficked women. Many young boys also work as male prostitutes, standing outside the main railway stations in major cities. Their high-class Italian clients pass on STDs to these children unaccustomed to using protection like condoms.²⁷⁹

Overall Mental Health

I have discussed primarily so far physical manifestations of sickness or health problems in immigrants, with the exception of gender violence that spans physical and psychological harms. Before moving on to the discussion on the determinants of health disparities between immigrants and Italians, it is appropriate to look at one last aspect of immigrants' health statuses: their mental health. This is especially relevant because damages to the mental health of immigrants could have ramifications on my question as to whether health problems influence future prospective immigrants. Additionally, poor mental health can manifest into other health-harming behaviors like violence or addiction.

The most basic contributor to immigrants' mental health statuses is the pure stress of being an immigrant, regardless of race or religion. The previously described health statuses and problems of immigrant, men, women, and children in the various social settings of work and home all put stress on the individual immigrants affected. Social workers in the health sector have noted immigrants' concerns about anxiety about becoming sick, dying in a foreign country, and anxiety about retaining their capacity to work.²⁸⁰ A Roman health worker noted that immigrants generally all had positive outlooks on their immigration, so initially they often feel

²⁷⁹ Sig. Andrea with Fratelli di San Francesco, July 20, 2006

²⁸⁰ "Immigrati, salute e sanità." *Osservatorio delle Immigrazioni* 2 (Nov. 2002): 15.

deluded. They thought everything was easy [in Italy], like finding work. Those that studied many years in their home country feel especially confused when they confront the stereotype that they (immigrants) are all ignorant.²⁸¹

In one study, nearly 60 percent of the immigrant interviewees maintained that it would be very useful, if not necessary to provide a psychological support service for immigrants. The immigrants who especially supported such a measure were primarily those who had been in Italy longer and also legalized immigrants. The authors conclude that this indicates that the psychological need is not confined to the “acute” phase of first coming to a host country.²⁸²

Other studies have shown that both a number of Italians and of other immigrants perceive immigration to be excessive in Italy. This attitude fuels the discriminatory and mentally damaging thinking described above. One study noted, for example, that while only 18 percent of Italians think that the number of immigrants present in Italy is already too high, even more immigrants think so, almost 30 percent of them.²⁸³ In regards to rules governing entrance into Italy and regulations for obtaining permanent status in Italy, 25 percent and 22.8 percent of Italian social workers and immigrants, respectively, think that the regulations should be more restrictive.²⁸⁴

A few variables regarding the demographic information of the respondents correlate with certain responses. Northern Italians consider the threat of immigration and the problems of hierarchy it creates in wealth and power lower, while central Italians consider them at a medium level, and Southern Italians at higher levels. Those who have attained a certain level of education also report lower levels of an attitude of threat towards immigrants. Those who have attitudes of

²⁸¹ Ms. Edoarda Trillò with Rome Local Health Clinic “C”, July 24, 2006.

²⁸² Losi, Ippolito, and Mazzara, *Gente in Movimento*, 45.

²⁸³ *Ibid.*, 10.

²⁸⁴ *Ibid.*, 17.

low threat and discrimination think that regulations should be less restrictive and visa versa for those with attitudes of high threat and discrimination.²⁸⁵

Another social condition leading to poor mental health outcomes in immigrants is a lack of cultural sensitivity among the host population. The quote by Kalthoum Bent Amor Ben Soltane in the section describing gender violence describes well how diversity is often seen as inferiority. In terms of cultural sensitivity, immigrants need help from the Italian population in combating discrimination and in increasing knowledge about immigration's positive effects on the country. Additionally, the immigrants could use education or outreach on how to handle discrimination.

Respect for cultural traditions and different religious and eating habits would help. For Arab Muslim immigrants, certain religious practices, for example, might draw undue attention and fuel discrimination. In addition to mosques in Italy serving as places of meeting, interaction, and socialization, certain rituals take place like exorcisms, which draw from people spirits responsible for diseases or natural disturbances.²⁸⁶ Other Muslim practices go against Italian legislation. Requests to circumcise children, for example, are refused by Italian health providers. Some debate has occurred about a compromise between ethnic and judicial concerns, with proposals for partial circumcision being debated. The National Committee for Bioethics says such a practice is justified from an ethical point of view, given that the Jewish community in Italy regularly practices circumcision.²⁸⁷ The lack of respect for such traditions fuels misunderstanding, stereotypes, and disrespect towards immigrants, which in turn adds to the stress and often isolation immigrants confront in their migration and integration experiences.

Lastly, the threat of addiction to drugs and alcohol, often due to stress, is real among

²⁸⁵ Ibid., 19.

²⁸⁶ Melfa, "The Muslim Communities in Sicily," 157-158.

²⁸⁷ Ibid., 175-176.

migrants in Italy. A Bologna newsletter on the health of immigrants notes a rate of alcohol addiction among Eastern European and Magredbi immigrants and notes that the later group is especially at risk for health problems given their “cultural un-preparation.” Most addicts among the immigrant community in Bologna are male (93 percent), have the average age of 30, around half have previously been in prison, and 44 percent have problems with stable housing. When studying immigrants in therapy programs and most again were men, most came from Morocco, Algeria, and Tunisia. More immigrant users were there for the first time (versus a larger percentage of Italian returnees) and the immigrant users had a lower average age than the Italian users (28.9 versus 32.7). Some health social workers have suggested that therapy programs be conducted through ethno-religious leaders of the various communities; such programs are only in their experimental stages. One therapy unit in Bologna caters to the homeless, immigrants, and especially irregular immigrants. Their work has revealed the “present emergency,” given that these individuals face grave difficulties in accessing mainstream health services. When they access only emergency services, they are not properly cured for addiction problems and run the risk of worsening their conditions and the security of the city.²⁸⁸

Dr. Giancane of the Metropolitan Epidemiological Observatory of Pathologic Dependencies in Bologna notes that immigrants do not arrive in Italy as addicts. Rather the Observatory’s studies have shown that a period of an average of three years passes before substance abuse begins. He also clarifies that it is not true that foreigners (usually referring to North Africans) use drugs in a less invasive and dangerous manner compared to other drug addicts. Intravenous drug use and the subsequent transmission of diseases is becoming more and more common. The recourse to substances, he continues, is also more and more uninformed and blamed on some “cultural protective factor,” which results in extreme and uncontrollable

²⁸⁸ “Immigrati, salute e sanità,” 10-12.

problems. There are also difficulties treating immigrants because of cultural differences and their inexperience with long-term therapies. Re-insertion in society issues are also especially difficult when talking about irregular immigrants in that successfully finding new work and easily accessing services is especially difficult for them.²⁸⁹

Conclusions on Arab Immigrant Health Statuses

We have talked about work problems, living situation problems, health problems specific to women and children, and lastly, the possible mental health problems of immigrants in Italy. I have presented a summary of the issues many immigrant families face in relation to their health in Italy, emphasizing statistics and issues of the Arab, predominantly Muslim, immigrant populations. For example, given the array of presented problems, it would be quite possible for an Egyptian family living in Rome to be dealing with the following issues: the husband is dealing with cut-back work hours due to an injury he sustained to his arm at a construction site a month ago. The wife, working several days as a maid, has to constantly ward off sexual advances from one of her clients and will face dealing with no extra income after giving birth to her second child in three months; she is additionally worried about her neighbors' coughs – five of them live in the apartment next door and she just cannot handle her other child getting sick again. This first child, now attending primary school, constantly complains about the Arabic lessons his parents make him take every Saturday.

What would be very interesting to present now is data to back such a story up. Unfortunately, I have not come across any data on the disease burden or morbidities of entire families or households. Such a study would be useful to my question about health problems

²⁸⁹ Ibid., 12.

influencing future migrants' choices in migrating. What I can evaluate now, given the presentation of the above issues, is whether or not the health migrant phenomenon really exists in Italy. While Italians seem to be sharing the burden of work-related accidents with migrants, most of the other numbers presented show that the burden falls increasingly heavier on immigrants. We have seen that given their lower socioeconomic status, immigrants live in more unsanitary conditions; immigrants make up the bulk of TB cases in Italy, contracting the disease after between six months and a year of being in Italy; foreigners have been reported to carry three and five times as many certain types of sexually transmitted diseases than Italians; immigrant women have more preterm births and low weight babies than Italians.

If we look back to the literature review and how the health migrant phenomenon has manifested itself in other host countries like the United States, Australia, and Canada, the immigrants are relatively healthy given their socioeconomic status until they have achieved certain levels of integration. From the information I have presented so far on Italy, immigrant health is not suffering at the point of integration, but rather through immediate factors in their living and work settings directly related to their low socioeconomic status in the host country. Thus, the healthy migrant phenomenon seems to exist to some point in Italy in that the immigrants who come are healthy. However, I have not found enough data on the long-term health conditions and the prevalence of non-communicable diseases of Arab Muslim or other immigrants in Italy to fully determine to what extent the health migrant phenomenon in Italy resembles the situation in other countries. Thus, the continuation of this discussion in the conclusion of this thesis towards policy recommendations will focus on these environmental factors rather than on acculturation as the current source of immigrant health problems in Italy.

After this presentation of problems, I can continue to demonstrate what additional social determinants make such challenges and disparities in health outcomes specifically for Arab Muslim immigrants difficult to address.

CHAPTER 3

DETERMINANTS OF DISPARITIES IN HEALTH STATUS

Discussing disparities in health outcomes between populations involves identifying issues that make meeting health needs doubly difficult due to certain factors like gender, class, religion, race or ethnicity, culture, and language. Often such discussions layer one disparity determinant on top of another, portraying a picture of the barriers disadvantaged individuals face when trying to achieve optimal health care. The work of Leith Mullings and Amy J. Schulz on such determinants of disparities in their book Gender, Race, Class & Health, however, is presented in their introduction and in other contributing authors' work as an "intersectional analysis." The intersectionality theory explains how various disparities act simultaneously; attributing a health problem to an isolated social factor, after all, rarely works. It also dispels thinking that attributes disease or health problems to historically held beliefs about a race's cultural or biological background. The following discussion on the determinants of disparities between the health status of Arab Muslim immigrants and Italians will utilize the intersectionality theory to demonstrate how various factors make meeting the health needs of these immigrants more difficult than for Italians.

Gender

While discussions on gender usually focus on women, both males and females face different stressors as immigrants. In Italy, and in other countries of immigration, women

immigrants might encounter gender discrimination in the workplace, just as Italian women still do. One issue, however, that separates immigrant women from Italian women are their birthing experiences in Italy. Without their extended family and friends present, immigrant women lack a support network critical to allowing her to return to work, care for other children, or getting daily chores done. In addition to possibly lacking the language capabilities to exploit the resources available to pregnant women or new mothers, legal immigrants might not even know about the many benefits Italian legislation gives to new mothers, like ample paid time off of work. Illegal immigrants and even legal immigrants who feel vulnerable in their work settings, regardless of laws that protect them, would be barred from such benefits altogether. As previously mentioned research shows, Arab immigrants in Italy have been noted for their willingness to have more children, thus, pregnancy might be a considerable source of stress for this population.

Arab Muslim women in Italy also have to deal with the prevailing notion that they are submissive and powerless. Some health workers in Rome, for example, claimed that in Arab families the wife is always in second place; they have difficulties talking directly to her and feel that some of these women are ignorant, even if they have been educated.²⁹⁰ Another Roman health worker described her experience with a Palestinian patient. The woman returned to the Middle East shortly after having her baby. A year later she came back fully veiled, and the health worker thought, “why cover this young, spirited woman?” The Italian woman assumed it was an imposition of the males in the girl’s family; the Palestinian woman told her, however, that she chose to veil herself for religious reasons.²⁹¹ This health worker also noted that when women come for abortions, doctors by law are supposed to determine how much of the decision was

²⁹⁰ Francesca Barbieri (also Margherita Sistieri and Massimiagno Copz) with Rome Local Health Clinic D, July 28, 2006.

²⁹¹ Ms. Edoarda Trillò with Rome Local Health Clinic “C,” July 24, 2006.

really the woman's. When an Arab woman comes, especially with her husband or other male figure, the stereotype leans more towards that she did not have a free choice in the matter.²⁹²

In addition to lacking a support network for reproductive issues and facing stereotypes when they walk into a hospital or clinic, Arab Muslim immigrant women might also have to take care of a household, like Italian women, but sometimes in addition to performing illegal or unreliable work. This set of dual responsibilities, maintaining precarious work and taking care of a household, might, therefore, be incredibly difficult due to the immigrant's stressful situation and dealing with previously mentioned problems like unhygienic living conditions and legal problems related to work or housing might be sidelined. Similarly, Arab Muslim male immigrants might have to deal with the stress of being responsible for his family and remaining a strong figurehead while possibly performing illegal or unreliable work. As mentioned above, the stress of being an immigrant in general contributes to health problems.

Another unfortunate circumstance that disproportionately affects males and male immigrants in increasing numbers in Italy is incarceration. In 1995, 8,628 immigrants were incarcerated, 97.3 percent from outside the EU and more than 90 percent of them male.²⁹³ Due to economic difficulty, to the challenge in finding full time work, or due to other reasons, some Moroccans chose to deal drugs in Italy. For this reason, many Moroccans can be found inside Italian jails – 4,015 of them in 2004. A lot of shame is connected to being incarcerated and often the immigrants will break off relations with their families back home. For such reasons, according to one study, many Moroccans would prefer to stay in the prisons rather than face an

²⁹² Ibid.

²⁹³ Geraci and Marceca, "Le malattie degli immigrati," 29.

expulsion sentence home.²⁹⁴ Stereotypes about Arab immigrants being drug dealers or violent possibly leads to over-incarceration.

In addition to feelings of shame and stress, and general overcrowding in prisons, Geraci and Marceca note the following conditions that could aggravate the worsening of immigrants' health in prisons: difficulties with communication (particularly in relating medical histories), cultural differences, problems of adaptation (different food habits), and a tendency towards masochistic acts.²⁹⁵

Class

Class, or more frequently described as the socioeconomic status, of an individual influences the quality of housing, and despite the fact that health care is socialized in Italy, the quality of health care one can access. Given that most Arab Muslim immigrants in Italy are coming to find better economic opportunities, or in some cases to escape political or social turmoil, they generally start out with a very low economic standing in the country, especially those who enter Italy illegally. Many in fact, have spent most of their savings just on reaching Italy. More than half the interviewed immigrants in one study spent US\$501 to US\$2500 to reach Italy, averaging US\$1800 for everyone.²⁹⁶

Additionally, services financially difficult even for Italians to afford become impossible for immigrants to finance because of a limited personal financially-stable network. Dr. Canitano described how some clinics offer orthodontic services at reduced rates, like the one in which she

²⁹⁴ Falvia Piperno, "Expulsion and Then? The Impact of Forced Repatriation in Albania and Morocco" in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 250, 255-257.

²⁹⁵ Geraci and Marceca, "Le malattie degli immigrati," 30.

²⁹⁶ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 48.

works at in Ostia, for the poor; people have to contribute 500 euro a year. If this is too much for an Italian, relatives will help, but foreigners often have no extended family in Italy to help them financially.²⁹⁷ Dr. Canitano also believes that those who succeed in getting health services are not so poor because the Italian bureaucracy is very complicated; if one is really poor or an alcoholic, it is difficult to enter the health system.²⁹⁸

Much as in the United States, a debate exists in Italy about the effects of “free-loading” immigrants on social service systems. According to Shaykh Palazzi, irregular immigration will raise the Italian public spending and therefore also the out-of-pocket expenses consumers pay (even though health care is socialized in Italy, members of the health care system must still pay a ticket and other fees when accessing the system, as will be explained in Chapter 4). When immigrants that consume healthcare services are aware of this argument and the resulting public opinion about immigrants, it can make integration hard. Therefore, he says, it is natural that extremist (Islamic) propaganda gains ground among those (Muslim immigrants) that have nothing to lose, those who never integrated into their host societies.²⁹⁹

Religion

Other issues that cause Arab Muslim immigrants difficulty revolve around their religion. Discrimination of Muslims has been widely noted in Italy and many Muslim Italians have documented this. A famous journalist Magdi Allam, for example wrote a book entitled “I love Italy, but do the Italians love it?” Allam is a pro-Western author and while trying to fight discrimination, many Muslim Arabs accuse him of being a tool of the West and anti-diversity.

²⁹⁷ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

²⁹⁸ Ibid.

²⁹⁹ Shaykh Prof. Abdul Hadi Palazzi with the Istituto Culturale della Comunità Islamica Italiana, July 24, 2006.

Other writers like Oriana Fallaci sensationalize the threat of “Eurabia” and Islam becoming Europe’s second most practiced religion. All these conflicting public views, in addition to stereotypes about Muslims being polygamous, repressive to women, over-zealous, prone to violence and extremism, etc. set the stage for Italians’ misunderstanding of Arab Muslim immigrant individuals in a country with no recent history of Islam. While not everyone is so prejudiced, discrimination and these preconceived notions still exist and make many social situations, like dealing with health care services, sometimes unpleasant.

While only 15.6 percent of immigrants reported have a bad welcoming experience, 51.4 percent claim it was optimum. Immigrants in the North versus the Center and the South reported better relations with Italians; those between the ages of 25 and 44, those who had taken some course of instruction, Christians, those who had been in the country longer, and legal immigrants also reported better relations as well.³⁰⁰ From this study, one can see that Muslim immigrants, particularly irregular Muslim immigrants (whether from an Arab country or elsewhere) experience less favorable social conditions in Italy. The manager of a Milan clinic, in fact, noted that it is much easier for South Americans and other Europeans to find work in Italy. He also said that it is probably easier for Arabs to live in France, given the country’s longer history of immigration compared to Italy.³⁰¹

The major stereotype against Muslims is that they are all religious extremists. A third generation Syrian Italian Sheikh explained that while many Westerners think that all mosques are breeding grounds for Islamic extremists in the West, it should be noted that extremists do manage several mosques in Europe and North America. He warned that if these countries do not start paying attention, they will find more Islamic terrorists in western countries’ immigrant

³⁰⁰ Ibid., 51.

³⁰¹ Sig. Andrea with Fratelli di San Francesco, July 20, 2006.

communities than in Arab countries. He finished by saying that this fact and peoples' tendencies to subsequently generalize about all Muslims creates more discrimination and fuels such extremism in countries like Italy.³⁰²

“By linking anti-terrorism measures and immigration control in the context of the ‘war on terror,’ many governments have encouraged — however unintentionally — xenophobia against migrants and refugees.”³⁰³

A study that ranked how Italians felt about immigrants contributing to integration on a scale from 1-9, for example, showed that Italians put “facilitating radicalization” at 6.77 and “being responsible for increased crime” at 3.83.³⁰⁴ Others note that common misperceptions include “Muslims do not drink, Muslims do not eat certain things, they are not always clean, they always lie...”³⁰⁵

In addition to discrimination and the many fears and questions the evolving term “Eurabia” incites, being members of a minority faith brings up the following concerns for Muslims in Italy: “obtaining official political recognition, defeating institutional discrimination, finding sources of *halal* meat and areas for prayer, securing provisions for Islamically approved cemeteries, and winning recognition for Islamic religious instruction and Islamic holidays.”³⁰⁶

Other issues like not eating pork, abstaining from alcohol, and fasting during the month of Ramadan while not directly interfering in health treatments, might not be known by some Italian health workers and thus, fully culturally competent care might fall short.

Ethnicity and Culture

³⁰² Shaykh Prof. Abdul Hadi Palazzi with the Istituto Culturale della Comunità Islamica Italiana, July 24, 2006.

³⁰³ Grant, “Migrants’ Human Rights.”

³⁰⁴ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 18.

³⁰⁵ Ms. Edoarda Trillò with Rome Local Health Clinic “C,” July 24, 2006.

³⁰⁶ Robert Ricks, “*L’affaire Fallaci* and Beyond: Challenges to the Muslim community in Italy,” (term paper, Georgetown University).

Different Perceptions of the Body

An important lesson in culturally competent care is drawing the distinction between “what we know we know,” for example, our telephone number, “what we know we do not know,” for example, quantum physics, and “what we do not know that we do not know,”³⁰⁷ like that sitting with your legs crossed with the bottom of your feet facing someone is considered very offensive in some cultures. Other taboos, like touching someone else’s head, are important things to remember when one tries to achieve culturally competent care. These perceptions of the body that vary between cultures have an effect not only on the quality of health services, but also on health outcomes because of a patient’s lack of comfort with the different style of care.

A study on trans-cultural nursing noted the various different perceptions of the body and health practices for the Middle Eastern community. The issue of modesty for women has already been noted and when not respected can lead to serious feelings of discomfort and rudeness. Health care providers can empower such patients by assigning them female staff and advising other personnel that one knock on the door before entering. Another common cultural practice is to wear amulets to protect oneself from the evil eye or one’s health. Other “folk remedies” like cupping or bleeding are no longer widely practiced.³⁰⁸ Other remedies like concoctions for soar throats or hot and cold theories of health are just as practiced and believed among Arabs as they are among Italians and many other cultures in their own forms.

Ms. Edoarda Trillò with local health clinic “C” in Rome told me “people that immigrate willing to accept to a certain sense another culture, and therefore, also ‘western medicine’ to a certain sense. Italians also practice alternative medicine, and other practices passed

³⁰⁷ Susan Nelson, “Women’s Health in the 21st Century,” (course, Georgetown University, fall 2006).

³⁰⁸ “Transcultural Nursing: The Middle Eastern Community,” CultureDiversity, (2005), www.culturediversity.org/mide.htm (accessed March 17, 2007).

down by generations. It does not matter if [the practice] is not scientifically based, or does nothing, it does not matter.”³⁰⁹

Therefore, it can be problematic if health care providers do not know about some of these traditions of immigrants’ cultures, but at the same time, when they are aware of such practices, it can also become problematic if they are conceived of as weird habits.

Discrimination

Discrimination due to Arab Muslim immigrants’ ethnicity can first be explained as causing negative effects on their health statuses. In the history of public health, numerous studies have been done on the negative effects racism and other forms of discrimination can have on one’s health. For example, in Leith Mullings and Amy J. Schulz, Gender, Race, Class & Health, researchers Caldwell, Guthrie, and Jackson quote a study by Sellers that notes “racial discrimination is associated with more psychological distress among youth;” the book also describes numerous situations in which race indirectly affects the quality of doctor-patient relationships and even diagnoses and treatment programs.³¹⁰

Numerous accounts attest to the presence of racism against immigrants in Italy. According to one study, immigrants in Italy feel needed, but not tolerated. For example, “in the markets of Genoa and Milan a thousand cases of hydroquinone [were] sold: dark-skinned immigrants use [it] to find work, a flat to rent, and accommodation with a family more easily.”³¹¹

³⁰⁹ Ms. Edoarda Trillò with Rome Local Health Clinic “C,” July 24, 2006.

³¹⁰ Leith Mullings and Amy J. Schulz, *Gender, Race Class & Health*, (San Francisco: Jossey-Bass, 2006), 177.

³¹¹ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 44.

Hydroquinone is used to bleach the skin. In one study, on a scale from 1-9, Italian social workers ranked discrimination in the housing market at 7.74 and at 6.65 in the job market.³¹²

One stereotype particularly of Arabs is that they are more proud than others; Italians supposedly criticize Arabs a lot for this pride.³¹³ The major stereotype most Italians note about Arab immigrants is their strict “management of women” and Arab Muslim women’s lack of a social position. Others claim “Arab women, North Africans, and other Africans are tied to their husbands; they’re cut; they wear a veil because their husbands make them, not because they chose to.”³¹⁴ Italian health workers constantly noted Arab women’s demand for female physicians as proof of these supposed cultural norms.³¹⁵

Discrimination both due to one’s religion and ethnicity, i.e. being Arab Muslims in Italy, can also be re-explained as a disparity. The stress discrimination brings that causes negative health outcomes also makes addressing other health needs stressful (and thus more difficult), fuels the legal exploitation of immigrants, and can lead to the social isolation of communities (which makes spreading health information or services more difficult).

One study, for example, noted that 46.4 percent of immigrants said they had no relations with immigrants of other origins. Such a lack of relations is more prevalence in the South and among Muslims and other non-Christians in all of the country. 22.2 percent of respondents said that relations with others from the same country were very strict – they lived in their own communities; most of these respondents lived in the North. More men than women also expressed having more relations with other co-nationals.³¹⁶ With this last statistic we can see how gender and isolation (possibly due to fear of discrimination) intersect to make Muslim

³¹² Losi, Ippolito, and Mazzara, *Gente in Movimento*, 17.

³¹³ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

³¹⁴ Ms. Edoarda Trillò with Rome Local Health Clinic “C,” July 24, 2006.

³¹⁵ Sig. Andrea with Fratelli di San Francesco, July 20, 2006.

³¹⁶ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 53-54.

women immigrants less integrated into the Italian society; lack of integration makes access to health information and language abilities come at a slower pace.

Inter-generational Identity Conflicts

Ethnicity also plays an important role in the health within immigrant families. Many values are often different among second generation immigrants from those of their parents. It is not rare, for example, that a parent refuses a daughter (and not the son) permission to go out. In one case in Sicily, a Muslim girl attempted suicide due to such restrictions, which she could neither understand nor tolerate. Thus, mental health issues arise among second generation immigrants in Italy, especially among the many immigrants that come from “non-Western” cultures trying to fit-in with their “western” acquaintances in school.³¹⁷ Some tribunals for minorities have difficulties in dealing with “cultural differences” of immigrants; sometimes they think parents are hurting their kids.³¹⁸

While some kids hate their parents for imposing cultural expectations that do not exist for the majority of their Italian counterparts, other immigrant children do not know their parents because they work all the time and they never see them after the move to Italy. The opposite is also true; after moving to Italy, some families feel closer.³¹⁹ Thus, a variety of dynamics surrounding cultural upbringing in immigrant families can have a variety of effects on the health of the family unit.

³¹⁷ Melfa, “The Muslim Communities in Sicily,” 174.

³¹⁸ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

³¹⁹ Claudio Baraldi, Sabrina Carotti, and Sonia Ceccato, “Forms of Multicultural Adolescent Female Identity. A Research in High Schools,” in *Stranieri in Italia: Reti Migranti*, ed. Francesca Decimo and Giuseppe Sciortino (Bologna: Il Mulino Editors, 2006), 292.

Several studies have shown the importance of culture to Arab Muslim immigrant families in Italy. In one such study, while only 10 percent of surveyed immigrants said that their children knowing their native language was unimportant, more Christians than Muslims said this was unimportant or of medium importance.³²⁰ The importance of keeping one's culture or connections with one's country of origin is also evident. At least 48 percent of surveyed immigrants keep in contact with relatives or friends in their home countries through weekly phone calls or mail. Those between the ages of 25 and 44, those with higher education, those living in Italy for less than two years, and irregular immigrants maintain more contact.³²¹

Communication

A major difficulty, and thus, disparity determinant for many immigrants is their inability to communicate adequately with health care providers. One immigrant from Ghana that picked tomatoes, for example, described total body pain, and unable to explain himself any better, the doctor did not realize he had a common muscular-skeletal problem.³²² Miscommunication can also result in feelings of disrespect. Many immigrants, for example, do not understand why they must wait a month or two for some services in the Italian health system, not realizing that an Italian would have to wait just as long.³²³

Only 28.9 percent of immigrants surveyed in Italy have taken an Italian course and only 28.3 percent of immigrants' children attend school in Italy. More immigrants residing in Northern and Central Italy have utilized these opportunities; the majority of immigrants in the

³²⁰ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 53.

³²¹ *Ibid.*, 55.

³²² Andrea Accardi with Medici Senza Frontiere, July 27, 2006.

³²³ Assistant of Signora Maria with NAGA, July 17, 2006.

South have not. Just over a quarter, (26.7 percent) of surveyed immigrants say they can scarcely speak Italian and 46.8 percent of them feel that can hardly write Italian. Less than half of the surveyed immigrants, 41.4 percent, feel that they speak Italian at a good level. The researchers of this survey found that comprehension of the language was better in the North and Center regions and much worse in the South. They also found that “irregular” immigrants were more likely to have a bad comprehension of Italian, likely due to their reluctance to access services like language courses.³²⁴

Conclusions on the Determinants of Disparities

So how do gender, class, religion, and ethnicity intersect to act as determining factors of health outcome disparities among Arab Muslim immigrants in Italy? Within one family, both the mother and father might be dealing with precarious work situations, which limits their time to access health structures and their time spent with any children they might have. This makes the children possibly more prone to accidents and might result in a lower level of socialization for the children in the immigrants’ host country culture. If the mother has a health problem, she might have to face the following challenges: she fears taking time off of work to go to the health clinic, she might also additionally have to ask her husband to find the time to accompany her, she fears that they might not be able to communicate exactly what is bothering her, and she might not be worrying about it. On the other hand, when she goes to the clinic, health care workers’ possible generalizations about Muslims or Arabs might lead them to attach some negative cultural significance to the cause of the problem, rather than treating her problem in a truly culturally sensitive manner. Thus, we can see how gender, class, religion, and ethnicity can come

³²⁴ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 47-48, 50.

together to make dealing with health problems additionally stressful for immigrants. The many health problems presented before that immigrants experience in Italy are not caused by the factors of gender, class, religion, and ethnicity, but rather these factors produce the disparities between the host and immigrant populations in health statuses – especially class, as I have noted that the living and work environments of immigrants in Italy contributes significantly to their health problems.

CHAPTER 4

HOW IMMIGRANTS ACCESS HEALTH CARE IN ITALY

For Immigrati Regolari

For legal immigrants in possession of a *permesso di soggiorno*, or the receipt of the renewal of this permit, it is obligatory to enroll in the National Health Service (*servizio sanitario nazionale*, or SSN) for the following motives. In addition to work or family reasons, the possible motives are: for political or humanitarian asylum, for being a minor, for being pregnant or just having given birth, for residing in a welcoming center, for a health reason, and for those awaiting an adoption, custody of a child, or citizenship. Fulfilling this enrollment obligation gives one rights, duties, and services in regards to health services equal to those of Italians. Family members are even guaranteed access to services.³²⁵

Those holding a permit to stay for at least three months and for motives other than those mentioned above have the option of enrolling the SSN on a yearly basis.³²⁶ European foreigners are covered just like the Italians; non-Europeans have to pay around 750 euro a year to enter the national health system.³²⁷ Those holding a permit to stay for less than three months do not qualify for enrollment in the SSN.³²⁸ These individuals must instead have private insurance or pay for any non-emergency health services they wish to utilize in Italy.³²⁹

³²⁵ “La legge sanitaria per gli stranieri immigrati,” NAGA, http://naga.it/a4_legge.html (accessed January 1, 2007).

³²⁶ Ibid.

³²⁷ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

³²⁸ “La legge sanitaria per gli stranieri immigrati,” NAGA.

³²⁹ Italian Ministry of Health, *Le 10 Regole per l'assistenza sanitaria agli immigrati*, <http://www.simmweb.it/decalogo.pdf> (accessed January 1, 2007).

Enrolling in the SSN involves presenting one's *permesso di soggiorno*, Italian fiscal code, and certificate of residence at the local health clinic (known as an *azienda sanitaria locale*, or ASL) indicated on the *permesso*. To make sure the enrollment in the SSN lasts as long as the foreigner's *permesso di soggiorno*, he or she has to show the expiration coupon to the local registry office.³³⁰

For *Immigrati Irregolari*

Irregular immigrants in possession of a receipt for a regularization application can temporarily enroll in the SSN until regularized, at which point enrolling becomes an obligation.³³¹ Otherwise, according to the MOH, irregular immigrants are insured for services, in accredited public and private offices, for ambulatory or emergency services, essential or continuative services, services for diseases or illness, and preventive medicine programs on individual and collective (family members) levels.³³² Among the “protected” conditions are pregnancy and motherhood, health of minors, vaccinations and international health interventions, and the diagnosis and treatment of infectious diseases. “Essential treatments” include “health services, diagnostic and therapeutic, for pathologies not dangerous immediately or in the short term, but which in time could damage one’s health or risk one’s life.”³³³ In order to access such services, except for those obtained in an emergency room, a foreigner must get a card with a

³³⁰ Italian Ministry of Health, *Le 10 Regole per l’assistenza sanitaria agli immigrati*.

³³¹ “La legge sanitaria per gli stranieri immigrati,” NAGA.

³³² Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 37.

³³³ Italian Ministry of Health, *Le 10 Regole per l’assistenza sanitaria agli immigrati*

straniero temporaneamente presente (foreigner temporarily present, or STP) code at the local ASL.³³⁴

Italian health care social workers are forbidden from declaring clandestine immigrants to the authorities.³³⁵ Because these services are guaranteed to everyone, health entities should not require information either about one's *permesso di soggiorno*. Communication with the Ministry of the Interior to reimburse the various entities serving holders of the STP is done anonymously so as not to compromise illegal immigrants.³³⁶

With the STP, foreigners get health care for up to six months (the card can be renewed until no longer needed); the STP does not cover family members.³³⁷ While certain services like dentistry are not generally covered,³³⁸ the STP card can be used at pharmacies.³³⁹ Irregular immigrants, just like any foreigner or Italian enrolled in the SSN, have to pay a ticket each time they access the health system. Irregular immigrants as well as other foreigners and Italians can make a “declaration of poverty” and after getting it approved, do not have to pay the ticket for six months except in certain cases.³⁴⁰

While the MOH only lists the above services as available to irregular immigrants, most of the other literature on immigration health explains the types of services available to irregular immigrants as “*medico di basse*,” or basic medicine. This “basic medicine” refers to the fact that only basic services are covered and that whereas Italians and other foreigners enrolled in the SSN have the opportunity to choose their own family doctor, foreigners with the STP have

³³⁴ Ibid.

³³⁵ Ibid.

³³⁶ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 37-38.

³³⁷ Assistant of Signora Maria with NAGA, interview with author, Milan, July 17, 2006.

³³⁸ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

³³⁹ Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 38.

³⁴⁰ Italian Ministry of Health, *Le 10 Regole per l'assistenza sanitaria agli immigrati*.

access only to a doctor of general medicine available at every ASL for all foreigners.³⁴¹ Irregular immigrants' children ages zero to six have the right to basic medicine (including vaccinations), to see specialists, and to free clinical exams from conventional, public, hospital, or regional structures. All minors ages six to 18 also have right to free and directly accessible basic medicine. These children, however, must pay a “ticket” when seeking the services of specialists (including lab analyses) like Italians.³⁴²

According to Geraci and Marceca, all *medico di basse* was previously supplied as an outpatient service by social private actors or by voluntary clinics; only recently, they claim, have some of the normative and administrative barriers, like the presence of the STP mechanism, to treating regular and clandestine immigrants softened.³⁴³ Dr. Arca with the Italian Ministry of Health noted that discussions continue at the governmental level about what fits under the definition of basic medicine.³⁴⁴

Data on How Immigrants Currently Access the Health System

Two concepts noted in the Italian literature about migrant health access are important to know before we present data on how immigrants access the health system in Italy. The first is that most immigrants over-use emergency care. For reasons to be expanded upon below, many immigrants take all of their important medical concerns right to the emergency room. Studies have shown that immigrants present in Italy for less time and illegal immigrants especially favor going to the emergency room (ER). The ER is immediately accessible, users can bypass

³⁴¹ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

³⁴² Ammendola, Forti, Garavini, Pittau, and Ricci, *Immigrazione Irregolare in Italia*, 37.

³⁴³ Geraci and Marceca, “Le malattie degli immigrati,” 6.

³⁴⁴ Dr. Arca with the Ministry of Health, interview with author, Rome, July 26, 2006.

bureaucratic paperwork,³⁴⁵ and its services are guaranteed to everyone, including those without documents of residence.³⁴⁶ I can attest to the ease of getting medical attention in the Italian ERs; I came down with a debilitating fever during the end of my stay in Italy in Palermo. I went to the ER, without a fatal condition, was seen and given a prescription within two hours, without having to present any documentation.

The second concept, the “*intervallo di benessere*,” or interval of wellness, is used to describe the period from the day immigrants first arrive in Italy to the day they first access medical services in the country.³⁴⁷ Scholars had considered this to be around one year, but recent work suggests that it has shortened. Forty-five percent of new Caritas Rome users come in one year after having been in Italy; 10.5 percent of total patients (eight percent women) do not access medical services until after three years of being in Italy.³⁴⁸ Between 1993-1994 the “well being interval” for migrants was 10 to 12 months after arrival; between 1995 and 1998 this interval shortened to two to three months. MSF research shows that 10.4 percent of migrants are sick after less than a month in Italy and 39.7 percent are sick after being in Italy between one and six months. They note that sub-Saharan immigrants and North Africans are almost always healthy upon arrival. Because half of the migrants are not enrolled in the SSN, MSF suspects that the interval of well-being might be slightly over-estimated in length.³⁴⁹ More data on this interval of wellness would be very helpful to this study; noting from which countries those who accessed

³⁴⁵ Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

³⁴⁶ Semi, “The Return of the Bazaar Economy,” 45.

³⁴⁷ Geraci and Marceca, “Le malattie degli immigrati;” A. Morrone, “Realtà e prospettive di un centro di dermatologia per immigrati,” Istituto Dermatologico San Gallicano (IRCCS), (Rome, 1999), <http://193.109.105.24/allegatiifo/migrazioni/abstracts/74°CongressoNazionaleSidevRealtà.pdf>, (accessed March 17, 2007); “Missione Italia: I Progetti di MSF in Italia,” Doctors Without Borders, http://www.msf.it/msfinforma/dossier/missione_italia/prima_pagina/31032005.shtml (accessed March 17, 2007); Aldo Morrone, “Quando gli uomini si spostano,” Istituto Internazionale Scienze Mediche Antropologiche e Sociali, <http://www.iismas.it/letture/quando.htm> (accessed March 17, 2007).

³⁴⁸ Geraci and Marceca, “Le malattie degli immigrati,” 9-10.

³⁴⁹ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 55-58.

health services after longer periods came from and the seriousness of the medical condition they presented would give us a better picture of who might be hesitant to access the Italian health care system for basic services.

Data collected on immigrants accessing Italian health care facilities show that immigrants are in fact accessing the health system to take care of some of the previously mentioned needs, especially for pregnancy and other reproductive health services. This demonstrates the important presence of women migrants in Italy. Geraci's and Marceca's figures show that in the Lazio region, 14.6 percent of the immigrants discharged from the hospital had been there for recovery from pregnancy/labor, 7.2 percent recovering from an infectious disease or parasite, 6.9 percent from nervous system diseases, 4.9 percent for digestive system diseases and disorders, 4.7 percent for psychological problems, 4.5 percent for muscular-skeletal disorders, 4.3 percent for respiratory disorders and diseases, and 3.4 percent for cardio-vascular disease. Major causes of hospitalization included: 7.7 percent for vaginal delivery without complications and 4.0 percent for esophagus / gastro-intestinal problems. Abortion at 25.8 percent and HIV or related pathologies at 6.1 percent are taken care of day hospitals.³⁵⁰

In the northern Veneto region, causes for hospitalization are: 21 percent obstetric or gynecology related, 15 percent digestion, 10 percent orthopedics, 7 percent respiratory, 6 percent psychiatric, 5 percent dermatology, 4 percent renal and urinary, 3 percent infectious disease, and 29 percent "other." Geraci and Marceca note that in the Center and in the North causes for hospitalization are mostly related to pregnancy or social/work conditions related to poverty.³⁵¹

The following data concerns the Rome Caritas Multi-ambulatory in the 1990s; it gives an idea about who comes to a hospital known for serving immigrants in Italy's capital. Ninety

³⁵⁰ Geraci and Marceca, "Le malattie degli immigrati," 5.

³⁵¹ Ibid., 5.

percent of the cases at this clinic served immigrants not enrolled in the National Health System. Most of the Caritas users were young (81.3 percent in 1999 were between the ages of 16-45), although users from North Africa and several other areas tended to be older. Forty percent of the users were women. Over 60 percent of them had a high school degree; at least 10 percent had college degrees.³⁵²

While only focused on the Rome Caritas hospital in Rome, the numbers in Table 10 show how the number of immigrants coming from Arab countries accessing this hospital's services for the first time declined in the 1990s. Because the number of immigrants coming from these countries surely did not slow in the same time period, what caused this decrease? Did word of mouth spread around about treatment quality at the supposed hospital for immigrants? Did the 1998 legislation cause fear about accessing public services? Immigrants from Europe increasingly accessed the hospital; those from Asia and America fluctuated but did not change too much; the number of Africans accessing the hospital also decreased. Did more health services to immigrants become available at this time in Rome that African and Middle Eastern populations found more appropriate?

³⁵² Ibid., 7, 9.

Table 10. Users of the Rome Caritas Poliambulatorio from 1992 to 1999³⁵³

paese di provenienza	1992 %	1993 %	1994 %	1995 %	1996 %	1997 %	1998 %	1999 %
totale Europa	653 17,5	837 19,6	877 25,3	1.006 35,0	881 33,5	1211 47,5	1.208 44,6	1.607 46,3
AFRICA, di cui:								
Marocco	151 4,0	132 3,1	99 2,8	62 2,7	72 2,7	73 2,9	61 2,2	37 1,1
Algeria	57 1,5	51 1,2	31 0,9	32 1,1	28 1,1	29 1,1	39 1,4	17 0,5
Tunisia	34 0,9	27 0,6	16 0,5	22 0,8	19 0,7	30 1,2	19 0,7	15 0,4
Egitto	51 1,3	63 1,5	58 1,7	59 2,0	39 1,5	31 1,2	28 1,0	17 0,5
totale Africa	1.528 41,0	1.567 36,7	866 24,8	632 22,0	502 19,0	523 20,5	498 18,4	382 11,0
totale Asia	839 22,5	865 20,3	837 24,1	575 20,0	897 34,0	449 17,6	609 22,5	941 27,1
totale America	684 18,4	946 22,2	850 24,5	643 22,3	347 13,1	338 13,3	384 14,2	509 14,7
TOTALE	3.726 100	4.266 100	3470 100	2.877 100	2.641 100	259 100	2.711 100	3.470 100
<i>numero ricoverati</i>	95	97	102	92	84	85	80	91
<i>% maschi/femmine</i>	57%	52%	53%	54%	70%	64%	64%	60%

Fonte: Area sanitaria Caritas di Roma, 2000.³⁵⁴

Geraci and Marceca do note that while the number of North Africans to use the clinic in the 1990s appears to show a decrease in use, data for sixteen years of Caritas (1983 – 1999) ranks Morocco number seven in users per nationality out of 16 countries with 1,463 users total, or 3.6 percent of total users.³⁵⁵

In addition to accessing Italian health structures, immigrants have also established ways to perform traditional cures in their communities. Chinese immigrants are most noted for practicing traditional (but often illegal) medicine in Italy. At least 10 percent of interviewed immigrants coming from various countries in one study use traditional medicine from their countries of origin.³⁵⁶ Access to some products and health professionals from Arab countries is even possible in Italy. A Moroccan pharmacy exists, for example, among the Moroccan meat stands, clothing and electronic stores, and other goods in the “bazaar economy” of Torino.³⁵⁷

³⁵⁴ Ibid.

³⁵⁵ Ibid., 8.

³⁵⁶ Semi, “The Return of the Bazaar Economy,” 45.

³⁵⁷ Ibid., 92, 100.

CHAPTER 5

PROBLEMS WITH ACCESS FOR IMMIGRANTS

One immigrant survey finds that overall the access to health services is not considered a difficulty; only 8.5 percent of immigrants interviewed said they had considerable or great difficulty in accessing health services. The authors of this study note, however, that despite that access to health services is not described as a difficulty, it brings into question whether immigrants are accessing appropriate services; the overwhelming recourse to run to the ER for most health problems would be an example, for instance, of inappropriate use of health services. The Italian social workers say that for the most part, the services immigrants request at the ER are not emergency in nature and that immigrant use of the ER is much higher than that of Italians.³⁵⁸ What are the factors contributing to this overuse of the ER? The information provided just below shows that immigrants face several social, but also logistical problems in accessing health services. These include problems concerning a lack of information, a greater need for cultural competency training of Italian providers, and regional economic and management variations that lead to differing health outcomes.

Lack of Information

Dr. Accardi with MSF affirmed that “all foreigners have access [to health services], communication and no capacity are the problems.”³⁵⁹ An employee of a local clinic in Rome also

³⁵⁸ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 46.

³⁵⁹ Andrea Accardi with Medici Senza Frontiere, July 27, 2006.

noted that access exists for irregular immigrants, but they do not come because there is a lack of information about services and about that they will not be declared to the authorities.³⁶⁰ She continued to explain that “[irregular immigrants] all wait and go to the ER because they do not know that people in the health system cannot say anything; the ER rooms get very full and this is a big problem. Even if they know, they still have fear, which the Bossi-Fini law made worse.”³⁶¹ MSF with their numerous interviews of migrant workers in southern Italy also confirmed this phenomenon, stating that first-off foreign workers do not access the National Health Systems because of: a lack of information on the physical location of health structures, a lack of information on the right to insurance, fear of entering a public structure and being denounced.³⁶²

Numerous studies have affirmed these individuals’ claims that immigrants, and often health structures, lack full information on the rules governing immigrants’ access to health services. Geraci and Marceca note that what the field of migrant health needs is reliable and complete information on immigrants and their health. In 1997, surveys of hospital effectiveness were conducted throughout the country. Out of the 11,695,413 files sent back, only 37,149 (0.32 percent) of them mentioned non-Italian citizens; 6,717 of these individuals were displaced persons. This reveals the unsatisfactory way information was asked and collected.³⁶³

Additionally troubling is another study that found social workers to be generally unaware of the “information gap” problem. In this survey, only a little more than six percent of the social workers considered immigrants to be dissatisfied with their services. Social workers cited the largest problems as language barriers, followed by bureaucracy and cultural differences. Ranked

³⁶⁰ Francesca Barbieri (also Margherita Sistieri and Massimiagno Copz) with Rome Local Health Clinic D, July 28, 2006.

³⁶¹ Ibid.

³⁶² Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 48-49.

³⁶³ Geraci and Marceca, “Le malattie degli immigrati,” 2-3.

low on their list of problems was knowledge of services; social workers thought that the immigrants are relatively well informed.³⁶⁴

Other studies show that immigrants lack knowledge about Italian laws concerning immigrants in general. In one study, 39.4 percent of surveyed immigrants said they had a poor knowledge of the regulations regarding immigrants in Italy; only 27.2 percent expressed a good knowledge of the regulations. The study also notes that men in general have a better knowledge of the regulations than women. Those between the ages of 24 and 44 also expressed better knowledge of the regulations.³⁶⁵ These are dangerous results given the discussion about the number of health problems that affect young and female immigrants in Italy.

Information About Enrollment in the Health Care System

Much of the information confusion concerns enrolling in the health care system itself, the most important step for accessing services. Both regular and irregular immigrants have to deal with the problems of language barriers and bureaucracy. Often materials explaining how to enroll in the health system are not translated into a wide variety of languages and the process of how to enroll can seem daunting and unclear. The worker in the Rome clinic said that many people even with *permessi di soggiorno* do not subscribe to the public health system because they do not know it is possible, or they perceive it to be too difficult.³⁶⁶ MSF found that 91 percent of the migrants who had previously paid to see a private doctor had not been informed of

³⁶⁴ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 64.

³⁶⁵ *Ibid.*, 51.

³⁶⁶ Francesca Barbieri (also Margherita Sistieri and Massimiagno Copz) with Rome Local Health Clinic D, July 28, 2006.

their right to enroll in the SSN or to get an STP code; 49 percent of the migrants who had received medical attention from charitable organizations also did not receive this information.³⁶⁷

The bureaucratic problems especially come to light with the issue of addresses. Cecilia Pani, a doctor with a big voluntary organization in Rome, explains that in a couple of ASL, for example, Bangladeshis or Arabs in ASL “A,” go to the window with their documents and sometimes the address is different on their *permesso di soggiorno* than their current residence. What is valid for the ASLs is the current residence, but sometimes the Italian workers do not know this and refuse to process the documents. In other cases, immigrants are guests of the renter, or ten people live in one place illegally and their hosts do not want them to give out the address. Dr. Pani notes that some organizations can give these individuals addresses, known as virtual addresses, to allow them to get health services or to get an identification card.³⁶⁸ Many immigrants, of course, would have no idea of these possibilities if they have not asked organizations about such problems.

Irregular or clandestine immigrants also have to wade through a myriad of rules that inhibit starting the process in the first place. For example, explains Roman gynecologist Dr. Canitano, immigrant babies have a protected status for six months in Italy, and can receive a *permesso di soggiorno* for this period. When the baby turns 6 months old, he or she turns clandestine again; so some mothers never come for services because if they do not have a *permesso di soggiorno* they figure it would be riskier and harder to appear and then disappear.³⁶⁹

Information Sources

³⁶⁷ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 62.

³⁶⁸ Cecilia Pani with Comunità di Sant’Egidio, July 28, 2006.

³⁶⁹ Dr. Lisa Canitano with vitadonna.it, July 22, 2006.

One source of the miscommunication is the means by which immigrants gain their information about health services in Italy. A study notes that for health assistance, 20 percent of surveyed immigrants turn to others from their country of origin (data supports the immigrant network theory); 13.6 percent turn to other actors of mediation (unclear as to who this refers to), 13.1 percent turn to Italian friends and acquaintances for help, 12 percent turn to employers at work, 7.5 percent turn to public health personnel, 6.4 percent use cultural mediators (translators sometimes present in hospitals and clinics, to be discussed further below), five percent turn to religious associations or individuals, 4.2 percent turn to non-religious organizations or NGOs, 2.6 percent turn to communal, provincial, or regional personnel, 0.8 percent turn to instructors of courses they had previously taken, 0.6 percent turn to regulatory forces like the police, and zero percent turn to diplomatic institutions.³⁷⁰ We can see that a very small percentage of immigrants turn to individuals actually in Italian health structures (13.9 percent – public health officials and cultural mediators) for information.

Another study notes that more than half of Italian social workers (55 percent) said that ten or fewer immigrants contact them every day for mediation in their work but over half of the respondents said they personally come into contact with only 1-2 immigrants per day. Less than half (41.7 percent) of the social workers said that immigrants have been significant participants in their service for more than six years. For a third of the social workers, immigrants constitute only up to five percent of the use of their services. Nearly half (48.9 percent) of the social workers said their service was under-used by immigrants.³⁷¹

Italian Cultural Competency Training and Similar Programs

³⁷⁰ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 49.

³⁷¹ *Ibid.*, 60-61.

Cultural Mediators and Translators – Not Widely Available

In terms of discrimination affecting one's access to health services, an Italian "professional on cultural studies in health" Dr. Cecchini claims that the health system in Italy does not have [adequate] cultural sensitivity training. Some cultural mediators exist, but they are not always present. Cultural mediators are like an informed translator; they receive training and explain not only medical jargon, but cultural differences to patients and doctors; they are often migrants themselves. Even though their work is paid, it is generally not a fixed post. When cultural mediators are not present, according to Cecchini, doctors get nervous and do not want to listen to the experience of the patient. Immigrants then get treated poorly.³⁷² A Milan clinic volunteer noted, doctors after all have stereotypes like those of any other person; the doctors in their clinic do study cultural competency and diseases particular to other populations.³⁷³

The Rome ASL "A" was in its first year of experimentation using cultural mediators in the summer of 2006. So far they thought that it was better for social workers to have the mediators present once or twice a week. They noted a nation-wide system in Italy with which the social worker can just call a number and reach people who can help in up to 100 languages; many Egyptians use this service at their clinic.³⁷⁴ This observation shows progress in the use of cultural mediators. Others have noted, however, the lack of cultural mediators, especially outside of the north.³⁷⁵

³⁷² Prof. Rosalba Terranova-Cecchini with Fondazione Cecchini Pace Istituto Transculturale Salute, July 18, 2006.

³⁷³ Assistant of Signora Maria with NAGA, July 17, 2006.

³⁷⁴ Francesca Barbieri (also Margherita Sistieri and Massimiagno Copz) with Rome Local Health Clinic D, July 28, 2006.

³⁷⁵ Cecilia Pani with Comunità di Sant'Egidio, July 28, 2006.

Training Health Staff and Clinics – Not Widely Practiced

One interview I did was at the first ASL in Rome with the specific objective of helping immigrants and social workers deal with immigrants; they are the only ASL with such an office (as of July 2006) that offers documentation, information, and instruction services, sometimes even translated in a variety of languages. They noted that ignorance exists, that people that migrate are not healthy; the workers in this office want to create a movement of ideas on the basis that culture is fundamentally important to health.³⁷⁶ The fact that only one of such offices exists in the local ASLs reflects a need for an expansion of such efforts.

One study showed that 70 percent of social workers say they received no specific instruction on how to deal with immigrants. Of the people that had received training, most were trained by the same entity they work for, or other public entities and official structures (not so much private and religious organizations). More than half of all the interviewees, however, consider their ability to respond to immigrant demands relatively high. The social workers consider possible future difficulties to be: the lack of a specific preparation and a lack of personnel. They consider hostility and prejudice of the general population small issues. Social workers also note improvements should increase the institutional space dedicated to immigrants. The researchers infer that this means the social workers think their services are already sufficient and efficacious and that the problems are more external.³⁷⁷

Management implications

³⁷⁶ Francesca Barbieri (also Margherita Sistieri and Massimiagno Copz) with Rome Local Health Clinic D, July 28, 2006.

³⁷⁷ Losi, Ippolito, and Mazzara, *Gente in Movimento*, 62, 64-65.

Voluntary Clinics

While this is perhaps not apparent to immigrants, or even most Italian users of the health system, the management of clinics affects one's ability to access them. In researching this topic, three different management structures: voluntary, those ruled by center-right politics, and those ruled by center-left politics, seem each to offer various challenges for immigrants.

Volunteer clinics have advantages and disadvantages. They often might receive better funding than their public counterparts due to unlimited private donations not contained in the state budget. Some groups do this to keep their own organizational freedom. The NAGA Voluntary Association of Social Assistance in Milan, for example, does not take financial contributions from the commune because it decided to not accept any political associations; they do not want the city to be asking them to do something the city should be taking care of itself.³⁷⁸

Other voluntary associations are well connected to the state, and even have strong ties with the Catholic Church. The Caritas Association receives a large part of its budget from the state. The Caritas system of volunteers in Rome claims to be connected to contacts, referrals, and assistance channels that not only “answer the need, but analyze it as well.”³⁷⁹ Dr. Canitano, however, claims that some other voluntary clinics, while full of good intentions, often do not provide good quality assistance and they are not connected to the public system.³⁸⁰ Because they are voluntary, for example, word of mouth among immigrants makes for very crowded waiting rooms in the summer in the few organizations that are still open because many of the smaller clinics close at this time.³⁸¹

³⁷⁸ Assistant of Signora Maria with NAGA, July 17, 2006.

³⁷⁹ Geraci and Marceca, “Le malattie degli immigrati,” 7.

³⁸⁰ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

³⁸¹ Luca Bettinelli with Caritas Ambrosiana, July 13, 2006.

These voluntary clinics might provide a great stepping stones for immigrants to gain knowledge about accessing the government system and help along the way, but they must be seen in this matter. If the Italian state really wants to be prepared for the settling of immigrant families that is happening, these organizations need to have a clear connection with the local government structures. We will see that this is being done successfully in the Lazio region below.

Regional Politics

While we have noted Italy's attempt on a national level in the 1998 law to clarify health protections for immigrants, the actualization of this law is being carried out at regional and local levels. In a study on regional interpretations of the 1998 law concerting the safeguarding of health, Geraci and Martinelli found 20 regional laws, one provincial law, one provincial law project on immigration, 12 modifications, 37 other joined regional laws, 89 regional decisions, 9 provincial decisions, 55 regional circulars and notes with specific reference to health, 56 specific projects, 18 regional health plans, and four drafts of plans.³⁸² Table 11 displays some of these laws. While the study discussed each region, this report will only focus on Lombardy and Lazio, the regions where Milan and Rome are located respectively, because that is where the interviews for this report took place.

³⁸² Salvatore Geraci and Barbara Martinelli, "Politiche Locali per il diritto alla salute degli immigrati," Società Italiana di Medicina delle Migrazioni (Rome, 2004): 1,3, <http://www.stranieriinitalia.it/briguglio/immigrazione-e-asilo/2002/ottobre/geraci-pol-locali-sanita!.pdf> (accessed January 30, 2007).

Table 11. Regional laws on immigration³⁸³

Leggi regionali sull'immigrazione

LEGGE REGIONALE	
ABRUZZO	n. 10/1990
BASILICATA	n. 21/1996
CALABRIA	n. 17/1990
CAMPANIA	n. 33/1994
EMILIA ROMAGNA	n. 14/1990
FRIULI V. G.	n. 46/1990
LAZIO	n. 17/1990
LIGURIA	n. 7/1990
LOMBARDIA	n. 38/1988
MARCHE	n. 2/1998
MOLISE	-
PIEMONTE	n. 64/1989
PUGLIA	n. 26/2000
SARDEGNA	n. 46/1990
SICILIA	(n. 55/1980)
TOSCANA	n. 22/1990
P. A. TRENTO	L.P. n. 13/1990 (D.L. n.128/2001)
P. A. BOLZANO	-
UMBRIA	n. 18/1990
VALLE D'AOSTA	n. 51/1995
VENETO	n. 9/1990

Lombardy enacted a plan in 1999-2000 for local entities and private social associations concerning the social, work, and cultural integration of immigrants. After another two years, the region set out a Social Regional Health Plan for 2002-2004 that guaranteed immigrants equal access to services and outlined the role of the Regional Observatory for Integration, which will monitor immigration flows in the region.³⁸⁴

According to both a NAGA volunteer and Dr. Canitano, the state is decentralizing and health is one of the arguments about whether regions should have more power. They noted that because Milan is traditionally to the right, laws are interpreted in a more restrictive manner. The

³⁸³ Ibid, 1, 3.

³⁸⁴ Ibid., 6.

NAGA representative thought that no hospitals existed in Milan for immigrants without *permessi di soggiorno* while such structures exist in Rome.³⁸⁵ ³⁸⁶

Dr. Canitano noted additional problems with the old center-right government led by Berlusconi that governed the whole country. She said that the government indicated that providers had to make sure people holding an STP ticket were really poor because of stereotypes that foreigners are rich; for example, apparently some of the Italian gypsy population are rich and really do pretend to be poor. Dr. Canitano noted the impossibility of controlling such a demand.³⁸⁷ Another episode she noted included when Berlusconi gave a present for all babies born in a certain year of 1000 euro. The decree, however, reserved this gift only for Italian babies, but foreigners had already received some of these gifts before the center-right leadership clarified the issue. The government asked to have the money back from the foreigners, (the center-left government in power now said, however, that the foreigners could keep the gifts).³⁸⁸

Turning to look more closely at a region traditionally governed by the center-left, Lazio we can see different instruments not present in Lombardy. According to Geraci and Martinelli, Lazio's health plan has regularized the access to health assistance for foreigners temporarily present through its many deliberations and circulars. Geraci and Martinelli note that through the region's thoroughness, its laws have fully adapted the provisions set out in the national law and even cleared up ambiguities within this framework. Geraci and Martinelli also note that through the involvement of both public and voluntary structures the region has built up a "mature experience" dealing with immigrant health problems, helped by their Council of Deliberations formed in 2001 to evaluate and monitor the region's progress on these issues. The region also

³⁸⁵ Assistant of Signora Maria with NAGA, July 17, 2006.

³⁸⁶ Dr. Lisa Canitano with Vitadonna.it, July 22, 2006.

³⁸⁷ Ibid.

³⁸⁸ Ibid.

has the Regional Group of Immigration and Health (GRIS) founded in 1995, which has brought together 40 public, private, and voluntary health institutions. GRIS put out “Guidelines for Health Assistance to Foreigners not belonging to the EU.” Geraci and Martinelli claim this is one of the only regions in Italy actively promoting the national laws evenly throughout the region.³⁸⁹

While I did not receive a balanced report on the problems perhaps center-left leadership may have caused for immigrants, the lesson is that the regional powers in Italy and loyalties to center-left or center-right politics leads to varying applications of the national laws concerning immigration. This results in varying degrees of access possibilities for immigrants in Italy.

Other Problems and Conclusions

It should also be noted that additional problems to accessing the health structures for immigrants in Italy include the determinants of disparities discussed earlier: gender, race, ethnicity, and religion. These factors contribute to additional logistic problems MSF noted that immigrants have in accessing the health structures in Italy like physical difficulties accessing the health structures like distance, work hours overlapping with clinic hours, or lacking means of transportation.³⁹⁰

MSF also importantly notes that the foreigners that do access a health structure are not correctly assessed due to the problems just discussed. Almost three fourths (72 percent) of the migrants seeking services from the MSF mobile clinic had seen a doctor before about the same problem and had not resolved the problem with the previous medical attention. MSF found that

³⁸⁹ Geraci and Martinelli, “Politiche Locali per il diritto alla salute degli immigrati,” 7.

³⁹⁰ Medici Senza Frontiera – Missione Italia, *I Frutti dell’Ipocrisia*, 48-49.

doctors before had given the migrants relatively “generic” diagnoses when in fact the migrants should have been referred to specialists, but this did not happen and thus the problems persisted.³⁹¹ Furthermore, the foreigners that receive a correct diagnosis then subsequently do not follow the correct therapy because of similar problems related to communication, logistical, and compliance challenges.³⁹²

In conclusion we see that immigrants face information barriers, dealing with service providers not frequently trained in cultural competency or mediation, confronting different management structures in various settings, and additional obstacles after accessing health care services in obtaining accurate diagnoses and completing treatments. By looking at the health problems of immigrants described in the first section of this thesis, we see how the interval of wellness is shortening for immigrants in Italy. Then, by looking at the problems immigrants face in accessing health services, we see why immigrants tend to overuse ER services and experience persistent health problems in trying to ameliorate these health problems.

³⁹¹ Ibid., 63.

³⁹² Ibid., 48-49.

CONCLUSION

The health status of an immigrant affects his or her integration and attitude about integration into the host country. Good health and also good knowledge of how to utilize health services helps fend off disillusionment and makes economic advancement easier. The health of immigrants is also relevant to the state of Italy because knowledge of this changing and increasing demographic helps the country better control its national public health issues, helps to make health policy targeted at these individuals more efficient, and the knowledge ideally helps to keep this needed population a strong and part of the Italian workforce and economy.

Given this impetus for the study of migrant health and Italy's position as a new country of migration, it was necessary to evaluate the Italian and European laws that affect migrant rights and health in Italy and the increasing presence of immigrant families (not just male workers) from North Africa, the Middle East, and elsewhere, taking root in Italian soil. Issues such as the health statuses of Arab Muslim immigrants upon arrival and then after some time in Italy, the factors that influence changes in the health statuses of these immigrants, the way in which these changes are disparities and the determinants that cause them, the way immigrants try and often fail to properly and successfully access health care services in Italy, and the problems that preclude this access were all examined.

Summary of Findings

The most common diseases immigrants deal with are respiratory, digestive, and orthopedics (musculoskeletal system) in nature and are related to the following summary picture

of immigrant health challenges in Italy. The stress of finding housing and housing situations themselves, particularly overcrowding and homelessness, cause health problems for immigrants like the spread of TB and STDs and problems related to sanitation like digestive and skin disorders. The work immigrants perform offers them poor legal protection and results in many accidents and exposure to health hazardous materials. Women immigrants in Italy face many challenges and poor health outcomes that relate to their reproductive health and that violence against women also presents itself in an array of health problems for immigrant women.

For the most part, immigrants are at greater risk of dealing with all of these health problems or share a relatively large burden of the problem within Italy. This brought into question whether or not the healthy migrant phenomenon really exists in Italy as it does in other host countries. It was concluded that without further studies on the long-term health statuses of immigrants and on their burden of non-communicable, chronic diseases in Italy, such an analysis was hard to make, but given the information presented, the phenomenon seems to not have taken hold in Italy given that immigrants experience health problems so soon after their arrival. Italy should remain aware of the healthy migrant literature and experiences of other more experienced host countries. Italy should be ready should this process also be shown to unfold within its immigrant population. Being a relatively new country of immigration, it can learn from other countries' experiences so as to formulate preventative actions against the possibly negative aspects of acculturation on immigrants' health. Scholars in the field of migrant health in Italy should study the lifestyle differences between Italians and the many diverse immigrant populations within its borders to identify possible acculturation issues that might in the future be shown to have an effect on the health of immigrants.

It also was explained how factors like gender, class, religion, and ethnicity of Arab Muslim immigrants intersect to make the health problems immigrants face in Italy manifest as disparities relative to the general Italian population. Given that, within the Italian health care system, immigrants staying in Italy for longer than three months and seasonal workers have the right to enroll in the health system and obtain services comparable or equal (depending on the immigrant's status) to those Italians receive, in theory, immigrants should be able to access Italian health structures and fix their health problems and not experience such disparities.

Yet, due to several problems such as lack of information, non-widespread use of cultural mediators and cultural competency training, management issues, and logistical issues many immigrants do not access the Italian health care system, or when they do, they often receive incorrect diagnoses, fail to enroll for the next time in the health system, and often do not or cannot further access the system to complete their therapies and completely fix or ameliorate their health problems. Thus, it would seem that while on paper the system is legally set-up appropriately to address the health needs of immigrants, in practice the processes for integrating immigrants into the system is actually inadequate.

The various European conventions and documents mentioned previously concerning migrants' rights to health services are, as pointed out, integrated into Italian law and practice, at least in theory. The 1998 Single Act in Italy sanctioned the inclusion of immigrants, even those irregularly and clandestinely present, to the same health rights and obligations as Italians. Further Italian programs and plans put out by the MOH have mentioned the need for the promotion and equality of health care for migrants and have highlighted the importance of targeting women and children immigrants in interventions. Article 2 of the 2006 Commission specifically mentions "promoting the access and utility of health services for immigrants present in Italy."

Given the broad language of these conventions and documents, even the latest 2006 Decree, the access situation in Italy reflects what is laid out in the Italian and European laws fairly accurately. While the Italian health care system has provided for access of all immigrants to services, and while it has implemented several instruments like intercultural training and cultural mediators, it does not seem yet to have implemented – in practice, more focused efforts on increasing this access to include most immigrants.

How to Reduce Disparities and Improve Access

To reduce the disparities Arab Muslim immigrant families face in Italy requires looking at the determinants of the health status disparities discussed in this thesis: gender, class, religion, and ethnicity. What Leith Mullings and Amy J. Schulz advocate throughout their book Gender, Race, Class & Health on their studies of similar factors intersecting to cause disparities is improved cultural competency training of all levels of health care workers, community empowerment, and additional research on the problems of particular ethno-religious or racial communities and their health outcomes and perceived health care and community needs.

Following this paradigm, to reduce disparities in health outcomes among the immigrant communities in Italy, particularly the Arab Muslim communities, Italy and her regions should continue to fund their programs that train cultural mediators. Cultural mediators not only carry out the function of translation, and thus, provide basic understanding in health care setting interactions, but they also are typically trained in cultural competency and are supposed to “translate,” or explain to both patient and to doctors the rationale behind everything said in health care encounters. This makes immigrants understand the Italian health care system, and thus,

allows them to put more trust in it, making it more likely that they will find it useful enrolling in and returning to the SSN for future problems.

Secondly, as has been already instituted in one ASL in Rome, part of any funding directed at immigrants within the Ministry of Health or National Health Care System should be used to establish more offices, personnel, or at least one position in each ASL on cultural competency. In Rome, this office has carried out invaluable tasks like translating materials on basic and essential information, for example clinic hours and raising awareness about common health problems, into various languages common among the city's immigrant community. If one such office or position existed at every ASL, this would help widen the presence of cultural competency in the Italian health care system and subsequently make addressing the frequent but treatable health problems immigrants experience hopefully more approachable for immigrants. These offices must also recognize the importance the factors of gender, class, religion, and ethnicity have in both the immigrants' and health personnel's perception of health problems and lifestyles.

In terms of community empowerment, immigrant cultural mediators (who are very common as these individuals more often than Italians have both Italian and other language skills) should be encouraged to speak to nearby immigrant communities about their legal rights as immigrants, rights pertaining to their living, working, and health care situations. This could be done in concert with local political authorities and NGOs to help reach all those immigrants who do not access the health structures and even those who do, but still lack information on these rights. While knowledge may not be able to overcome exploitation, especially for irregular immigrants, in the sense that immigrants still might fear facing their landlords or employers despite having knowledge about their rights, this is the first step in mobilizing action to

strengthen these rights for immigrants. Strengthening immigrant rights will then hopefully and eventually better their housing and working situations, which will in turn counter many of the health problems immigrants in Italy are now facing. Such work could be promoted in concert with the previously mentioned European Platform for Migration Workers' rights, which seeks to increase advocacy on the behalf of immigrant rights.

Additionally, more research needs to continue on the immigrant populations of Italy. The work of Dr. Geraci and many others already focuses on immigrant health in Italy, and organizations like Doctors Without Borders and Amnesty International publish amazingly thorough qualitative and quantitative studies on the plight of immigrants. All of the various materials on immigrant health in Italy address the issues both from the point of view of health professionals and from the concerns of immigrants themselves. Nonetheless, as I have pointed out before, more work needs to be done on the long-term health status of immigrants, as Italy becomes an even more established country of immigration. More research also needs to be done on the local housing and work situations of immigrants to identify more specific and concrete solutions than those presented here. More research on individual immigrant communities would also be very useful to identify the full range of challenges and needs of Italy's very diverse immigrant population. All this work is being made possible through the increased training of cultural mediators and the very new and limited amount of university and graduate programs on migration now being initiated in Italy. Such programs should continue to be funded and recognized, as well as the researchers quoted throughout this thesis, to make this suggestion possible.

Lastly, Italy must also put increased effort into integrating these individuals into their health system in order to fully address the health needs of immigrants and to reduce the

disparities in their health outcomes. The major issue seems to be the lack of information immigrants have on the availability of access to the health system. This information needs to be widely spread among immigrants in Italy, in addition to information that dispels fears and misconceptions about immigrants accessing health services. Article 2 of the 2006 Decree also lists as a task of the commission “promoting campaigns of information and supervision of these goals.” Given the data presented, these campaigns should become a major focus of the commission in order to increase access for immigrants to the SSN and subsequently to reduce the burden of health problems immigrants are currently facing.

A two-pronged informational campaign, one part of the campaign targeting regular immigrants and the other targeting irregular immigrants would be an effective way of formulating outreach messages. Previously suggested was that current immigrant cultural mediators should help spread this information among their communities. State involvement, however, is also necessary within various Ministries to help make the message more widespread. Employers, all immigration offices, educational facilities, formal and informal immigrant community centers, and especially all hospitals and ASLs should integrate this informational campaign into their encounters with all immigrants in Italy. The MOH should provide such parties with simple, translated pamphlets on how regular and irregular immigrants can formally enroll in the health system. Political posters and advertisements are also commonplace in Italy along major and minor streets. Translated posters advertising the fact that accessing health services is very cheap and without consequence on one’s legal status could also be used. While this would involve some funding, it does not require training funded by the State, merely continued coordination and distribution of the informational materials. If advocates can arrange more funding and political will for the initiative, further direct outreach activities would also be

beneficial. In each district, that is in each ASL district, one or several employees, with the aid of immigrants in the community, could carry out a door-to-door canvassing campaign, passing out this information to everyone in the area. Given the studies that suggest that many immigrants get their information about health services in Italy from other co-nationals, Italy could take advantage of this observation and fund immigrant “social entrepreneurs” to spread the message among their communities.

Several possible problems or obstacles exist in implementing the above suggestions to reduce disparities among the health outcomes of immigrants in Italy. They include: funding, motivation to reach out to immigrants about their rights, and the fact that irregular immigrants still have little rights anyways. Given that the Italian MOH instituted a Commission on the health of immigrants this past December, there might at least be more impetus for funding such suggestions. The major obstacles exist with the motivation for outreach and protecting irregular immigrants. Immigrants, including cultural mediators, are already busy trying to make a living and are already helping their communities by acting as a liaison in a public structure; asking them to extend their efforts beyond the health clinics might be unrealistic. Furthermore, given the political attention surrounding irregular immigration in Italy, as in many countries, any efforts to strengthen their rights will likely be met with resistance. Despite these problems, the presented suggestions are not too grand and idealistic to not at least be implemented on a small scale in cities and towns with adequate health system human and financial resources.

Hopeful is the fact that within the 2006 Decree for the Commission on Immigrant health, several tasks of the Commission described in Article 2 do correspond to my suggestions. Article 2 identifies the following tasks of the commission that overlap with my suggestions: to “develop the utility of cultural mediators...,” to “promote projects of training for health social workers in

the fields of intercultural medicine, health education, and for various groups of immigrants,” and to “identify areas of research and specific elaboration for specialized institutes.”

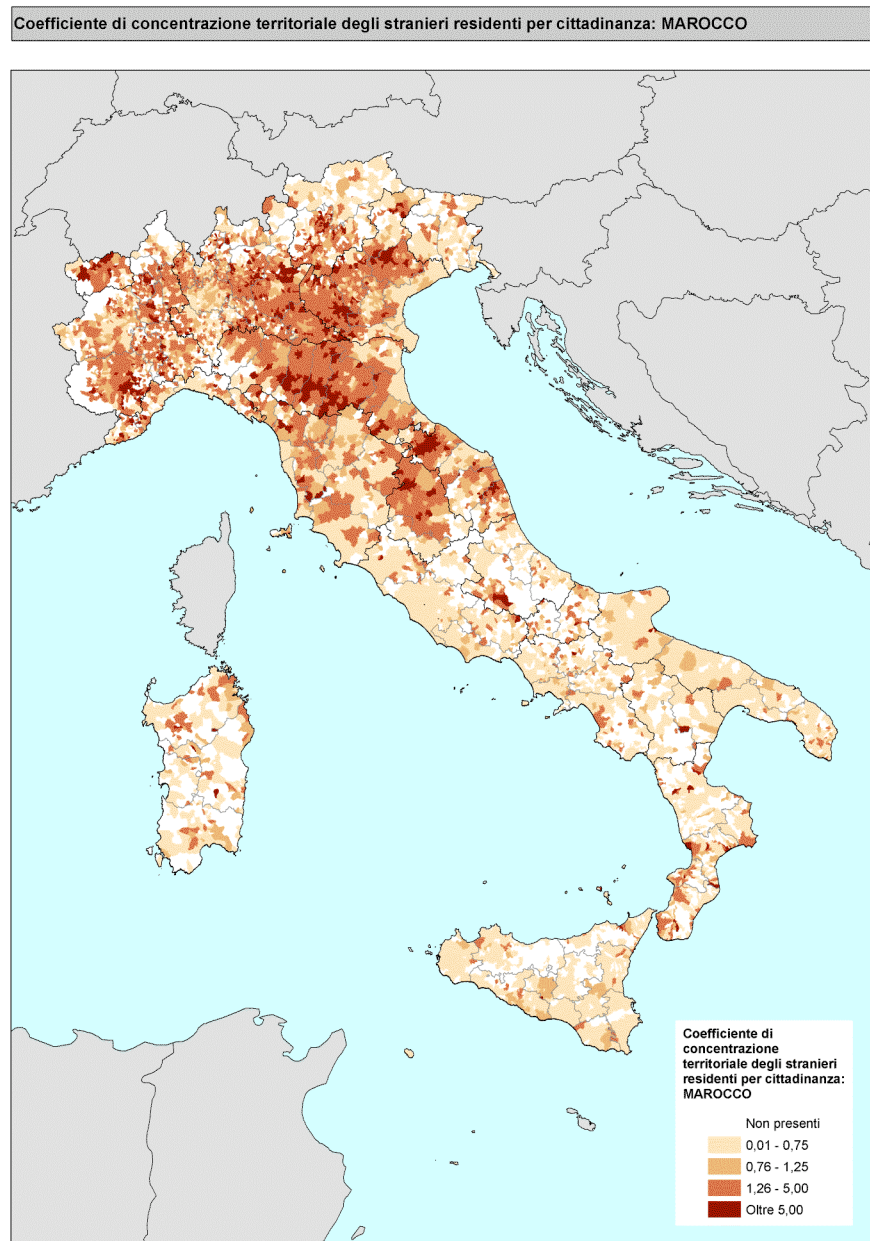
Final Comments

The health problems of immigrants in Italy can be effectively dealt with if comprehensive and fully supported programs are implemented now to address them. Given Italy’s relatively new status as a country of immigration, Italy can follow the example of more traditional host countries. Actions to ameliorate the health and health care access problems immigrants face in Italy that the government, Italian NGOs, and immigrant community groups can promote have been identified. Further research is needed to evaluate the needs of the Arab Muslim community and other communities from their own perspectives, always keeping in mind that within communities and immigrant families, each immigrant is an individual. Health needs should also be further analyzed on this level as well.

APPENDIX A

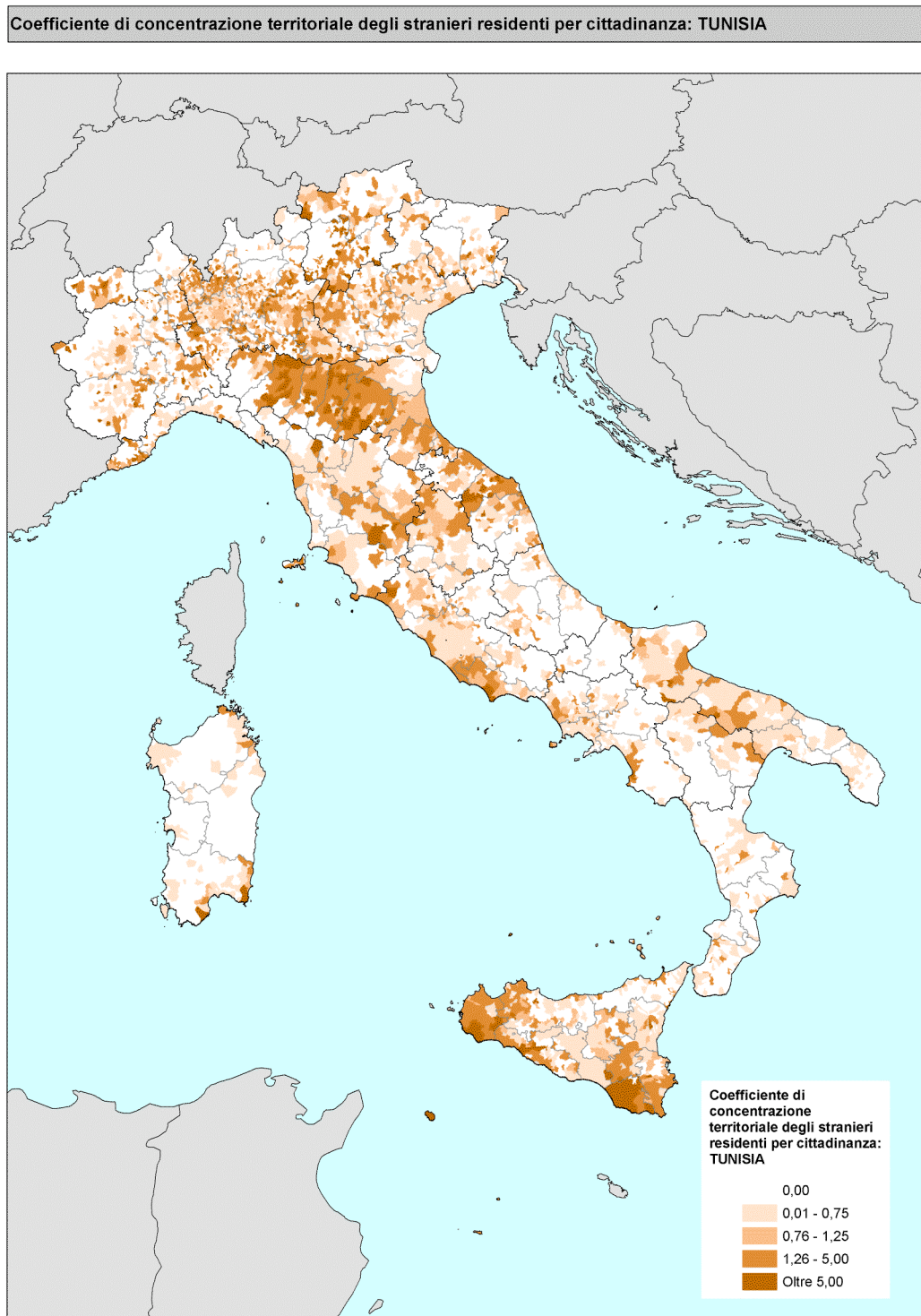
DISPERSION OF MOROCCAN AND TUNISIAN IMMIGRANTS IN ITALY

Figure 1. Dispersion of Moroccan Immigrants in Italy³⁹³



³⁹³ “Tutti i coefficienti di concentrazione territoriale degli stranieri,” 14° Censimento Generale della Popolazione e delle Abitazioni 2001, ISTAT, <http://dawinci.istat.it/daWinci/jsp/MD/misc.jsp?p=2&pd=20> (accessed December 2007).

Figure 2. Dispersion of Tunisia Immigrants in Italy³⁹⁴



³⁹⁴ Ibid.

APPENDIX B

MACRO THEORIES OF MIGRATION, CONTINUED

The neoclassical economics theory, the dual labor market theory, and the world systems theory all explain migration in more macro terms. The neoclassical economics theory says that international migration is caused by geographic differences in the supply and demand of labor. The theory holds that the elimination of wage differentials will halt migration, that other markets besides the labor market do not affect international migration, and therefore, governments should manage migration through labor policy in both host and origin countries.³⁹⁵

The dual labor market theory says that migration is caused by the inherent and permanent labor demands of modern industrialized societies. This “push factor” results from “structural inflation,” explained as the inability of employers to simply find workers willing to do unskilled work by simply raising wages because this would require a raising of wages throughout the job hierarchy. Immigrants take these jobs because they do not view themselves as part of the receiving society and because their home communities value overseas labor and remittances. The need for labor, according to the dual market theory, also results from economic dualism, or the presence of bifurcated labor markets in industrial economies and the changing demography of labor supply in developed countries in that women and teenagers are no longer willing to put up with poor work conditions and low wages, thus opening a demand in labor willing to be filled by immigrants.³⁹⁶

Last of the macro theories, the world systems theory posits that migration results from the “penetration of capitalist economic relations into peripheral, non-capitalist societies.” This

³⁹⁵ Massey, Arango, Hugo, Kouaouci, Pellegrino, and Taylor, “Theories of International Migration, 433-434.

³⁹⁶ Ibid., 440-444.

penetration involves land consolidation, mechanization, the introduction of cash crops, the removal of raw materials that puts former peasants in paid positions, the feminization of labor for factory work, factory made products that compete in local markets, improved and therefore cheaper transportation and communication links, increased ideological links through administration and consumption changes, and bifurcated labor markets in “global cities,” all of which displace traditional forms of labor and/or change the social fabric of communities and thus instigate migration.³⁹⁷

PERSISTENCE THEORIES OF MIGRATION, CONTINUED

The institutional theory describes the development of (underground market) entrepreneurs and institutions to help hopeful migrants enter a destination country despite the limited number of entry visas offered by these countries and the subsequent development of voluntary organizations in the sending countries to protect the rights and treatment of both legal and undocumented migrants. These institutions, whether dealing with legal or illegal advice, become part of immigrants’ trusted social capital network. This theory’s implications are difficult for governments: stricter policies or police work only feeds the black market and results in resistance from humanitarian groups.³⁹⁸

Myrdal’s theory of cumulative causation says that each act of migration affects the social context of subsequent acts of migration, usually in a pro-movement way. Later work has defined six socioeconomic factors that are influenced by a single act of migration: the distribution of income, the distribution of land, the organization of agriculture, culture (tastes of social

³⁹⁷ Ibid., 444-448.

³⁹⁸ Ibid., 450-451.

mobility), the regional distribution of capital, and the social meaning of work. The implications of this theory are that social, economic, and cultural changes due to migration have caused an internal momentum for migration, not easily stopped by government regulation and that once “immigrant jobs” are so defined, host governments will not be able to recruit native workers back into these positions.³⁹⁹

Lastly, migration systems theory states that migration systems arise from the “exchange of goods, capital and people [between] a core receiving region... and a set of specific sending countries linked to it by unusually large flows of immigrants.” The implications of this theory include the fact that geographic proximity is not necessary to belong to a system, nations can belong to more than one system, and as politics and economics evolve so will the systems.⁴⁰⁰

³⁹⁹ Ibid., 451-454.

⁴⁰⁰ Ibid., 454.

APPENDIX C

INTERNATIONAL TOURISM AND THE MIGRATION OF HEALTH PROFESSIONALS

The issue of tourism mostly involves migration in the form of tourism, not in the form of voluntary economic migration or forced migration. According to the World Tourism Organization, tourism accounts for 30 percent of all services work and a greater number of people are now traveling to tropical zones all over the world and coming back with diseases. Diseases like diarrhoea and malaria add costs to health care systems. Hepatitis A and other STI transmissions are also common problems.⁴⁰¹

A larger phenomenon, the migration of health professionals, is much more extensively covered in the literature. The migration of health professionals from developing countries to more developed countries is an old phenomenon, however, today the pace has increased and patterns have become more structuralized. This has led to human resource crisis in many of the sending countries, for example, throughout sub-Saharan Africa. Poor planning on the part of the developing countries, increased health care demand in these countries, the production of well-trained but not “meaningfully” recruited health professionals in these countries, better wages in developed countries, the recruitment by developed countries of professionals from these countries, and increasingly inter-changeable diplomas are all factors contributing to this phenomenon. The so-called “brain drain” of health professionals causes multiple problems for developing countries. Many of these countries are facing major health crises, like HIV/AIDS,

⁴⁰¹ Carballo and Mboup, “International migration and health,” 10-12.

without the personnel to complete WHO programs, in addition to losing major investments in the training of these migrating professionals.⁴⁰²

⁴⁰² Ibid., 10-12.

APPENDIX D

2006 DECREE FOR COMMISSION ON “HEALTH AND IMMIGRATION”

Article 2 of the 2006 decree identifies the objectives of the commission as: (i) promoting interventions of prevention for the foreign population, (ii) promoting the access and utility of health services for immigrants present in Italy in a manner that provides paths of assistance, with particular attention to females, minors, and workers, (iii) the development of competent professionals for foreign immigrants in the health field, and (iv) to confront the health prejudice against foreigners and to sustain international cooperation.⁴⁰³

Article 2 also identifies the tasks of the commission. They are: (i) monitoring, analyzing, and developing the quality and equality of organizational processes that safeguard immigrant health (regular and irregular immigrants) in regards to their social fragility, of diverse institutional levels, of the state and local entities and of the organizations of national health service, (ii) propose solutions for problems eventually detected with interventions of the organizational, operational, administrative, and legislative types, (iii) propose interventions aimed at social-health integration, (iv) identify areas of research and specific elaboration for specialized institutes, (v) develop the utility of cultural mediators in order to facilitate the relationships between single administrators and the foreigners belonging to diverse ethnic, national, linguistic, and religious groups, (vi) promote campaigns of information and supervision of these goals, (vii) promote projects of training for health social workers in the fields of intercultural medicine, health education, and for various groups of immigrants, and (viii)

⁴⁰³ Ibid.

identification, in Italy and abroad, and diffusion of experiences of excellence through seminars, conventions, and publications.⁴⁰⁴

Article 2 identifies the priorities of the commission as: maternal-child health, health in places of work, mental health and physical discomfort, diseases related to prostitution, the homeless, FGM, and the education and insertion of foreign doctors.⁴⁰⁵ Article 3 talks about the composition of the commission; it includes various members of the Ministry of Health, NGO members representing both Italians and various immigrant associations, and immigrant legal and other specialists.⁴⁰⁶ Article 5 discusses the financing of the Commission. It budgeted €3,000 for 2006 and €10,000 for 2007 and 2008 each.⁴⁰⁷

⁴⁰⁴ Ibid.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid.

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