Presidenza del Consiglio dei Ministri

MIGRATION AND HEALTH

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Presentation

The opinion, as the title suggests, focuses on the relationship between migration and health. Drawing on a series of substantiated data, from epidemiological data to data regarding the number of landings on the Italian coast, the opinion calls attention, first of all, to the emergency which is putting under heavy strain the sustainability, not only in financial terms, of the various measures that have been commendably implemented by Italy in recent years to manage the migratory flows, from the rescue phases at sea and provision of initial health-care aid, to widespread reception throughout the various municipalities of the country. The phenomenon, however, is not only considered here in this perspective, as an emergency: there is in fact also migration that is now rooted and has become permanent, the proof being that there are over 5 million foreigners resident in Italy, of which, in 2015 alone 178,000 became Italian citizens.

The methodological choice to give particular significance, especially in paragraph 1, to statistical data and studies, deferring more specific bioethical considerations to the last paragraphs, is not random and stems from the belief that such a complicated and sensitive topic on a social, political and cultural level should be dealt with having, first of all, a solid basis of empirical knowledge. Such an approach also seeks to dispel some common myths (such as the one attributing to the presence of migrants an allegedly uncontrolled spread of infectious diseases) and unjustified alarmism, as a result of misinformation if not outright prejudice.

The focus of the opinion is the protection of “health” itself, a principle enshrined as a social right within Italian constitutional identity, that is, for the good of the individual and the community to be ensured in its essential and non-discriminatory content to everyone on national territory regardless of their having reached the country legally, be they illegal migrants, refugees, asylum seekers or so-called economic migrants. The opinion goes on to develop some basic considerations, briefly summarized as follows:

a) emphasis is placed on a fact and aspect that is so important and yet so often ignored regarding the psychological consequences of the events which bring migrants to Italy; they are often forced to endure abuses and other forms of inhuman and degrading treatment. In other words, the problem occurs frequently in terms of mental or psychological health, which is also included in the concept of health, but which is usually not the subject of due attention. In this regard, special attention is addressed to people, such as women and children, who are particularly vulnerable (paragraph 3);

b) as regards physical health, although the epidemiological data are not particularly worrying, it should be remembered that the hospitality offered to

migrants in terms of protecting their health can not be dissociated from the affirmation of the principle of solidarity which also operates inversely, that is, as the source of duties for migrants themselves to participate in essential forms of collective health protection, undergoing diagnostic investigations and prophylaxis that are indispensible in order to control and extinguish any epidemic outbreaks.

c) lastly, consideration was given to the care relationship and the need for this to develop from an intercultural perspective (paragraph 4), without, thereby, renouncing an understanding of health that is compatible with the public service and its broadest possible safeguard.

The various final recommendations:

- recall the responsibility of the international community on the phenomenon of migration and the causes at its origin, while at the same time calling on it to share the extraordinary commitment, exemplified by Italy in recent years, to saving innumerable lives and guaranteeing respect for the right to health as a fundamental and universal human right;
- highlight the criticisms raised by a very heterogeneous application of the State-Regions Agreement of 20.12.2012 (paragraph 2), proposing, therefore, to reinforce the role of coordination and direction by the Ministry of Health;
- propose to rapidly develop adequate accounting and reporting of the expenditure actually incurred by the NHS for the health of the irregular migrant population;
- propose to establish a dividend on the resources of the most industrialized countries to be paid into an institutional fund for the poorest countries;
- call for the introduction of the crime of torture into our legislation and that it should be suitably punished in order to counteract the dramatic experiences to which migrants and in particular women are subjected - arbitrary detention, inhuman treatment, repeated sexual assault, prostitution under blackmail - experiences that can also take place in Italian territory (for example, when perpetrated by the skippers in Italian territorial waters);
- suggest setting up special forms of reception for women who have repeatedly suffered violence during the course of their journey to Italy;
- advise increasing the commitment to health education, including strengthening the functions of certain services, such as family counselling and mental health services;
- recommend a progressive increase in the intercultural skills of those working in the NHS and appropriate enhancement, within the university training courses for future physicians and health professionals, of *Medical Humanities*, and studies and research regarding the therapeutic relationship within an intercultural perspective;

- invite the relevant Professional Orders to update their codes of ethics, with explicit reference to the duty of professionals to take into account the different cultural identities of patients.

The draft opinion was drafted by the working group coordinated by Prof. Antonio Da Re and composed by Prof. Carlo Casonato, Andrea Nicolussi, Monica Toraldo di Francia and, among the advisory members, by Dr Maurizio Benato and Carlo Petrini.

Useful integrations for the drafting of the document were received from Profs.: Salvatore Amato, Luisella Battaglia, Carlo Caltagirone, Stefano Canestrari, Lorenzo d'Avack, Mario de Curtis, Marianna Gensabella, Assuntina Morresi, Laura Palazzani, Lucetta Scaraffia, Massimo Sargiacomo, Grazia Zuffa and, the advisory member, Anna Teresa Palamara.

The final draft, which took into consideration the many observations made in plenary discussions, was prepared by Prof. Antonio Da Re, with the help of Professor Monica Toraldo di Francia.

The text has also benefitted from the information that emerged during the hearings, which took place June 23, 2016, with Drs. Antonio and Concetta Mirisola and Antonio Fortino, respectively CEO and Medical Director of the National Institute for the promotion of the health of migrant populations and controlling poverty related diseases (Rome), and on December 15, 2016, by Prof. Maurizio Marceca, the Department of Public Health and Infectious Diseases, La Sapienza University of Rome, and the president of the Italian Society for Migration Medicine.

Finally, our thanks go to Dr. Salvatore Geraci, Head of the Caritas Healthcare Area of Rome, and Dr. Teresa Dalla Zuanna of the School of Specialization in Hygiene and Preventive Medicine, University of Padua, for the advice provided to those coordinating the work on drafting, on some specific issues addressed in the opinion.

The opinion was unanimously approved by those present in the plenary session of the 23 June 2017 by Profs.: Salvatore Amato, Luisella Battaglia, Stefano Canestrari, Carlo Casonato, Francesco D'Agostino, Bruno Dallapiccola, Antonio Da Re, Lorenzo d'Avack, Mario de Curtis, Carlo Flamigni, Silvio Garattini, Marianna Gensabella, Assuntina Morresi, Andrea Nicolussi, Laura Palazzani, Massimo Sargiacomo, Lucetta Scaraffia, Monica Toraldo di Francia, Grazia Zuffa.

Favourable votes were also expressed by consultative members, Dr Maurizio Benato and Carlo Petrini.

Prof. Carlo Caltagirone and consultative member Prof.ssa Anna Teresa Palamara both absent from the plenary session, subsequently approved the document.

Introduction: some terminological clarifications and the methodology used

The almost daily images broadcast by the mass media constantly remind us how the phenomenon of migration has taken on huge dimensions in recent years. It is estimated that in 2015 there were around 244 million migrants in the world, of which 21.3 million were refugees and 3.2 million asylum seekers; a total of 65.3 million were "forced migrants" (50% women), including internally displaced persons in their own countries, due to growing global social, economic and political instability. The causes driving people (and indeed, very often, forcing) millions of human beings to move are many and varied. Some of these are dramatic such as the outbreak of wars, terrorist violence, the recrudescence of clashes and local conflicts, the spread of famines, as a result of devastating environmental crises, the steady worsening of the economic and social conditions in the countries of origin, the violation of the most basic human rights; other causes, certainly less dramatic, have, however, to do with the desire to improve existential conditions that are often of mere subsistence, therefore seeking elsewhere a more dignified life for themselves and their children.

The decision to leave one's country, burdened with the uncertainties, doubts and suffering that this entails, is the prelude to an often long and terrible journey, which can even last years. Migrants eager to reach the Italian shores, before their boarding unsafe boats, in crammed conditions, captained by unscrupulous smugglers, have endured days and days of land transfer, long waiting periods, sometimes in dilapidated and overcrowded collection facilities, in which they are often subjected to violence, blackmail and harassment of all kinds. Not all of them eventually manage to get to our shores or to be rescued at sea: the Mediterranean has registered the highest migrant death toll in recent years. According to data provided by the International Organization for Migration, the United Nations Agency for Refugees (UNHCR) and the European Border and Coast Guard Agency (FRONTEX), 3279 migrants died in 2014 in the Mediterranean, in an attempt to reach Europe, this already huge number then grew to 3771 in 2015 and rose to 5096 in 2016. In 2015, according to Unicef 700 children lost their lives at sea. The number of people who disembarked in Italy during 2014 was 170,100; while in 2015, the number decreased (153,842), it increased in 2016 (181,436)[1]. This increase of 18%,

[1] For the data given here, one can refer to the following websites:
- International Organization for Migration, http://www.italy.iom.int/it;
- UNHCR, http://data2.unhcr.org/en/situations/mediterranean;
- FRONTEX https://europa.eu/european-union/about-eu/agencies/frontex_it.
See also the Dossier Statistico Immigrazione 2016, published by the IDOS Research and Research Centre, in partnership with the magazine Confronti, Rome 2016. *The Dossier* also represents the source of some of the data that will be listed in paragraph 1. However, it should be stressed that the data on the migration phenomenon are often fragmented and incomplete;

recorded in 2016 compared with the previous year, experienced a further surge in 2017: considering that in the first six months of the year, the number of people who disembarked was 80,360, while in the same period of 2016 it was 70,222.[2]

When examining the data relating to Italy one must take into account the fact that currently in European countries only regular migrants and refugees are accepted, therefore only a minority of all those who disembark in Italy. This leads to a chronic emergency situation which is putting under heavy strain the sustainability, not only in financial terms, of the various measures that have been commendably implemented by Italy in recent years to manage the migratory flows, from the rescue phases at sea and provision of initial health-care aid, to widespread reception throughout the various municipalities of the country. The seriousness of this situation makes it imperative to place the problem on the political agenda for its not only immediate but also long-term management; and this management must necessarily be included in a policy agreed at European and international level.

These data, in their stark reality, do not tell the whole story about the phenomenon of migration and the extent to which it has transformed Italian society in recent years. There is in fact also migration that is now rooted and has become permanent, the proof being that there are over 5 million foreigners resident in Italy. Not only that: in 2015 alone 178,000 became Italian citizens, thus increasing the number of those (about 1,150,000) who, coming from a foreign country, have in time acquired Italian citizenship; at the same time, there may also be the return movement of non-EU citizens who leave our country, for example due to the non-renewal of the residence permit. The recent emergency drives us to view the migratory phenomenon from a particular perspective, which is precisely that of the urgency with which we must cope with the rescue of incoming migrants, their identification with screening of the applications of asylum seekers and refugees, to the subsequent relocation in facilities throughout the territory, to the promotion of reception and integration or in cases to initiate deportation procedures. However, it should not be forgotten that the migration phenomenon is far more extensive and complex and has long been rooted in the daily life of our country: just think of economic and trade activities, services for people, especially older people, the school system and education, all areas in which the presence of foreign citizens is very significant, and not just from a purely numerical point of view.

A terminological clarification is therefore indispensable: in fact, in public discourse the terms "migrant", "displaced person", refugee", "asylum seeker" are sometimes used inappropriately. At international level, there is no

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some discrepancy and oscillation, among the various sources, including institutional ones, must be taken into account.

[2] Source: Ministry of the Interior; vd.r www.libertaciviliimmigrazione.dlci.interno.gov.it/it/documentazione/statistica/cruscotto-statistico-giornaliero.

unanimously recognized definition of "migrant". In general, the term applies to people who freely decide to move for reasons of personal convenience, without the intervention of external factors.

According to the Treccani dictionary, the term "displaced person" applies to any "person forced to abandon his land, his country, his homeland as a result of war, political or racial persecution, or disasters such as volcanic eruptions, earthquakes, floods, etc. (in these latter cases the term "displaced" is more common)".

In international law, "refugee" is the legally recognized status of a person who has been forced to leave his country and has found refuge in a third country. The Geneva Convention[3] defines "refugee" as *"*a person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events is unable or, owing to such fear, is unwilling to return to it'*.*

"Asylum seekers" are all those who have left their country of origin and have applied for asylum in a third country, but are still awaiting a decision by the competent authorities regarding the recognition of their legal status as refugees. Therefore, the category of "asylum seeker" includes people in heterogeneous situations, and the asylum application may have different outcomes[4].

Beyond these clarifications and the general indication to avoid as far as possible the adoption of an emergency perspective in the analysis of the migratory phenomenon, the objective of this opinion of the National Bioethics Committee is to draw attention to the protection of "health", principle carved into the Italian constitutional identity as a social right, that is to say as a good of the person and of the community, to guarantee, in its essential content and without discrimination, to whoever is on the national territory, regardless of the fact that people have come to our country in a regular way or not, whether they are irregular migrants, refugees, asylum seekers or so-called economic migrants. It is obvious that the purpose of safeguarding health is reflected in a more or less direct way with the organization and management of migration policies, from the possibility of making agreements with the African countries and the Mediterranean basin to try to govern incoming flows and try to hit the human traffickers, to the responsibilities of the European Commission in the allocation of quotas of asylum seekers in different European countries and not only in

[3] United Nations Organization, Refugee Status Convention, Geneva 28 July 1951.

[4] Regarding the legal obligations of reception, according to international, European and national legislation, see *Rapporto sull'accoglienza di migranti e rifugiati in Italia. Aspetti, procedure, problemi*, Ministry of the Interior, 10.15.2015, pp. 11 ss., In www.libertaciviliimmigrazione.interno.it/dipim/export/sites/default/it/assets/pubblicazioni/Rapporto_accoglienza_ps.pdf. In particular, Table 3 (page 12) distinguishes the different types of residence permits (for political asylum, for subsidiary protection, for humanitarian protection) and the respective expected benefits.

those where the arrival by sea or by land occurs, to the subsequent measures on the spot concerning the identification of migrants or, on a different note, the application for a residence permit. Nevertheless, the focus of the opinion is not on these or other important aspects of migration policies; rather, it addresses the issue of health, examined according to the approach of everyday bioethics rather than that of frontier bioethics.[5]

The argumentative style adopted in the drafting of these pages is in some ways atypical, especially when compared with that of other NBC opinions. Much importance is attributed to a detailed analysis of the various health problems related to the migratory phenomenon: in doing so, it was decided to let the statistical data and studies "speak" for themselves, especially in the first part, deferring more properly bioethical evaluations to paragraphs 3-4. This is a precise methodological choice, in the conviction that such a complicated and sensitive issue, on the social, political and cultural level, must be faced first of all with a solid basis of empirical knowledge. It is all too easy to foresee that such information, although updated at the time of publication of the opinion, will soon be outdated and in need of being reviewed; nevertheless, the methodology proposed here does not lose value, because it allows to adequately instruct the topic, throwing light on the socio-economic, demographic and environmental determinants, which have a considerable impact on the relationship between health and migration; moreover, the anchoring to reality makes it possible to dispel some of the myths which abound (such as the one attributing to the presence of migrants the cause of an alleged uncontrolled spread of infectious diseases), as a result of superficial knowledge if not of outright prejudices.

We must therefore approach the topic in question from a descriptive standpoint, although this is not sufficient. Migration, in the forms taken in recent years, is an overwhelming and disturbing phenomenon, which marks an epochal turning point in the history of peoples, groups and individuals, and is accompanied by countless stories of suffering, injustice, violence, death, offense, humiliation. We cannot remain indifferent in the face of these real stories. The references to human rights and to those fundamental ethical principles that characterise our Constitution are put here to a demanding test. The NBC believes that this ethical and cultural heritage should not be considered outdated, rather it must be even more valued and translated into

[5] The distinction between everyday bioethics and frontier bioethics is given by Giovanni Berlinguer (everyday Bioethics, Giunti, Firenze 2000), who was President of the National Bioethics Committee between 1998 and 2001. As mentioned in the opinion of the NBC *The living conditions of women in the third and fourth age: bioethical aspects of social health care,* July 16th 2010, "Frontier bioethics is concentrated ... on the most problematic and conflicting bioethical issues regarding personal and public choices concerning in particular the so-called border states (birth and death); the problematic nature of these issues often depends on their radically innovative character, the result of the continuous development of biomedical sciences and the applications of technology. On the other hand, everyday bioethics moves in a dimension closer to the common experience of people; more than the exceptionality of borderline cases, it considers - as it were - the normality of situations".

concrete and achievable forms. This is precisely what has already occurred in recent years, in which we have witnessed an extraordinary mobilization of Italy, not only institutionally, in order to cope with the migration emergency. This mobilization has represented one of the clearest ways of protecting life, with the rescue of hundreds of thousands of people at sea, the effective defence of human rights, and the concrete reception of migrants in various places within the country. It would be unfair not to highlight all this, even in the face of the critical issues and difficulties, which there have been; and it is indeed our duty to express a sense of gratitude to those who, in various ways, have devoted themselves in the various phases of rescue, first reception, and the subsequent insertion of migrants in peripheral facilities.

The opinion also takes into account significant experiences that have been developed in recent years in Italy, often supported by a rich and articulated normative production, attentive, in various ways, to the protection of health, and doing so in accordance with an intercultural approach. Going into more specific detail regarding the contents that will be investigated, the opinion analyzes some essential data, including epidemiological data (paragraph 1), also highlighting the critical issues raised by a very uneven application of the State - Regions Agreement of 20.12.2012 (paragraph 2). The fundamental problematic areas are reconstructed around the basic character of health as an asset of the individual and of the community, which the migratory phenomenon places in particular in its relational aspects, because, among other things, it is migration itself that connects people and different cultures, juxtaposing the western culture of health, more oriented towards the individual and his individual subjectivity, with a culture more focused on the community dimension.

The opinion then develops some basic considerations, which can be summarized as follows:

a) first of all emphasis is placed on a fact and aspect that is so important and yet so often ignored regarding the psychological consequences of the events which bring migrants to Italy; they are often victims of violence and other forms of mistreatment. The problem of health, in other words, frequently occurs with regard to newly arrived migrants on the national territory, during their first stay, under the profile of mental or psychological health, which is also included in the concept of health, but which is usually not the subject of attention. Special attention is addressed to people, such as women and children, who are in particularly vulnerable conditions (paragraph 3);

b) as regards physical health, although the epidemiological data are not particularly worrying, it should be remembered that the hospitality offered to migrants in terms of protecting their health can not be dissociated from the affirmation of the principle of solidarity which also operates inversely, that is, as the source of duties for migrants themselves to participate in essential forms of collective health protection, undergoing diagnostic investigations and

prophylaxis that are indispensible in order to control and extinguish any epidemic outbreaks;

c) lastly, consideration was given to the care relationship and the need for this to develop from an intercultural perspective (paragraph 4), without, thereby, renouncing an understanding of health that is compatible with the public service and its broadest possible safeguard. The difficult balance is given by ensuring respectful attention to people and their cultural identities and also ensuring the conquest of civilization represented by the value of health protection, which our country, by virtue of the fact of being the host country, has the right and interest in ensuring.

The whole path develops within a specific bioethical perspective in which health is a basic good of the individual and therefore it can and must be protected and regards all those in our territory; the safeguarding and development of this good requires active intervention and a renewed assumption of responsibility, both by doctors and health personnel and society as a whole, avoiding all forms of discrimination, based on gender, culture, political ideology or religion, and therefore reiterating in its renewed topicality the universalistic and humanistic value of the medical ethics tradition.

1. The phenomenon of migration in Italy and general health conditions

1.1 General socio-democratic data

According to the latest data compiled and published by ISTAT, the foreigners residing in Italy as of 1 January 2017 totalled 5 million 29 thousand. They made up 8.3% of the total number of residents in Italy. At the same date, there were 2,425,000 households with at least one foreign member in Italy. Three quarters of these are composed exclusively of foreigners. In 2016 the number of babies born to foreign citizens was 92 thousand (2.2% fewer than the previous year). Of these, 61 thousand were births to foreign partners; 31 thousand were births to Italian partners. In 2016, therefore, babies born to parents who are both foreigners (61,000) were about a seventh of all births registered in the year and one in five babies had a foreign mother. According to data for 2015, the number of non-EU foreigners regularly present in Italy was almost 4 million, with an increase of 55 thousand units compared to 2014. The flow of new entries of non-EU citizens to our country has been decreasing since 2014. During 2015, 238,936 permits were issued, with a 3.8% decrease compared to the previous year.

The unemployment rate of foreigners (around 17%) is decreasing, but continues to be higher than that of Italians (around 12%).

The level of education of foreigners is slightly lower than that of the Italians: among foreigners aged between 15 and 65 years, almost half have at most

middle school, 40.1% have a high school diploma and 10. 1% a degree (compared with 15.5% among Italians). 72.7% of foreign minors were born in Italy.

As far as geographical origin is concerned, sufficiently precise data are available on residents and applicants for foreign stay (for various duration periods) while it is more difficult to monitor passing migrants and asylum seekers. More precisely, those who in 2015 had applied for a residence permit came mainly from West Africa (21.8%), South Asia (19.6%), Europe (19.2%). The top ten foreign communities present in Italy are as follows: Romania 22.9%, 9.3% Albania, Morocco 8.7%, China 5.4%, Ukraine 4.6%, Philippines 3.3%, India 3. 0%, Moldova 2.8%, Bangladesh 2.4%, Egypt 2.2%.

According to data from the Ministry of the Interior[6], in 2016 those arriving in Italy were mostly people coming from Africa, in particular from Nigeria (21%), Eritrea (11%), Guinea (7%), Ivory Coast (7%), Gambia (7%), Senegal (6%), Mali (6%), Sudan (5%), Somalia (4%) as well as Bangladesh (4%). In the first six months of 2017, the nationalities declared at the time of disembarkation were approximately the same in percentage terms, with some variations (for example, the number of migrants from Bangladesh is on the rise). In Europe, the most represented countries in 2016 were Syria (23%), Afghanistan (12%) and Nigeria (10%). However, the number of migrants from Syria and Afghanistan declined sharply over the course of the year, as previously they generally entered Europe via Greece, whereas it is now much more difficult to do so.

It may also be interesting to consider religious affiliation, at least taking into account estimates for residents and applicants for residence permits; the distribution is as follows: Christians 53.8%, Muslims 32.2%, afferent to oriental religious traditions 6.7%, others 1.7 (and 4.4% includes those who call themselves atheists/agnostics).

Finally some economic data. Foreign taxpayers, regardless of their origin and the manner in which they arrived in our country, total about 3.5 million, 8.7% of total taxpayers. In 2015 (2014 tax year), they declared revenues of € 46.6 billion, paying € 6.8 billion in IRPEF tax (4.5% out of a total of € 151.2 billion). It should also be noted that pension contributions paid in 2014 amount to 10.9 billion (5% of the total)[7]. Despite a widespread negative perception by the public, these and other data regarding the public revenues produced by foreigners, such as consumption tax, fuel tax, taxes on residence permits and citizenship, in addition to the aforementioned IRPEF and social security contributions, it emerges that the weight on public expenditure of regular

[6] Consultable at www.libertaciviliimmigrazione.dlci.interno.gov.it/it/documentazione/statistica/cruscotto-statistico-giornaliero

[7] R. GAROFOLI, L'impatto fiscale dell'immigrazione in Italia, in *Rapporto annuale sull'economia dell'immigrazione 2016,* by the Fondazione Leone Moressa, Il Mulino, Bologna 2016, pp. 209 ss.

immigration is not particularly high, with a final credit balance that stands between 1.8 and 2.2 billion, depending on the calculation method used - marginal or standard cost;[8] there is less impact on public pension and health care by foreigners compared to that of Italians, and this is explained both due to demographic composition (it is a population that on average is younger and in working age), and on equal terms of age for a lower consumption of drugs and a lower access to specialist medical services.

Obviously there are the enormous costs, dictated above all in the last few years by the emergency landings and rescue expenses and for the preparation of the various reception facilities. In this regard, in the 2017 *Economics and Finance Document* of the Ministry of Economy and Finance[9], it is very clearly explained that "the marked increase in flows and presences at the end of 2016 is reflected in the data available today, which update and increase the estimates presented in the Draft Budgetary Plan. According to the current data, relief operations, health care, housing and education for unaccompanied minors are, net of EU contributions, equal to 3.6 billion (0.22 percent of GDP) in 2016 and expected to amount to 4.2 billion (0.25 percent of GDP) in 2017, in a steady scenario. If the inflow of people were to continue to grow, spending could rise up to 4.6 billion in 2017 (0.27 percent of GDP)"[10]. Of course, only a fraction of this figure, presumably less than half of 13%, would be reserved for health care costs, compared to the amount for sea rescue (18.8%) and reception (68.2%).[11]

1.2 *Access to health services and the state of health*

From the ISTAT survey on "Condition and integration of foreign citizens", conducted in the years 2011 and 2012, it is estimated that 10.5% of the resident foreign population, aged between 18 and 64 years, carry out medical examinations in the absence of disorders and symptoms (on average in a month). The prevalence is slightly lower than the Italian population, which is 15%. The ratio is reversed if we consider emergency admissions to hospitals: people arriving from countries defined as "Strong Migratory Pressure" (PFPM)[12]

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[8] Cf. A. STUPPINI, *L'impatto economico e fiscale dell'immigrazione, in Dossier Statistico Immigrazione 2016* (IDOS), a cura della Fondazione Leone Moressa, Il Mulino, Bologna 2016, pp. 315-323; *Rapporto sull'accoglienza di migranti e rifugiati in Italia. Aspetti, procedure, problemi,* gruppo di studio coordinato da A. GOLINI, Ministero dell'Interno, 15.10.2015, pp. 49-55.

[9] Deliberato dal Consiglio dei Ministri l'11 Aprile 2017: www.dt.tesoro.it/modules/documenti_it/analisi_progammazione/documenti_programmatici/def_2017/Sez.1_-_Programma_di_Stabilita_2017.pdf; si veda la sezione III.2: "Emergenza migranti, sicurezza e salvaguardia del territorio - Costi eccezionali per il soccorso e l'accoglienza dei migranti", pp. 40-47.

[10] Ivi, p. 47.

[11] Ivi, p. 45, table III. 2., which shows that 13% would concern the item "Health and education".

[12] We define "A Strong Migratory pressure" countries of Central and Eastern Europe (including those outside the European Union) and Malta, the countries of Africa, Asia (excluding South Korea, Israel and Japan), Central and South America and Oceania (excluding Australia and

resort to these in a significantly more consistent way compared to the Italian population.

In 2013, there were about 543 thousand hospitalizations of foreign citizens, equal to 5.7% of total hospitalizations in Italy. The significant differences in hospitalization among the various Regions reflect the different distribution of foreign citizens within the territory. The use for hospitalization services by migrants, excluding admissions linked to pregnancy and childbirth and traumas, is lower compared to Italians.

The recourse to voluntary interruptions of pregnancy is still on a very large scale: 34% of women who resort to voluntary interruption of pregnancy in Italy are foreigners. The abortion rate of foreign women is 19 per 1000, which is three times higher than for Italian women (and four times higher for younger women), therefore making necessary the provision of proper information on how to avoid an unwanted pregnancy, consistent with one's religious and moral vision.

Data on the health of the irregular migrant population are fragmented due to elusive and dynamic nature of the phenomenon, and certainly deserve more attention and analysis from our governmental administrative accounting apparatus, to be able to record the amount of public resources absorbed, and request their reimbursement to the respective embassies present in Italy, or to the international authorities, currently this is not possible due to the complete absence of accurate accounting data measuring the phenomenon. On the other hand, data concerning the regular migrant population are more reliable[13].

Looking at most of the personal stories of migration, past and present, it can be generally asserted that, after the first phase of physical stress caused by the arduous travel conditions, the state of health of the immigrants on their arrival is substantially good, considering the absence of organic or infectious diseases. In this respect, there has been talk of the "healthy migrant effect"[14] that can find a plausible explanation in the fact that those who arrive have gone through a sort of selection process. Over time this positive effect tends to diminish and in the long run it can even vanish completely, giving life to what has been termed

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New Zealand). Consider then that the majority of hospital admissions (93.1%) of immigrants in Italy come from the so-called PFPM.

[13] T. SPADEA, T. DALLA ZUANNA, L. MONDO, R. RUSCIANI, *Le nuove migrazioni dai paesi poveri*, in G. COSTA, M. STROSCIA, N. ZENGARINI, M. DEMARIA, *40 anni di salute a Torino. Spunti per leggere i bisogni e i risultati delle politiche,* Inferenze, Milano 2017, pp. 270-274, in http://www.epiprev.it/materiali/2017/Torino_40_anni/40anni_singole.pdf.
More in general, rich in data and information are the proceedings of the various congresses of the Italian Society of Migration Medicine (SIMM), which since 1990 monitors the commitment, including clinical and study, of many groups, bodies and associations, engaged in Immigration field, regular and not (www.simmweb.it). See also the document *Immigration and Health: lines for targeted interventions on migrants arriving with the recent migratory flows,* of Section III of the Superior Council of Health, especially in paragraph 2 (The health profile of immigrants) and 2.1. (Epidemiological data).

[14] O. RAZUM et al., *The 'Healthy Migrant Effect' – Not Merely a Fallacy of Inaccurate Denominator Figures*, in "International Journal of Epidemiology", 2000, 29, pp. 191-192.

"exhausted migrant effect"[15]: a deficient or inadequate diet, the shelter in unhealthy and bad housing, the radical change in lifestyles, assumption of risky behaviour, being subjected to discrimination, racial or other, the difficulties of linguistic and cultural understanding contribute to a drastic deterioration of overall health conditions. In addition to this, there is, frequently, a reluctance to approach health services; this reluctance may in turn result from difficulties, partly due to the cultural background of origin or a very low level of education, or difficulty in orientation within the set of norms and structures that regulate the performance of health services or, in the case of those without a residence permit, from fear linked to their irregular legal status.

1.3 Focus on Infectious disease

It is generally believed that the most common diseases among immigrants are infectious ones. In reality it is a representation that is undoubtedly oversized, which often gives rise to unjustified fears and stigmatization. It is true that in Italy, in recent years, the number of tuberculosis cases in people born abroad has increased (from about 37% to 58% of total cases notified, considering the time span from 2003 to 2012), but this occurred in parallel with the increase in the number of migrants. If we analyze the incidence of notified tuberculosis cases related to people born abroad compared to the resident foreign population, there has been a significant decrease: the incidence among foreigners has almost halved, compared with a substantial stable incidence in the overall population. In other words, the number of tuberculosis cases in migrants increases much less than their numerical increase.

Many immigrants come from countries where the prevalence of HIV infection (Acquired Immunodeficiency Syndrome, AIDS) is particularly high. The incidence of infection among the foreign population resident in Italy is almost four times higher than the Italian population (albeit with a decrease in the complete number of cases): even in this case the incidence is gradually decreasing. Regarding viral hepatitis, the data indicate an excess of risk among foreigners especially for hepatitis B, while there do not appear to be significant differences between Italians and foreign residents regarding hepatitis A and C.

Scabies and skin infections are typical of disadvantaged social groups, homeless individuals, people with severe psychiatric disabilities and closed communities. Poor personal hygiene and overcrowding are the first risk factors for contagion. It is therefore totally inappropriate to speak of predisposing ethnic or geographical factors.[16] Scabies, moreover, even if very contagious, is a pathology that if correctly diagnosed can be resolved in a short time with targeted therapy, and this should be emphasized if only to resize the many

[15] P. BOLLINI, H. SIEM, *No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities on the Eve of the Year 2000,* in “Society Science & Medicine”, 1995, 41, pp. 819-828.
[16] See the aforementioned document Sezione III of the Consiglio Superiore di Sanità, paragraph 4 on “Allarmismi e falsi miti”.

messages aimed at engendering in public opinion fears that are altogether disproportionate compared to the real risks. On the other hand, if more information can avoid prejudices, it is also necessary to reassure the population that migrants are also called upon to respond to the duty of solidarity towards collective health, subjecting themselves to diagnosis and monitoring, always carried out with respect for their person, and necessary to prevent or control any outbreaks of infectious diseases.

Finally, it is estimated that influenza vaccination coverage among migrants at risk of complications (the elderly and individuals affected by certain chronic diseases) in the 2012-2013 season was 16.9%, compared to 40.2% of Italian citizens. Finally it should be remembered that art. 35 of the Consolidated Law (Legislative Decree No. 286/1998) establishes that vaccinations are also guaranteed to foreign nationals who do not comply with the rules governing entry and residence in our country.

*1.4 Mental discomfort: "invisible wounds***"**

In looking at the relationship between health and migration emphasis should be placed, at this point, on the crucial importance for the purposes of any integration project of a seriously underestimated aspect: that of the disturbing spread of mental illness and mental health issues, which may be expressed at various levels of severity and complexity, among the migrant population. According to the epidemiologist James Kirkbride, of the University College of London, it is a scandalously ignored tragedy: this underestimation of the phenomenon would not occur, however, if it were an epidemic concerning physical health.[17] Despite the weight of scientific evidence on the subject and extensive literature, in our country, as indeed in much of the rest of Europe, the measures in this regard are still fragmentary and often only of an emergency nature. At the same time it must also be recognized that examples of "good practices" are not lacking, to be taken as a model for a future structural management of the phenomenon. In fact, there are many organizations, more or less institutionalized, which in recent years have worked, in synergy with local health structures, to provide support and assistance to migrants also in terms of mental health, recognizing the many "invisible wounds"[18]. These joint efforts, although praiseworthy, are however aimed at a limited number of

[17] Cited in A. ABBOTT, *The Troubled Minds of Migrants. The Refugees and Migrants Surging into Europe are Suffering Very High Levels of Psychiatric Disorders. Researchers are Struggling to Help*, in “Nature”, vol. 538, 13 October 2016.

[18] Among these: the Italian Society of Migration Medicine (SIMM); the Protection System for Asylum Seekers and Refugees (SPRAR), consisting of the network of local authorities that access funding from the National Fund for asylum policies and services; the Centro Astalli Association which co-manages the *SAMIFO* project, the *Forced Migrants Health service*; the Humanitarian Association against Torture; the centres of Caritas; the National Institute for the promotion of Health in migrant populations and fight against poverty diseases (INMP); the Italian Council for Refugees Onlus (CIR) that manages the *VI.TO. Kairos* - Reception and Care of Torture Victims.

beneficiaries, compared to the extent of the phenomenon, and even in this case they are present only in some areas of the national territory. It should also be noted that the Ministry of Health, with the launch of "Guidelines for the programming of assistance and rehabilitation interventions as well as for the treatment of mental disorders of refugee *status* holders and subsidiary protection *status* that have suffered torture, rape or other serious forms of psychological, physical or sexual violence[19]", intended to reformulate the NHS services, to respond more adequately to the complex needs of health, both physical and psychological, of the most vulnerable and fragile components of the migrant population.

Going further into the problem, recently Doctors Without Borders (MSF) has published a Report, entitled *Traumi Ignorati*[20], which stems from a study on the mental health needs of asylum seekers residing in the Centres of Extraordinary Reception and their ability to access local services. More specifically, the starting point for identifying the extent of the problems and the potential factors that influence them was provided by a survey, always organized by Doctors without Borders, conducted among the asylum seekers hosted in the CAS (*Extraordinary reception centres*) of the Province of Ragusa through interviews, followed by psychological support activities.[21]

Although aware that the number of patients interviewed and subsequently taken on board is relatively small, the Report provides data in line with the epidemiological evidence in the literature on the subject, highlighting at least 60% of those involved present symptoms of mental distress - disorders post-traumatic stress disorder, personality and cognitive disorders, anxiety states, depressive episodes, etc. - associated with violence suffered in the past and / or

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[19] Ministero della Salute, Decreto 3 aprile 2017 (GU, Serie Generale n. 95 del 24.04.2017). For an illustration of the various initiatives promoted in Italy on the topic of mental health, see the report on *Immigrazione e salute mentale nell'Italia* del 2016, by Caritas Italiana e Fondazione Migrantes (text prepared by the Società Italiana di Medicina delle Migrazioni, with the contributions of M. Mazzetti, M. Aragona, M. C. Monti), in http://viedifuga.org/wp-content/uploads/2016/11/05_Immigr_e_sal_mentale_It_2016.pdf.
See also, M. ARAGONA, S. GERACI, M. MAZZETTI (edited by), *Quando le ferite sono invisibili. Vittime di tortura e violenza: strategie di cura*, Pendragon, Bologna 2014.

[20] See *http://archivio.medicisenzafrontiere.it/pdf/Rapp_Traumi_Ignorati_140716B.pdf*.
The overall analysis was conducted in the Provinces of Milan, Rome and Trapani, chosen for the significant number of reception centres present. The Report has been presented in various institutional locations and also resonated in the national press.

[21] In this phase of the study (from October 2014 to December 2015) "the widest possible range of participants was included to ensure that the voices of people from different ethnic groups and geographical areas were represented. The detection tool has been structured in such a way as to gather information on the characteristics of migrants present in the CAS, both in the initial phase of global screening and in the subsequent phase of selecting and taking charge of individuals in need of psychological support. In both phases information was collected on the socio-demographic characteristics of individuals, on the duration of the trip, on the date of arrival in Italy, on the potential traumatic events suffered". 37.7% of respondents said they had suffered traumatic events before the migration (family member killed / kidnapped / detained, risk of life, physical violence, involvement in fighting ...) or during the journey (combat situations), family members kidnapped / jailed, sexual violence, torture, detention, abduction, forced labour, death of children, family members, friends, drowned companions, asphyxiated or for diesel injuries ...).

living conditions in the reception centres (isolation, inactivity, expectation and uncertainty of the future). As in other investigations on these aspects, also in the Report there are three distinct migratory phases, each of which is marked by painful, often traumatic experiences - arbitrary detentions, torture, repeated sexual violence - which strongly affect the state of health, both physical and mental: 1) The situation prior to the departure from the country of origin, 2) the experience of migration and travel, 3) the arrival and subsequent living conditions following the migration period, which, in turn, can bring out past trauma. From this point of view the post-migratory phase acquires an increasing importance, because suddenly these people realize that they have lost everything, that they no longer have any control over the relevant aspects of their life and no social status[22]. If this discomfort is not promptly intercepted in the first reception phase, and there is no plan to identify specific risk factors on which to calibrate appropriate approaches to psychological support, the health status of this population of more fragile migrants may worsen, making it increasingly difficult to design rehabilitation programs aimed at facilitating social inclusion.

Those who have experienced these devastating experiences of repeated violence and torture are far more exposed to developing a change in personality and manifesting symptoms of Post-traumatic Stress Disorder, a psychic state characterized by "daytime and night-time intrusions (memories and distressing nightmares of experienced trauma) associated with emotional and physical reactions, disorders involving sleep, memory, attention and concentration"[23], in which the person concerned is in a condition of absolute impotence.

The pain of these wounds can turn out to be so destructive and irrepressible as to put at risk the same possibility of treatment and rehabilitation because the violence perpetrated by man on another human being can destroy all defences, severely affect the personality and cause a total loss of self-confidence and in humankind as a whole. If to all this we add the difficulties that these people already so tried may encounter in adapting to the living conditions of the reception centres and, more generally, of the host country one can understand the complexity of the need for help, acceptance and protection of these forced migrants. The victims of inhumane and degrading events should therefore be immediately taken care of by multidisciplinary teams (doctors, psychiatrists,

[22] The troubled minds of migrants, cit..

[23] Thus we read on p. 29 of the collective volume: *Le dimensioni del disagio mentale nei richiedenti asilo e nei rifugiati. Problemi aperti e strategie di intervento,* SPRAR-Ministero dell'Interno, Anci, Cittalia 2010, which is the most exhaustive reference text for this part of the document: vd. http://www.sprar.it/wp-content/uploads/2016/06/Le_dimensioni_del_disagio_mentale_-_Cittalia_2010.pdf. In light of these analyzes, which concern the violence perpetrated in the countries of origin or transit of the migrant, it is necessary to recommend an even stronger commitment in countering the actions of violence that are also carried out in Italy. See the report by L. TONDO and A. KELLIE, *Raped, Beaten, Exploited: the 21st-Century Slavery Propping up Sicilian Farming,* in "The Guardian", 12 March 2017, https://www.theguardian.com / global-development / 2017 / mar / 12 / slavery-sicily-farming-raped-beaten-exploited-romanian-women.

psychologists, socio-health workers, cultural mediators, etc.), with a specific preparation, able to envisage and implement paths aimed at the reconstruction of identities damaged by torture, as well as reconstructing the sense of one's own existence, of trust in others and in human relationships. This should be done with the awareness that the operators involved in similar activities are required to establish with the victims of degrading treatments and torture an "extremely complex, demanding and emotionally intense" relationship, which can in turn can expose to "vicarious" traumas. This highlights the need for operators who accept to engage in this type of therapeutic path, inserted into multidisciplinary teams and following a model of community intervention, to not only have a solid professional background and be willing to follow an continuous educational activity but they should also able to recognize in themselves the symptoms of stress resulting from their inevitable emotional reactions to prolonged listening to dramatic and terrible stories, stories of extreme suffering caused by intentional violence and multiple human losses.

2. Right to health: legal profiles

2.1 General framework

The contemporary conception of health is characterized by amplitude and complexity, features that must be taken into account when dealing with the phenomenon of migration. From the point of view of its content, first of all, the definition given by the World Health Organization as early as 1948 is well-known, according to which it is "a state of complete physical, mental and social well-being" and not simply the absence, of disease or infirmity. Such a broad formulation of health prevents, however, from making it the content of a fundamental right, which could not be directly guaranteed in such wide terms even to citizens alone.

A second profile of the complexity of health, in fact, concerns the limit and extent of its being guaranteed by the legal system. In this sense, one can speak of the right to health both in positive terms, i.e. as an individual and social right to receive provision of a specific medical or health service, which can be essential or accessory, as well as in negative terms, as individual protection coordinated with the principle of personal freedom (from torture or inhuman and degrading treatment, from unwanted treatment, from clinical trials). In the Italian Constitution health is protected in the context of ethical and social relations, where it is placed in a fruitful relationship with the principle of solidarity, in the sense that it is recognized as a fundamental right of the individual, as well as in the interest of the community. Solidarity is therefore directed in both directions: solidarity towards people in need of care, but also solidarity of each individual towards the needs of public health. In fact, the second paragraph of art. 32 of the Constitution recognizes the possibility of legal provision of compulsory health treatments, such as vaccinations, aimed also at the protection of

collective health and provided that such obligations are respectful of the human persons involved.

Depending on the more or less broad content assumed by the right to health, therefore, the legal system recognizes its protection in more or less intense terms. And this intensity is conditioned by the need to contain costs and balance with other relevant interests that can sometimes also be linked to the specific legal status held by the foreign person involved.

In terms of the right to freedom from degrading treatment or unwanted medical treatment, for example, the status of citizen or foreigner is of no relevance, since such acts are prohibited to any person regardless of status. When, on the other hand, the foreign person requests specific treatment from the health service, also in order to promote what can be subjectively perceived as a state of health, the system intervenes selectively (a) allowing treatment but not placing the burden of the cost of treatment not considered essential on the NHS; (b) charging the NHS for treatments that are considered essential.

In addition to such interventions (sub a and sub b), the State can also prohibit treatments that are considered prejudicial to health. In 2006, for example, Italy included art. 583 bis that punishes with 4 to 12 years of imprisonment anyone who, in the absence of therapeutic needs, causes a mutilation of the female genital organs[24], even though such circumstances were obviously punishable even before, as a personal injury. Although this is a criminal case applicable to anyone, regardless of the status of citizenship, this offense was introduced as a result of the risk of spreading the practice of infibulation introduced in Italy by African, Arab and Southeast Asian populations. In this sense, the protection of the dignity and psychological and physical integrity of women, and of every human person, is an indispensable principle, which can not be ignored or even reduced, under the pretext of recognizing cultural differences. The continued absence in our legal system of the crime of torture should also be denounced, the introduction of which would fight with greater intensity the most odious practices committed against foreigners (and others).

With reference to the medical services covered by the NHS (sub b), the various countries, including European countries, have different disciplines. Italy, on the basis of the constitutional recognition of health as a "fundamental right of the individual" (Article 32), distinguishes itself by recognizing a wide range of free treatments even to those illegally present on the territory. Even irregular foreigners, in this way, have the right in Italy to all urgent or essential services, even if they are ongoing; at the same time, they are obliged to participate in the duties of solidarity for the protection of collective health.

[24] It refers to clitoridectomy, excision, infibulation and any other practice that causes effects of the same type.

2.2 Access to health services

The Italian Constitution, and in particular Articles 2 (on the subject of inviolable rights), 3 (on the principle of equality) and 32 (which provides for the fundamental right to health of every individual), constitute the main point of reference for health of immigrants.

The Italian constitutional jurisprudence has arranged that for all foreigners, whatever their status (i.e. their respective position with respect to the rules governing entry and stay in the State), the irreducible core of the right to health should be protected. The sentence n. 252 of 2001 of the Constitutional Court specified that, if "the right to health treatment necessary for the protection of health is" constitutionally conditioned "by balancing needs with other constitutionally protected interests", in any case there must be "the guarantee of an irreducible nucleus of the right to health protected by the Constitution as an inviolable area of human dignity"[25].

This approach of strong guarantee of the health of foreigners, even irregular ones, is specified by art. 35 of the Consolidated Law (Legislative Decree No. 286/1998) of immigration which assures them both urgent or essential, even continuous, outpatient care and hospital treatment, and preventive medicine programs to safeguard individual and collective health. The same text guarantees, in particular: a) the social protection of pregnancy and maternity, and equal treatment with Italian citizens; b) the protection of the child's health in implementation of the Convention on the Rights of the Child of 20 November 1989, ratified and enforced pursuant to the law of 27 May 1991, n. 176; c) "vaccinations according to the law and within the framework of collective prevention campaigns authorized by the regions"; d) international prophylaxis interventions; e) prophylaxis, diagnosis and treatment of infectious diseases and eventually the remediation of related outbreaks.

At every moment of being present in Italy, and also in the period of time between the entry into the national territory and the presentation of application for asylum, foreigners therefore have the same conditions of access to basic and continuous care as those of other citizens.

From the moment the asylum request is presented, the migrant has the right/duty to register with the NHS. However, this registration is not automatic, as it is necessary for the foreigner to present the relative application to the health institution of the place of residence along with a residence permit and tax code[26]. Recently, the Ministry of Health has issued a note communicating to the Regions a procedure agreed with the Inland Revenue to speed up the

[25] This sentence is a so-called. interpretation of rejection.

[26] The conditions of access to the provision of health services of asylum seekers depend in fact on registering with the NHS, to which the holders of the asylum application permit are required to register (Article 21 of Legislative Decree No. 142/2015 and art. 34 of Legislative Decree No. 286/1998).

possibility of registering with the Regional Health Service (SSR) through a provisional tax code.

By registering with the NHS, the foreigner enjoys full equality of treatment, the same rights and duties, as Italian citizens in health care, including the choice of primary care physician or paediatrician, access to family counselling centres and mental health departments, emergency services, access to forensic services, prescription charge exemption[27].

With reference to the wider tendency of international law to recognize on equal terms the right to benefits provided by the NHS, it is worth recalling a ruling by the Constitutional Court (No. 306 of 2008), which recognized the accompanying allowance for a Albanian citizen, regularly residing in Italy for over six years, married with two daughters and totally unable to work (in a vegetative state following a traffic accident) and yet without a residence permit, due to lack of meeting income requirements[28]. In this decision, in particular, it was argued that "the generally recognized rules of international law include those that, in guaranteeing the fundamental rights of the individual regardless of belonging to certain political entities, prohibit discrimination against foreigners, legitimately residing in the territory of the State".

From what has been stated, it is clear that Italian law, thanks to the establishment in the Constitution and a strong thrust from the Constitutional Court, recognizes to every person, regardless of the state of regularity or otherwise on the national territory, a particularly broad field of health protection, linked to the protection of human dignity.

The extension of the guarantee throughout the national territory, however, has been, and still is, hampered by uneven conditions of a procedural and administrative nature; conditions on which the Committee wants to draw attention to, in order to ensure full and effective enjoyment of the right to health for all.

[27] Art. 8, co. 16, of the l. n. 537/1993 and subsequent amendments. The exemption from the payment of the ticket is also provided for people suffering from chronic diseases (D.M. No. 329/1999) and for patients suffering from rare diseases (D.M. No. 279/2001). The provisions concerning the exemption from the payment of the ticket for the disabled are provided for by the ministerial decree of 1 February 1991. The procedures and modality for requesting the exemption have been updated by the Ministry of Health decree of 23 November 2012, *Definizione del periodo minimo di validità dell'attestato di esenzione dalla partecipazione al costo delle prestazioni sanitarie.*

[28] The sentence deals with the distinction between long-staying foreigners and foreigners with residence permits. The principle is however applicable to every foreigner. The "Court considers that it is manifestly unreasonable to subordinate the assignment of a welfare benefit such as the accompanying allowance - whose preconditions are ... total disability to work, as well as the inability to walk unaided or to carry out the everyday acts of life – legitimate entitlement to the permanence of the stay in Italy that requires for its issue, among other things, possession of an income".

2.3 Critical issues in the Italian health service and the different application of the State - Regions Agreement of 20.12.2012.

In defining health policies concerning the health of migrants, it can certainly be argued that the Agreement signed by the Permanent Conference for relations between the State, the Regions and the Autonomous Provinces on 20.12.2012 represents a very significant point of arrival, aimed at guaranteeing the protection of the right to health also to the foreign population[29]. In the Agreement certain important principles are in fact set forth, for example, the mandatory registration to the NHS of a number of subjects: firstly foreign minors, even if born to parents who are irregularly present migrants in Italy and without a residence permit, and then non-EU citizens who have applied for regularization or emergence from undeclared work and who are awaiting definition of the procedure. The Agreement also provides for the provision of essential as well as continuous care to temporarily present foreigners (STP), including all the healthcare services that ensure the principle of continuity of urgent care and the possible resolution of the morbid event that emerged; and again, among the many cases considered, the procedures for the provisional release of the STP code are established in order to facilitate access to treatment and definition of the exemption criteria for the same STP, as well as equalization of care levels and organization of the STP code to the ENI code (European not registered).

Unfortunately, the potential of the text signed at the end of 2012 was only partially exploited, also due to a strong lack of homogeneity in the reception and application at territorial level of its contents. To this there are initiatives added which are aimed at weakening the innovative scope, for example the refusal in some cases to prepare measures to extend the choice of paediatrician also to the children of irregular immigrants, as established by the Agreement itself and more recently by the art. 14 of the law 47/2017, which provides for the registration with the NHS of children in a state of neglect. To date, according to data provided by the Italian Society of Migration Medicine (SIMM), only thirteen regions and the Autonomous Province of Trento have made the formal implementation of what was established in December 2012, however a complete implementation does not necessarily follow; other regions, even without ratification, apply it in part. The final result is that we are thus faced with a very uneven application, a fragmented patchwork, of the concrete indications provided by the Agreement, starting with the one concerning registration with

[29] The text of the agreement is in http://www.statoregioni.it/Documenti/DOC_038879_255%20csr%20-%205%20quater.pdf. For a more general view of the criticalities, but also of the potential, of the NHS see the recent opinion of the NBC *In defence of the National Health Service (SSN),* January 26, 2017.

the Regional Health Service (SSR) of minors with parents without a residence permit.[30]

These differences in application, often due to differences in interpretation between the various regions of the same legislation, are certainly not the best guarantee to favour the concrete possibility of treatment; It is easy to imagine that cumbersome, organizational deficiencies and bureaucracy are serious obstacles to gaining access to health services, especially by the most vulnerable categories (minors, women, the elderly) of the foreign population, already in itself vulnerable. Professional categories, voluntary associations, local institutions are called to an effort of common commitment to prevent bureaucratic and organizational rigidities from making concrete the operative indications of the Agreement between the State, Regions and Autonomous Provinces; on another level, a strengthening of the role of coordination and orientation of health policies addressed to foreigners by the Ministry of Health is required.

3. Conditions of particular vulnerability

3.1 The different types of reception centres[31]

The reception system for asylum seekers in Italy is very complex and consists of structures that over time have joined and overlapped with those already present, in compliance with Italian regulations and applications of European directives produced in response to landings.[32]

After rescue at sea, which already provides emergency health care, migrants are housed in *First aid and assistance centres* (CPSA) - government facilities located near landing sites, where the stay lasts only for the time necessary for their transfer to other centres (approximately 24/48 hours). In this phase called first aid, basic health care assistance is provided and possible transfer to hospitals. Other government structures used are the R*eception centres* (CDA), established as early as 1995 and still operative, which

[30] S. GERACI, F. ARRIVI, V. PETTINICCHIO, G. CIVITELLI, *Minori diseguali: la legge e il diritto all'assistenza sanitaria, non è uguale per tutti*, Comunicazione, in Atti dell'XVI Congresso Nazionale SIMM: *Persone e popoli in movimento. Promuovere dignità, diritti e salute*, Torino, 11/14 May 2016, Pendragon, Bologna 2016, p. 114.

[31] For the information contained in this paragraph, please refer to the aforementioned *Dossier Statistico Immigrazione* 2016 (IDOS), and to the two editions, 2015 and 2016, of the Report on International Protection in Italy, by Anci, Caritas, Cittalia, Migrantes Foundation, Sprar - Ministry of the Interior, with the collaboration of the United Nations Agency for Refugees (UNHCR): vd. http://www.interno.gov.it/sites/default/files/t31ede-rapp_prot_int_2015_-_rapporto.pdf http://www.anci.it/Contenuti/Allegati/Rapporto%20protezione%20internazionale%202016.pdf. Very useful is also the consultation of texts, and related links, edited by Salvatore Geraci and reported in the portal of the Istituto Superiore di Sanità: http://www.epicentro.iss.it/argomenti/migranti/AccoglienzaItalia2016.asp.

[32] The legislation referred to is mainly the Understanding between the Government, the Regions and Local Authorities of 10 July 2014, and Decree Law 142 of 18 August 2015, implementing various European directives.

guarantee first reception to non-regular foreigners, traced on Italian territory, for the time necessary in order to identify and verify the regularity of their stay in Italy.

Upon arrival, migrants in poor health and requiring urgent interventions generally have travel-related health problems (hypothermia, burns, trauma, gastroenteritis, epilepsy) or obstetric problems[33]. The belief, often fomented by the media, that newly arriving migrants bring infectious diseases which are already under control or have disappeared in Italy, has been refuted by monitoring systems implemented in response to the emergency. The syndromic surveillance system developed by the Istituto Superiore di Sanità aims to rapidly report potential epidemics in the reception centres. In Sicily, during the period 1 March-31 August 2015, the only reports were for cases of dermatological diseases, such as scabies, and some cases of measles and chickenpox[34].

After the first aid phase, migrants applying for international protection are transferred to first reception facilities, that is to say Hub centres on a regional or interregional basis. To get an idea of the numbers, the migrants filing for asylum in 2016 were 123,600 and in 2015 the total number of requests was 83,970. The still operational system for first–line reception is composed by *Reception centres for asylum seekers* (CARA), centres for the identification and initiation of procedures related to international protection, even if they should be replaced by the Hubs as regards their functions. The first reception phase should last a maximum of one month, the time to complete the asylum application and be re-located in the second reception centres. Migrants who do not apply for international protection or do not have the requisites to do so are held in the recently established *Centres for Repatriation* (CPR)[35] in substitution of the *Centres of identification and expulsion* (CIE), in both cases foreseen to avoid the dispersion in the territory and allow the execution of the relative provision by the Police Forces[36] (see paragraph 3.2).

In the government centres (CPSA, CDA, CARA, CIE or CPR) the managing bodies that have under contract the provision of services are required to offer health care support, consisting of:

- *on entry medical screening and compilation of a health card* for each guest, also aimed at an immediate assessment of the psycho-social profile, in order to identify particularly vulnerable subjects[37];

[33] A. FIRENZE, V. RESTIVO, V. BONANNO, N. ALEO, S. PACE, M.G.L. MARSALA, M. PALERMO, *Stato di salute degli immigrati approdati sulle coste italiane,* in "Epidemiologia e Prevenzione", 2014, 38 (6) Suppl. 2, pp. 78-82.

[34] See http://www.epicentro.iss.it/argomenti/migranti/ReportSpeim.asp.

[35] From D.L. 13 del 17 February 2017.

[36] Information on the type of government centres, the regulatory references and the requirements to be met are on the website of the Ministry of the Interior, http://www.interno.gov.it/it/temi/immigrazione-e-asilo/sistema-accoglienza-sul-territorio/centri-limmigrazione.

[37] It goes without saying that screening is justified solely on the basis of medical reasons, as is clearly foreseen by the procedures adopted in this regard in our country. *Screening* aimed at

- *medical first aid*, which includes a medical facility for urgent outpatient treatment, with the presence of medical and paramedical staff;

- *possible transfer to hospital facilities*.

As part of the medical assessment on entry, first aid and subsequent examinations, it is bioethically important that:

- the initial medical evaluation of migrants (medical history etc.) is made by doctors who possibly have an epidemiological knowledge of the diseases of the countries of origin and is based on scientific evidence of guidelines of Medical societies, aimed at identifying not only infectious/transmissible diseases, thus protecting the public health of the host country, but also non-infectious/non-communicable diseases, to protect the individual health of migrants;

- the medical evaluation, carried out scrupulously according to the principle of respect for the human person and in the presence of cultural interpreters/mediators, is accompanied by the reassurance that the examination is only for medical purposes, so as not to cause further anxiety, and provide basic information on health conditions (diagnosis, therapies, prevention), with assessment of understanding through *health literacy* tools;

- the results of the medical evaluation should be used only for health purposes to protect public and individual health and can not be used as grounds for expulsion.[38]

From the first reception centres, migrants waiting to know the outcome of their asylum application are transferred throughout the Italian territory to second-line reception centres, which should always be structures provided by the local authorities that adhere to the *Protection System for Asylum seekers and refugees* (SPRAR). These bodies, using the National Fund for asylum policies and services, guarantee at the local level "integrated reception" interventions and provide, in addition to board and lodging, also information, support, assistance and guidance measures, through the construction of individual paths for socio-economic integration[39].

This system, however, failed to fill the need for reception that followed the increase in flows since 2014. For this reason a large number of *Extraordinary Reception Centres* (CAS) have been set up, with the aim of temporarily compensating for the overcrowding in government centres and SPRAR system congestion. The centres are activated by agreement with the prefecture of the territory and contracted data to local management agencies. With the continuation of the flow the system is unbalanced, filling the CAS, which should

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making expulsion possible (in the case of infectious diseases, for example) would not be bioethically justified.

[38] See the Guidelines for Border controls. *La frontiera dei controlli. Controlli sanitari all'arrivo e percorsi di tutela per i migranti ospiti presso i centri di accoglienza,* 2017, Draft for public consultation, by the Istituto Superiore di Sanità, Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà, Società Italiana di Medicina delle Migrazioni.

[39] Information on SPRAR: www.sprar.it and http://www.sprar.eu/images/SPRAR_-_Manuale_operativo_2015.pdf.

only be "extraordinary" and which now number about 3100 throughout the national territory and are home to 73% of asylum seekers, compared to 7% in government centres and 20% in SPRARs.[40] As of January 31, 2017, the asylum seekers present in Italy were 174,573. Among the regions, in first place by number of presences is Lombardy with 13%, followed by Lazio, Campania, Piedmont, Sicily and Veneto each with about 8% of presences.

After making a request for international and humanitarian protection, migrants have the right and duty to register with the NHS, as already explained in paragraph 2.2, and have access to health services like Italian citizens, and in particular, to prevention services, which also protect collective health, since it acts to bridge the gap of the influx of a population with a vaccine coverage rate that is lower than the Italian one.

While positively assessing the progress made, with peaks of excellence especially in the SPRAR system and despite the access to care in all phases of reception being guaranteed by regulation, there are still many critical issues, some with a significant impact on health:

- the network created is still insufficient compared to the number of landings. This leads, especially in periods of greater influx (February-July), to situations of overcrowding and promiscuity, even among vulnerable people;

- there is an excess of CAS, centres dedicated to emergency and assistance which are not structured and programmatic, and therefore much more limited in scope in the type of provision of support that they can give to their guests. This lack of planning combined with overcrowding, fuels the sense of insecurity, fears and xenophobic sentiments of the residents near the centres, especially the Hubs;

- the absence of specific national legislation for the regulation of CASs and their decentralization fuel a strong heterogeneity in the services provided and make control over them as well as control over the use of public resources allocated to them problematic;

- the dependency on reception facilities by the Ministry of the Interior, on the one hand, and on health structures by the Ministry of Health, on the other, makes planning and collaboration difficult. There is also an increase in the workload for healthcare facilities, due to a substantial lack of personnel and the lack of specific training to assist foreign patients with a history of recent migration;

- the multiple and rapid transfer of asylum seekers from one facility to another is not accompanied by a system that allows tracking the health data of the individual. So it is possible that some procedures are carried out several times on the same person, with a waste of resources and considerable discomfort for the patient. Some solutions are being tested to address this need,

[40] These data date back to December 2015.

such as providing an individual electronic health card[41], but it is still in the initial stage;

- the criticality, already noted in paragraph 2.2, regarding the heterogeneity of the application of regional health standards, also has implications for the management of services for asylum seekers;

- lastly, rigorous control of the procedures and modalities for assigning and implementing the services provided by the reception centres and the data managed by external bodies must be ensured.

3.2 *Irregular and transitory migrants*

When we speak of migrants arriving on the Italian border, special attention is given to those who are not entitled to international protection, and therefore should be immediately rejected. One of the indications of the European Commission to deal with the exceptional migratory flows was to establish *Hotspots*, structures built in the countries of first arrival in Europe, in order to distinguish those migrants in need of international protection from so-called economic migrants. This procedure should then be followed by relocation in European countries of those migrants with the right to protection. The project, established in May 2015, has never worked for the real unavailability of other European countries to accommodate relocations, for repatriations that can not be implemented because of the high costs and the absence of agreements with the countries of origin and lastly due to the reduced capacity of the centres in the face of incoming numbers. These critical issues regarding the system are then combined with completely inadequate and undignified conditions of stay which go well beyond the 48 hours planned and sometimes even exceed 30 days, as reported by the *Extraordinary commission for the protection and promotion of human rights.* of the Senate, in its *Report on the Centres of Identification and Expulsion in Italy*;[42] the conclusion of this Report is very clear: "The appraisal of the hotspot approach, [...] can only be considered deficient and highlight the substantial failure of the European plan: compared to the achievement of a rate of identifications of over 94%, positive results have not been achieved in terms of relocated persons and repatriated persons. At the end of December 2016, only 2,350 people were relocated from Italy to other Member States out of the total of 40,000 provided for in the European plan".

[41] Cf. http://www.ansa.it/canale_saluteebenessere/notizie/sanita/2017/03/14/ansa-sanita-prime-tessere-sanitarie-digitali-a-342-migranti_966b599f-e1bb-4975-9253-15f9d75b2f6f.html. See also: *International Organization for Migration. ReHealth project. Implementation of the PHR* and related information in http://re-health.eea.iom.int/implementation-phr-project; CARE *Common Approach for Refugees and Other Migrants' Health. Monitoring of Migrant's & Refugee's Health Status*, in http://careformigrants.eu/monitor-of-migrants-refugees-health-status/.

[42] Reported in http://www.asylumineurope.org/sites/default/files/resources/cie_rapporto_aggiornato_2_gennaio_2017.pdf

Although much concern is aroused by new unentitled arrivals, in response to which media pressure pushes to close the borders, the quota of irregular migrants on Italian soil is mainly given by *overstayers*, those who entered regularly have an expired entry visa or residence permit and remain all the same.

It is not possible to have reliable data on the number of irregular migrants. Estimates say that there were 350,000 in 2014 and 404,000 in 2015[43]. Looking at the last decade the number of irregular presences in Italy is declining, just consider that there were 34,104 irregular foreigners intercepted in 2015, while there were 119,923 in 2005, probably due to the effect of Italy's economic crisis and its reduced attractiveness as a place to find work and better living conditions.

As already described in paragraph 2.2, even irregular migrants on Italian soil are entitled to urgent and essential services, to the protection of maternity and childhood and to interventions for the protection of collective health. There remains the question of how these services are able to intercept and fill the health needs of these people: it is difficult to have certain information on how many there are in total and on their health, and the distinction between regular and irregular is labile and subject to status changes. What is certain is that irregularity often accompanies situations of great social and health fragility: in addition to the precarious working condition (being unemployed or working illegally), many irregular workers are homeless, victims of trafficking and victims of torture. The few data available come from some of the centres that provide care for these categories of migrants. The INMP polyclinic (National Institute for the promotion of the health of migrant populations and for the fight against Poverty diseases), in Rome, has collected data on the accesses that there have been since 2008, about 60,000, and on hospital admissions[44]. What is found is a substantial overlapping of the health profile of other migrants, with a "healthy migrant effect", and hospital problems mainly related to maternal and child health, and traumatism for men. It is also important to underline that the higher prevalence of infectious diseases in this category is limited, and there are minimal risks of transmission to the host population. However, this profile includes a greater exposure to violence and detention, reduced access to services, and the condition of poverty, therefore making it an extremely vulnerable category.

[43] These and many other data, constantly updated, can be found on the ISMU Foundation website *Iniziative e studi sulla multietnicità;* see in particular the section *Monitoraggio dell'immigrazione* (responsabile scientifico Gian Carlo Blanciardo), http://www.ismu.org/monitoraggio-dell'immigrazione/.

[44] See Antonio Fortino's speech on "Cosa sappiamo della salute degli irregolari", presented at the I'INMP conference on *Epidemiologia della salute della popolazione immigrata in Italia: evidenze dalle indagini multiscopo ISTAT* (6.5.2016), http://www.inmp.it/index.php/ita/Eventi/Eventi-INMP/Eventi-Nazionali/Epidemiologia-della-salute-della-popolazione-immigrata-in-Italia-evidenze-dalle-indagini-multiscopo-ISTAT.

A few words on "transiting" migrants, that is, those passing through Italy in an irregular situation staying in temporary settlements or occupied buildings their aim being to reach other European countries and apply for asylum there. This category is the bearer of urgent medical needs and, in fact, it is not reached by the health system. The endeavour, by networks of governmental and non-governmental organizations, is to reach them with travelling medical teams that bring an active offer of health, ensuring the offer of primary health care with cultural mediation. INMP also provides data on this activity: the 12,000 people examined in 2 years were mostly young men, and the most frequently encountered conditions were dermatological diseases (scabies, pediculosis), and upper respiratory tract infections. The cases of active tuberculosis diagnosed were limited to 2.

Faced with this situation, some considerations can be formulated:

- these categories are extremely vulnerable, and it is important to make every effort to reach them actively and to guarantee their health and, indirectly, protect the community;
- given the difficulty of reaching these persons, it is of fundamental importance to avoid transmitting the fear that rescue personnel will be able to report them as irregular migrants;
- alarmism must be avoided, also because their state of health is relatively good; instead epidemiological surveillance must be ensured;
- it is important for services to be implemented as far as possible in compliance with the law, these should be homogeneous, accessible and provided by adequately trained personnel, also as regards relating to other cultures.

Lastly, a few words on the tools in place to contrast irregular migration. The migrants who refuse identification procedures, those whose request for asylum has been definitively rejected and those found in an irregular position on Italian soil should be temporarily placed in the *Centres for identification and expulsion* (CIE) now replaced by *Centres for repatriation* (CPR). The CIE have been highly criticized by humanitarian organizations and international institutions, as well as by the Special Committee of the Senate. The critical points encountered by the latter are numerous: structural deficiencies, inadequate detention methods in terms of protection of the dignity and rights of the detained, excessive maximum length of stay (currently 12 months), the presence in the centres of individuals with very different situations (ranging from former prisoners to people who have lost their jobs and subsequently also their residence permit), with many consequent tensions, detention of persons with uncertain legal status and therefore de facto not subject to deportation (such as Roma), lack of protection for vulnerable groups, in particular women victims of trafficking. From the point of view of health, in particular, there is the difficulty of forming relationships and the lack of confidence of the detainee towards the doctor, who is perceived as a custodian. There are frequent episodes of self-harm and the number of people taking psychotropic drugs is high, without

adequate psychiatric assistance. In the face of all the problems encountered, the ineffectiveness of the system must be underlined. In 2015, of the 5371 detained migrants, only 51% were repatriated.

It must also be remembered that even the expulsion (or repatriation or conduction to the borders if one prefers) of illegal migrants, although it is a measure provided for by national and international law as an indispensable tool to ensure and restore legality, on an existential level, it can not be considered a "painless" act. It is evident that the detention and transport of a subject against his will implies the use of means of restraint, which take place under the direct responsibility of the police, but without specific judicial control. Although we will never know how much this further form of affliction, this further invisible wound will mark their lives, we can not ignore that, if we have solved our problem, we have also added violence to violence, suffering to suffering. The fact that the state is applying its laws does not cancel out the drama: it only pushes it beyond the borders. It is important for public opinion to be aware of all these tragic implications and, therefore, of the complexity of the ethical and juridical problems behind the easy oleography of "sending them home".

3.3 Unaccompanied minors

All over the world, vulnerable and socially disadvantaged people find it more difficult to access health care; they fall ill more frequently and die earlier than those with a privileged social position. These inequalities obviously also affect childhood and are on the increase. When we speak of children of foreign parents we often refer to a wide range of very different situations; in fact, their differences both on the socio-demographic level and on the legal status level are significantly reflected in physical and psychological health conditions. The children of foreign parents can be: born in Italy to regular parents, immigrating with them; born in Italy or immigrants but with a period of prolonged separation from their parents; children of irregular immigrants; children of refugees; Rom/Sinti in traveller's camps; children in single-parent nuclei (or orphans); unaccompanied minors.

Minors constitute a significant part of the people who have come to Italy in recent years, mainly through landings on our coasts; and among them, there are many unaccompanied foreign minors (MSNA). In 2016, 25.846 unaccompanied minors arrived in Italy, more than double compared to 2015 (12.360). They account for 14.2% of all persons disembarking in Italy (181.436 in 2016) and 91.6 of all minors arriving in Italy (28.223, of which 2377 were accompanied minors)[45].

The male component has by far greater prevalence (93.3%) while also predominant is the number of minors close to the coming of age with 56.6% of

[45] Elaboration by *Save the Children* on Ministry of Interior data, Department of Public Security, in Atlas *minori stranieri non accompagnati in Italia*, Save the Children 2017, p. 29, https://www.savethechildren.it/sites/default/files/AtlanteMinoriMigranti2017.pdf.

17-year-olds forming the total, followed by 16-year-olds (26%) and 15 year olds (9.8). The countries with the greatest influx are Egypt, Gambia, Albania, Nigeria and Eritrea: more than half of the unaccompanied minors originate from them.[46]

One of the reasons why they come to our land alone is that their families make them leave, in the hope that they will have better life opportunities and maybe they can, once they arrive at their destination and have consolidated their position in the host country, be joined by another family member, for example a brother; this migratory project then clashes with the long desert crossings, with work activities, in order to finance the trip, under conditions of exploitation and humiliation, with periods of detention, especially in Libya.

In many cases children are victims of trafficking and for this reason it is essential that their status, upon arrival in Italy, be recognized in order to activate the appropriate measures for their protection and safeguarding. It can not be ruled out that some declare themselves to be minors, even if they are not, because they trust in this way to receive better assistance; others, of very young age or even babies, may unfortunately have acquired the status of unaccompanied minor with the death of the parent or of a relative during the Mediterranean crossing. In dubious cases it is important to proceed with the assessment of age and in any case to take all necessary measures to prevent losing track of unaccompanied minors, with their moving away from the reception facilities, for example with the aim of reaching relatives or friends who live elsewhere, but with the risk of them aggravating their precarious condition or even their being recruited by criminal groups.[47] For these reasons it would be so important to promote foster care for unaccompanied minors rather than admission to reception facilities[48].

In this regard, some provisions deserve to be mentioned, namely the "Protocol for the identification and for the multidisciplinary holistic assessment of the age of unaccompanied minors" and the Regulation aimed at establishing the procedures to be adopted to determine the age of minors unaccompanied, who are presumed to be victims of trafficking.[49] The Protocol and the Regulations provide that age is determined according to a multidisciplinary procedure, which also takes into account the cultural and ethnic origin of the minor. This is a first step in a journey that will also include medical examinations, designed to assess the child's health conditions, any pathologies contracted in the country of origin or during the trip, the presence of possible mental disorders, due to trauma and violence, as well as interviews aimed at establishing what the

[46] See http://www.lavoro.gov.it/temi-e-priorita/immigrazione/focus-on/minori-stranieri/Documents/Report-di-monitoraggio-MSNA-31-dicembre-2016.pdf.

[47] Report Oxfam Italia, *Grandi speranze alla deriva*, 8.9.2016, https://www.oxfamitalia.org/wp-content/uploads/2016/09/MSNA-Sicilia_mediabrief_8-set-2016_FINAL_DEF.pdf.

[48] Therefore, as established by art. 7 of the recent law 7 April 2017, n. 47 on *"Disposizioni in materia di misure di protezione dei minori stranieri non accompagnati".*

[49] More precisely, it refers to the Protocol adopted by the Conference of Regions and Autonomous Provinces (16/30 / CR09 / C7-C15, March 3, 2016) and "*Regolamento recante definizione dei meccanismi per la determinazione dell'età dei minori non accompagnati vittime di tratta, in attuazione dell'art. 4, c. 2 del d. lgs. 4 March 2014"* (D.P.C.M., 10/11/2016 n. 234).

development of the child migration project could be. This development may include the request for international protection or, if the conditions for the asylum request are not met the possibility of assisted repatriation or regularization of the child's stay in Italy.

The Protocol and the Regulations, as was said, are aimed at determining the age of child victims of trafficking, when this can not be ascertained through identification documents; they assert respect for the best interests of the child, with the aim of ensuring adequate protection; these provisions could then apply to all unaccompanied minors, regardless of their status as victims of trafficking. For this reason, the NBC adopts the auspice formulated by the Association of Juridical Studies on Immigration (ASGI) and the Italian Society of Migration Medicine (SIMM) that the provisions referred to above regarding the determination of age should be applied by analogy to all unaccompanied foreign minors, even when they are not victims of trafficking or do not qualify for asylum.

3.4 The condition of women

Why do women undertake the long and often terrible journey from their countries of origin to arrive, across the sea in Italy?[50] Female migration depends on many factors: starting from economic reasons, to avoid dangers and threats of various kinds, for family reunification, but also to have different chances of life and to expand, as women, their ability to choose. Many come from sub-Saharan Africa, Gambia, Somalia, Cameroon, the Democratic Republic of the Congo and, above all, Nigeria. It is common for them to leave in groups with family, friends, acquaintances, from which they are separated during the journey so as to make them more fragile and open to blackmail.

There are many points of view from which we could analyze the reality and experience of migrant women. Here we will limit ourselves to considering only two aspects, which are very different from one another, that is, on the one hand, the terrible phenomenon of trafficking, trafficking in persons and exploitation, in conditions of serious subordination and violence, to which many women, often minors, are subjected on their migratory journeys (a), and on the other the experience of pregnancy and maternity of immigrants now residing in Italy (b).

a) *Trafficking in human beings* and *smuggling of migrant*s are two distinct types of crime, but they have similarities. According to the terminology adopted by the UN[51], trafficking consists in recruiting, retaining and transferring people with the aim of exploiting their performances, which may be forced labour, the

[50] M. REGATTIN, *Il lungo viaggio delle donne migranti*, 3 giugno 2016, http://www.socialnews.it/articoli-mensile/viaggio-donne-migranti/.

[51] *The United Nations Convention against Transnational Organized Crime and the Protocols Thereto,* adopted by General Assembly resolution 55/25 of 15 November 2000, https://www.unodc.org/unodc/treaties/CTOC/; see also art. 601 of our Criminal Code on "Trafficking in Persons".

exercise of various activities dictated by subjection, even slavery, mendacity, but also prostitution; obviously the ways in which exploitation is pursued reside in coercion, in the abuse of power or even in obtaining a consensus, which however is fictitious, because it is the result of a deceptive and dominant relationship. Smuggling, on the other hand, favours irregular entry into a State, upon payment of sums of money by consenting customers. However, it often happens that migrants, once they come to an agreement, on a fee, with the traffickers to illegally enter a foreign country, find themselves in a condition comparable in all respects to the victims of trafficking; this occurs because already during the trip they are subjected to serious forms of violence, deception and coercion, by the traffickers themselves and other subjects, such as criminal groups and corrupt state officials, involved in various ways in the organization and management of irregular migratory flows.

Among the most defenceless victims of the phenomena of human trafficking and smuggling (the latter, in turn, often being reducible - as we said – to trafficking) are undoubtedly women, especially if they are young or even very young. A recent report by *Save the Children* reconstructs in detail the sexual exploitation of now tens of thousands of young Nigerians, through a dense criminal network operating in Nigeria and then during the transfer by land and sea and finally in our territories and our cities.[52] The *Save the Children* document reports gruesome news about the abuse and violence that women are subjected to during the land transfer journey and the sea crossing, by the traffickers themselves, but also by other figures with whom they come into contact.[53]

Once the migrants have disembarked, very few of them are able to declare to the Police Authority and the reception staff that they are victims of trafficking, conversely, they could be monitored and protected in suitable reception facilities; the blackmail, abuse and humiliation they have experienced are so serious that these victims continue to remain subjugated to the criminal network, which will over time start them into prostitution in the sidewalks of our countries and our cities. The control over their lives continues in a strict way, for example with the obligation to take psychotropic drugs or to move continuously from city to city, to evade police control and avoid the creation of close ties with customers or with social workers and voluntary organizations.

But it is not only Nigerian women who suffer this ordeal during the crossing of the Sahara desert, in the routes through Libya and then in the places where they are locked up while they await to be able to embark. The stories gathered in a recent Amnesty International report all tell of group torture and rapes in

[52] Save the Children, *I minori vittime di tratta e sfruttamento: chi sono, da dove vengono e chi lucra su di loro*, edited by V. COPPOLA, E. LO IACONO, July 2016, https://www.savethechildren.it/sites/default/files/files/uploads/pubblicazioni/piccoli-schiavi-invisibili.pdf.
[53] Ivi, p. 11.

Libya.[54] A further "hell" is then represented by the crossing of the Mediterranean on increasingly dilapidated boats, in which women, among other things, are the first victims of the so-called "rubber boat disease". In fact, the rubber boats used are no longer fuelled by diesel, but by gasoline, and while the men are made to grip onto the sides, the women are forced to crouch on the bottom of the boat with babies in their arms. During the journey the petrol leaks out and, combined with the salt water becomes a "devastating mixture" that corrodes the skin "causing deep sores. Terrible chemical burns".[55]

On the gravity of the phenomena described above, the Council of Europe has also authoritatively issued a document prepared by the *Group of Experts on Action against Trafficking in Human Beings* (GRETA).[56] Among the recommendations expressed therein, there is the recommendation for the provision of care for those who are presumed to be victims of trafficking from the moment of their arrival, blocking any expulsion procedure and indeed ensuring that they remain in Italy, in proper facilities; and when repatriation of the victim is possible, it is hoped that this will be voluntary. But in addition to this, the Italian authorities are explicitly invited to develop international cooperation to "fight and dismantle the criminal networks involved in trafficking and to prosecute those responsible".[57] It can also be added that alongside the necessary activity of repression, it is essential to promote information campaigns and awareness campaigns on the risks associated with undertaking this journey and the brutal conditions to which they may be subjected.[58]

b) Considering now the situation of foreign women residing in Italy, especially when they are facing a pregnancy, a fact emerges with sufficient clarity: due to socio-economic disadvantaged conditions, they often have difficulty in accessing pregnancy health services; their children are therefore exposed to a greater risk of illness. An extensive survey carried out in Lazio on about 300,000 births has shown that the risk of giving birth to a very premature baby is more frequent for foreign women and especially for those coming from poorer areas such as West Africa and sub-Saharan Africa.[59] Foreign women,

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[54] https://www.amnesty.org/en/latest/news/2016/07/refugees-and-migrants-fleeing-sexual-violence-abuse-and-exploitation-in-libya/.

[55] P. BARTOLO, L. TILOTTA, *Lacrime di sale,* Mondadori, Milano 2016, pp. 115 ss.

[56] Council of Europe's *Group of Experts on Action against Trafficking in Human Beings Report on Italy under Rule 7 of the Rules of Procedure for evaluating implementation of the Council of Europe Convention on Action against Trafficking in Human Beings,* 30 January 2017, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000016806edf35.

[57] Ivi, p. 21 and more widely pp. 18-21.

[58] Cf. Save the Children, *I minori vittime di tratta e sfruttamento*, p. 40.

[59] Vedi L. CACCIANI, S. ASOLE, A. POLO, F. FRANCO, R. LUCCHINI, M. DE CURTIS, D. DI LALLO, G. GUASTICCHI, *Perinatal Outcomes Among Immigrant Mothers Over Two Periods in a Region of Central Italy*, in "BMC Public Health", 2011, 11:294; M. DE CURTIS, R. LUCCHINI, *It's Time for a New Healthcare Policy in Italy to Improve Prognosis of Newborns of Immigrant Parents,* in "British Medical Journal", 4 April 2010, http://www.bmj.com/content/340/bmj.c468.short/reply#bmj_el_233878.

although younger than Italian women at the time of delivery and therefore theoretically at lower risk, give birth more often to preterm infants, with a low birth weight and with clinical problems. For example, fetal-neonatal hemolytic disease due to RhD alloimmunization is much more common in the births of immigrant women, compared to the births of Italian women. The cause is due to the fact that, in the country of origin, Rh negative group women who have given birth to a child of Rh positive group often have not carried out immunoprofilaxis with anti-D immunoglobulins and consequently in subsequent pregnancies the disease is more frequent. It can be hypothesized that the increased risk observed in this population of newborns depends on a series of conditions linked to the social, economic and cultural disadvantage of mothers during pregnancy(more precarious and heavier work activity, inappropriate diet, poor hygiene and housing, late or inadequate obstetric care).

A significant part of the pre- and post-natal pathology in this at-risk population could be prevented with a more adequate organization of maternal and child care. An important role can also be played by family planning clinics as a place of education for responsible motherhood. It is essential to ensure to all women and their children the full equality of access to services during pregnancy and childbirth, with no differences in ethnicity and social status, with equal dignity and security. In this respect the Italian law fully guarantees the right to assistance for pregnancy and childbirth. However, there is a need to improve information on the services provided to women during pregnancy, also in order to overcome the distrust that may lead many women not to undergo obstetric controls during pregnancy and to adopt harmful lifestyles.

Then there is a more general condition of difficulty and discomfort: becoming mothers during migration involves a double vulnerability, since the external culture of the host country is no longer coherent (or not completely) with the internal one; the external world no longer corresponds to expectations and appears unknown and mysterious; the mother and the group of family women are not present. Hence the loneliness and nostalgia: the confirmations needed by the new mother are also absent and often inadequate messages come from health workers; the husband (if there is a husband) is often in difficulty. This situation determines in many women a strong sense of insecurity, a state of confusion, what has been called "elaborative loneliness", which is the source of many *postpartum* depressions. Becoming a mother, for many women, is traumatic but, what is more serious is that this trauma can be transmitted from one generation to another. What then should be done to reduce the vulnerability of mothers and prevent the vulnerability of children? As will be explained later, in the last paragraph of the Opinion, it seems necessary to strengthen anthropological formation (birth rites, representations of conception, pregnancy, breastfeeding, etc.), to become more aware of the complexity of intercultural communication, to develop new reception methods, to make explicit the reason for our practices, to reinforce, where possible, knowing *other things*, rather than using our knowledge to disprove theirs.

Lastly, a separate matter itself is the domestic, physical and psychological violence that migrant women can be the victims of. Also in this case there are no figures and data to refer to regarding the different communities present on our territory. It is in fact a largely hidden phenomenon, which is difficult to bring to light due to the many obstacles that hinder the possibility-ability to report it: the difficulty for many women to recognize the abuse, especially for those coming from countries with strong patriarchal domination, isolation, language barriers, economic dependence on the spouse, the fear of losing residence permits in the case of women arriving in Italy for family reunification, or being removed from their children and marginalized by the community, etc. If it is not easy for Italian women to turn to anti-violence centres, it is even less so for foreign women. From this point of view, the activity of providing information on subjective rights and support that is taking place locally in many of the associations, structures and organizations is of great importance (e.g. the anti-violence centre The Waves of Palermo, Land Tracks in Imola, the Commission regional equal opportunities of the Piedmont Region), which with different strategies and particular initiatives - including by word of mouth - are battling to help migrant women in difficulty. In this framework the self-organization experiences of immigrant women in some cities should be highlighted, and above all, the work of cultural mediators who, having experienced a history of violence, awareness and redemption, have managed to become protagonists of their emancipation.

4. Interculturality and clinical ethics

4.1 Respect for differences: recognition and limits

In recent decades, the topic of integration policies best suited to tackling the challenges posed by the great multiethnic and multicultural migratory flows has been the subject of discussion in many disciplinary areas, so much so that the literature in this regard is now extremely vast; nevertheless it is worth mentioning schematically some aspects of this debate, relevant to this NBC Opinion.

A key point, from which much of the discussion was started, is in fact represented by the underlining of how an individual or a group can "suffer real damage, a real distortion, if the people, or society that surround them mirror an image of them which limits or diminishes or humiliates them";[60] in other words, the lack of recognition, or the misrecognition, of one's own identity, that is singular and particular (belonging to a particular community, ethnicity, tradition, culture, religion, etc.), can be considered one of the most destructive forms of oppression under way against a minority. In this regard UNESCO, in 2001,

[60] Ch. TAYLOR, *Multiculturalismo: la politica del riconoscimento,* trad. it., Anabasi, Milano 1993, p. 9.

approved the *Universal Declaration on Cultural Diversity*, which states that "the defence of cultural diversity is an ethical imperative, inseparable from respect for the dignity of the human person" (Article 4); by culture we mean "the set of spiritual and material, intellectual and affective traits that characterize a society or a social group", and furthermore it "includes not only arts and letters, ways of life, coexistence, value systems, traditions and beliefs"[61].

If it is therefore true that the promotion of cultural pluralism should now be among the most urgent tasks of Western liberal democracies, we must ask ourselves whether the framework of our constitutional principles can still offer an adequate framework for a policy of non-assimilative inclusion, not "blind to differences "and respectful, within certain limits, of the" cultural rights "of the different communities present in the territory. The answer must be sought in the idea of a human person, perceived by the constituent fathers as the cardinal value in the ordering of the new society, which presents the double character of uniqueness and of relationality[62]: art. 2, the Republic "recognizes and guarantees the inviolable rights of man, as an individual and in social groups where he expresses his personality"; and then, based on the art. 3, "it is the task of the Republic to remove the obstacles of an economic and social order" that "hinder the full development of the human person". In these articles the ethos of rights is combined with an ethos of duties, thus postulating a solidaristic bond between citizens. In the light of these principles, read in evolutionary terms, we can also state that it is the same principle of equality, expressed therein, that calls for differentiated treatments for the most disadvantaged, aimed at mitigating the effects of past oppression and/or actual disparity and to achieve, as far as possible, effective equality[63].

The question therefore becomes: to what extent is it possible to recognize and guarantee the protection of cultural diversity within our constitutional framework? And what are the unassailable limits? The limit can only be constituted by fundamental human rights and freedoms, among which, prominent for the bioethical point of view of the application of biology and medicine, is "the right to their physical and mental integrity."[64] The UNESCO document itself warns that "No one can invoke cultural diversity to threaten human rights guaranteed by international law, nor to limit their scope" (article 4); and again, "everyone must be able to participate in the cultural life of his choice, and exercise its forms, within the limits imposed by respect for human rights and fundamental freedoms" (Article 5). "Hospitality" in relation to other cultures

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61 http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/CLT/diversity/pdf/declaration_cultural_diversity_it.pdf.

62 S. COTTA, *Persona (filosofia del diritto), in Enciclopedia del diritto, XXXIII*, Giuffrè, Milano 1984, pp. 159-169.

63 Cf. A. PIZZORUSSO, voce *Eguaglianza: Diritto, in Enciclopedia delle scienze sociali*, Treccani, 1992, vol. III, pp. 491- 497.

64 In this regard, see the Oviedo Convention on Human Rights and Biomedicine (1997), art. 1 and the Charter of Fundamental Rights of the European Union (2000), arts. 1, 3.

(in the broader sense above) can not therefore extend to practices that violate these rights, such as, just to give an example already mentioned, the different practices of the so-called "Female genital mutilation". Cultural diversity can neither justify the rejection of the protection of the health of children nor the refusal to participate in the protection of collective health, always moreover to be carried out in ways that respect the persons involved.

*4.2 Ethics of rights and "care ethics***"**

Moving on to the more properly ethical plane, in a society open to significant cultural pluralism it is the recognition of the existence of "others", others like us and necessarily different from us, to be considered, that is, in their common and universalist characteristics of being a person, as in their concrete difference and biographical uniqueness, and that, depending on the circumstances, they can ask of us respect and solicitude, help, care or attention, that is, to be recognized and treated in certain ways.[65] The ethical conceptions moving in this direction start out from this more complex conceptualization of moral commitment, re-thought as a work of integration between the ethics of justice and rights and the "ethic of care" (or "taking care"), in a perspective of flexible rules and responsive attention to cultural and relational contexts, to the diversity of situations and to the particularity of each case. This perspective is reflected in today's application of recomposing the various aspects of the individuality of the subject-object of medical care in a knowledge and practice that are able to combine technical expertise and human interest in the person of the patient. There is here an enhancement of the relational dimension, of communicative exchange, within a practice whose purposes are multiple and changeable: restoring a previous state of health, alleviating suffering, supporting and respecting in the therapeutic relationship the ability to self-determination of so-called "patients", but also, sometimes facilitating an evolutionary transformation, an increase of awareness and trust. In this perspective the same principle of "informed consent" can be read as a regulatory principle which, if placed into the reality of medical practice, may encounter difficulties in its application, because in some cases the assumed autonomy of the "adult and competent patient" can turn out to be a simplified abstraction. Autonomy, as a capacity for self-determination, is not something that the subject possesses or does not possess at all, and it is not without degrees, rather it is a human capacity that the social, cultural, relational context can help to develop, can support or instead, depress.[66]

[65] S. VECA, *La penultima parola e altri enigmi. Questioni di filosofia*, Laterza, Roma-Bari 2001.
[66] B. WILLIAMS, *L'idea di eguaglianza*, in Id., *Problemi dell'io*, trad. it., il Saggiatore, Milano 1990, pp. 278-301.

4.3 The care relationship in an intercultural perspective

Merging with the different cultures of origin of immigrants are a plurality of diversified references to medical practices of various kinds, consolidated ethical codes, religious affiliations, local traditions, which are of considerable importance in guiding and conditioning individual (and collective) behaviour, requests for care, availability to undergo certain therapies.

In the relationship with the patient, the doctor uses a body of knowledge that deriving from a scientific and professional formation consolidated over time and from the concrete experience forged within certain cultural and social contexts. We know that even in conditions of a substantial commonality of cultural horizons between doctor and patient, therapeutic choices can give rise to conflicts, precisely because they are inevitably conditioned by multiple factors, that are not only strictly scientific.

Foreigners bring with them a plurality of references to cultures, traditions, religions, thanks to which they lead lifestyles that are sometimes profoundly different from those adopted by the host population; even the requests for therapeutic intervention can sometimes be rather atypical, based on unconventional medical practices, which are not adequately substantiated on the scientific level (and obviously it must be specified that abnormal and not scientifically supported therapeutic requests can also come from Italian citizens).

There are also situations, increasingly frequent in Italian hospitals, which need to be assessed in a cross-cultural perspective that is attentive to differences. For example, the family members of a deceased male Muslim are opposed to the body being washed and dressed by female personnel, considering it an affront to the dignity of the dead relative. Many Muslim patients are opposed to being visited and treated by male health personnel, consenting in some cases only if they are granted the presence of a family member or another woman as a witness. Some women, for example of Muslim faith or from China, refuse to give birth by Caesarean section and so on.

All this undoubtedly represents a challenge for both the convention and statute of care professions, as well as for our health organization. With regard to this last aspect, it is important to underline the importance that a specific therapeutic intervention can have on the sick person and family members, also for the meanings and symbolic value that it takes on (for example, for interventions that in various ways they are related to being born and dying); from this point of view the need of patients and their relatives to express a ritual, linked to specific meanings of living and dying, should also be taken into account, as far as possible, by an organization of services that is respectful of cultural diversity. Included in this important purpose, for the recognition of specificity, is the ability to succeed in places of care to ensure respect for a) different eating habits, starting with the binding prescription for some patients not to have certain foods and drinks ever or only in certain periods of the

year;[67] b) different representations of the time and public holidays, as known variables in the different religious traditions; c) different ways of experiencing and interpreting modesty, to be duly taken into account in hospital rooms and outpatient clinics.

It should be added that even on the epistemological and philosophical level of medicine, it is recognized that the perception of health, illness, corporeity and death is largely forged from past experiences, family histories, meanings from the culture of belonging; hence the opportunity to consider the methodological differences between approaches to health and disease in terms of scientific explanation on the one hand and understanding-interpretation of the patient's experience on the other.[68] Among other things, within a community of foreigners that speaks the same language and comes from the same country you can meet subjects with very different personal stories and cultural backgrounds, from those with a low level of education to those who graduated before migrating. It follows that easy stereotypes should be avoided and the temptation to apply medical evaluations in a uniform way: when dealing with a patient, in fact, one is not faced with a culture, but a person who is the bearer of a culture or many cultures. For this reason, the *patient centred* approach, which in itself has its own justification, in the case of the relationship with the foreign patient proves to be most fruitful.

4.4 Medical ethics and professional deontology

Until recent times, medical ethics has been built around the fundamental value of doing what is best for the patient (beneficence). In recent decades, the question that characterizes this principle and that the doctor is constantly forced to ask himself is what treatment respects the patient's values and the freedom of his choices? If this task, by its nature, demanding, even more difficult is the doctor interfacing with ways of behaving, beliefs, social customs that differentiate the condition of immigrants from that of the integrated citizen in our community. We have already mentioned the recently acquired importance of the principle of autonomy in bioethics and in medical practice. According to this principle, understood in its abstractness, the autonomy of the doctor contrasts with the autonomy of the patient as a person who turns to a professional, not only to seek help or a technically flawless opinion, but in order to use his knowledge and expertise to achieve a free and informed choice. However, in different cultures, the patient's decision-making autonomy is not valued, since the assent to the medical act must, if anything, come from a community decision that is in relation with the patient; for this reason there are patients who explicitly refuse to express their consent or dissent to the medical act, precisely

[67] This theme has already been dealt with by the NBC in the opinion *Differentiated Nutrition and Interculturality*, 17 March 2006.

[68] A. PAGNINI, Introduction. *Prolegomeni a una medicina come scienza*, in Id. (edited by), *Filosofia della medicina*. *Epistemologia, ontologia, etica, diritto*, Carocci, Roma 2010, pp. 17-47.

because the concept of autonomy is not perceived as being relevant. It is not so rare that especially female patients delegate decisions about their health to their husbands or other male relatives. In some cultural contexts, especially in Africa, it is the entire family group or the tribe they belong to that makes decisions about the individual.

An intercultural approach must certainly take account of this and of the value assigned to the community dimension; however, precisely because such an approach is not limited, so to speak, to depicting diversity and reinforcing it, it can be productive for a cultural perspective that favours the community bond to also consider the value of personal autonomy (and vice versa, it can be fruitful for those who strongly emphasize the value of autonomy to decline it rather in terms of *relational autonomy*). Moreover, it is the same *Code of Medical Deontology* (2014) that wants to reconcile these different but not necessarily contradictory instances: it being understood that, the patient's expression of his consent (or dissent) to the medical act is a priority, to be implemented "in written and signed form" (Article 35), and that this is aimed at "comprehensible and exhaustive information" on the part of the doctor (Article 33), the Code contemplates the possibility of "information and communication to third parties ", with the consent of the patient (Article 34), as well as the patient being able to "delegate to other subject information "(Article 33).

The importance of parental and community ties here seems to find a possible enhancement, though - it should not be forgotten that - the origin of the decision to inform and even delegate other is the expression of the patient's autonomy. Doctors and care professionals are therefore called upon to encourage the formation of an autonomous decision-making awareness on the part of the patient, however involving the circle of relatives and friends, in a complex balance, especially on the concrete level of clinical practice, of principles and instances.[69] What is to be avoided, above all, is the defence of the value of the community from becoming an excuse for perpetuating forms of dependency, even highly accentuated forms, of the female on the male, and more generally forms of dependency of the individual subject on the group. Appropriately, the *Universal Declaration on Bioethics and Human Rights* (2005) UNESCO[70], the representatives of developing countries have contributed decisively to the drafting, recognizing that "the importance of cultural diversity and pluralism must be given the right emphasis", stating, however that, this can not be a pretext for "violating respect for human dignity, human rights and fundamental freedoms, neither the principles established in this Declaration, nor

[69] The NBC Opinion on *Pharmacological trials in developing countries* 27 November 2011, addressed the same question arguing that "the involvement of other figures in the process of disclosure of informed consent is acceptable and understandable, but it can never replace free personal expression".

[70] The Italian version is published in *L'Unesco e la bioetica. I testi fondamentali*, Center for Ethics and Law in Biomedicine 2008, pp. 20-28, https://celab.ceu.edu/sites/celab.ceu.edu/files/attachment/basicpage/29/italiantranslationfinal.pdf.

to limit its scope "(Article 12); with regard to consent then, it states that: "Any preventive medical, diagnostic or therapeutic intervention must be carried out with the prior free and informed consent of the person concerned, based on adequate information" (Article 6).

However, the complexity does not only concern the principle of autonomy, but also involves the principle of justice: for example, to what extent, can respect for cultural diversity which may require diversification of care, and, in all probability, entails an increase in health expenditure, be acceptable?

To the new questions regarding the recognition in the medical and health field of differentiated rights we must find rational and shared responses. An answer in this direction can certainly come from a progressive increase in intercultural competences of those who in various capacities are involved in the care of the patient (doctors, nurses, midwives, ...), as well as from the involvement of intercultural mediators (supported by interpreters), especially in particular therapeutic settings. The health organization should also bear in mind that often the mere requirements of efficiency, with their consequential bureaucratic automatisms, can result in the distancing of the service provided form the real needs of people, especially those who are bearers of different or particular medical conditions.

The reaction of health professionals to the issues raised by the phenomenon of multiculturalism is probably not different from those present in society as a whole. They range from declared hostility to unconditional reception. Both behaviours, those inspired by a perspective of assimilation, which refutes the attribution of any value to differences, as well as the merely relativistic one which recognizes all differences, even those that are problematic or even threaten physical and mental integrity, are to be avoided, because they are in fact an obstacle to good care[71].

But how can we understand each other? The terrain of understanding between different cultural horizons can be found in the comparison of symbols, with the underlying conceptions of value that they possess. In the encounter with different cultures, medicine should acquire the art of narrative knowledge, to better understand the needs of patients and the significance of their being taken into care.[72] It is not a question of renouncing the expertise made possible by *Evidence Based Medicine*, rather it is a question of integrating it with other skills. This is a strongly felt instance, especially as regards clinical practice, by those who would like to introduce *Medical Humanities* into the academic training courses of future doctors and health professionals; under this profile, medicine is also considered as "art", as a knowledge of how to treat the asymmetry of the doctor-patient relationship, activating communication paths through the "narration" of illness and suffering. In this way the doctor tries to promote a

[71] This thesis is already clearly supported in an opinion by the NBC, which dates back to 1998: *Bioethical problems in a multi-ethnic society.* See also the 2003 opinion on *ritual slaughtering and animal suffering.*

[72] G. BERT, *Medicina narrativa,* Il Pensiero Scientifico Editore, Roma 2006.

cultural relationship, to decipher codes of expression, ways of relating to illness and pain that are sometimes distant from our mentality.[73] It would be equally important to promote medical training[74] that considers the influence on individual and collective health exerted by various determinants (socio-economic, demographic, environmental determinants, ...) and the interconnections between globalization and health, with regard to the respect of equity and human rights.

The reference not to underestimate the importance, also under the therapeutic profile, of cognitive and empathic attention to the biographical aspect of the disease - in the English language *illness* is the disease experienced, while *disease* is the disease in the organic sense - it is also a distinctive element of that vein of medical anthropology, of phenomenological orientation, which conceives the "body" as the foundation of subjectivity and experience of the world. In this perspective, the narration of the disease, as part of the therapeutic interview, and the consequent possibility of connecting imaginatively experiences and events in a story, with many variations, full of subjective meaning, becomes an essential moment of the "cure"[75]. These characteristics of the relationship between the practitioner and the foreign patient therefore recall how important it is for every professional-patient relationship, and indeed medicine itself, to be, as mentioned, *patient-centred*.

A commitment is thus made for the doctor and for the various health professionals, that is to update and implement medical ethics, considering foreign patients, as well as Italian patients, in their entirety, being made up of relationships, beliefs, habits, customs and religious rituals, and trying to understand their experience of suffering. It is an unavoidable commitment, which also is a challenge for the Professional associations and their various deontologies. The deontological codes in force of the most common care professions (physicians, obstetricians, nurses) are strongly convinced of the duty to protect the health of every individual, without any discrimination and regardless of cultural or ethnic affiliation; moreover, the duty to assist every human being finds an additional specification when the individual is in

[73] M. MARCECA, M.L. RUSSO, *Il paziente straniero*, in “Salute e Territorio”, 2012, n. 191, pp. 124-128.

[74] According to the proposal of the RIISG (Italian Network for the Teaching of Global Health), which includes academic institutions, scientific societies, non-governmental organizations, associations, groups and individuals involved in training in global health, both at university level and civil society . It should also be borne in mind that with the growing number of immigrants in our country the problem of the treatment and control of communicable diseases or parasitic etiology has resurfaced, diseases that are of clinical importance and social relevance for public health control. In order to respond to the cultural needs for in-depth analysis and updating on the clinical, epidemiological and control aspects of these diseases, which are generally related to the poverty of developing countries of origin, specific training of health personnel is necessary. This is the subject of the disciplinary branch of "Tropical Medicine", whose contents are now better included in the broader denomination "Medical Geography", which clinically integrates the study of the relationship between man and environment and diseases.

[75] B.J. GOOD, *Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente*, trad. it., Edizioni di Comunità, Torino 1999.

conditions of fragility, vulnerability and need[76]. And yet, the Codes lack explicit reference to issues of interculturality and the duty of the professional to understand the different cultural identities of affiliation of patients. This is a shortcoming that needs to be addressed, to highlight how attention by the professional to specificity, even to the cultural specificity, of the patient, makes the intervention of care more respectful, complete and effective.

Recommendations

- The NBC recalls the responsibility of the international community on the phenomenon of migration and on the causes that are at its origin; furthermore, with a view to effective international solidarity, it invites the community to share the commitment, demonstrated in recent years in an exemplary manner by Italy, to save countless human lives and guarantee respect for the right to health as a fundamental and universal human right.

- With regard to the effective implementation of the State-Regions and Autonomous Provinces Agreement of 20.12.2012, the NBC recommends strengthening the coordination and guidance role of the Ministry of Health: to avoid as much as possible inconsistencies both in terms of interpretation and application of the rules intended to protect the health of all foreigners, those with a regular residence permit, as well as applicants for international protection, those in transit or temporarily present.

- It also recommends that the provisions of the State-Regions and Autonomous Provinces Agreement of 20.12.2012 be implemented as required by Law 7.4.2017, n. 47, regarding registration with the Regional Health Service of all minors, regardless of their administrative status, and especially those in conditions of vulnerability or unaccompanied foreign minors (MSNA), foreign minors temporarily present (STP) and EU-citizen minors without health coverage in their country of origin (ENI - non-registered European), providing for exemption from the prescription charge (national single code) to make the health services really usable.

- It recommends rapid development of adequate accounting and reporting procedures on the actual costs incurred by the NHS for the health of the irregular immigrant population, in order to measure the amount of public resources used. These methods are necessary not only for internal purposes, to promote a precise knowledge of the phenomenon, but also for reasons relating to relations with other states; they are in fact an indispensable instrument for the request for reimbursement to the states of origin, although these may be insolvent countries. In addition, knowledge of the total amount of expenses not reimbursed to the Italian state also would highlight the efforts made by Italy for

[76] For the *Codice di Deontologia Medica* (2014), see in particolar art. 3 and art. 5, 8, 32. For the *Codice Deontologico dell'Infermiere (*2009) see art. 4; and also art. 2, 3, 6, 32, 33, 34. With regard to *Codice Deontologico dell'Ostetrica/o* (2010, 2014), refer above all to art. 2.1. e 2.2., in addition to art. 2.13., 3.1.

the health of people who migrate to Europe, this spending actually also benefits other EU countries, especially those to which migrants in transit on Italian territory are destined. These costs should therefore not be fully borne by the Italian NHS, but should also be considered in the context of European solidarity.

- The NBC proposes the establishment of a dividend on the resources of the most industrialized states, to be paid into an institutional fund to ensure decent living conditions for those who live in the poorest countries.

- It denounces the seriousness of the conditions to which migrants are often subjected, and especially women in their long trips to flee their homes and their countries; these degrading conditions, which strongly affect their state of health, both physical and mental, may include the dramatic experiences of arbitrary detention, torture, sexual violence, prostitution under blackmail, experiences that may also occur in Italian territory (for example perpetrated by smugglers in Italian territorial waters). Also in consideration of this, the NBC calls for the crime of torture be introduced into our legal system and that it should be properly sanctioned.

- The constant and consistent presence of women who have repeatedly suffered violence during the journey of arrival in Italy, often for long periods – lasting months and sometimes years – and who fall pregnant as a result of forced sexual relations, elicits the requirement for specific forms of reception. It is in fact necessary to find methods and trained personnel to help them first of all to disclose the violence to which they have been subjected, in order to allow treatment of the physical and psychological damage, and to adequately face the birth of a child conceived in these circumstances in such a dramatic situation. Indeed, the care for their condition must allow them to resume their lives in the most normal way possible, without past traumas becoming an insurmountable obstacle to every form of insertion and future project.

- In relation to the severity and diffusion of the phenomena of mental illness and psychopathological disorders affecting migrants, due to the great suffering arising from the particular conditions of the transfer, and which may continue during the stay in our territory, the NBC recommends that In addition to urgent measures, in-depth psychiatric research should be promoted, with particular regard to post-traumatic stress disorder, as requested by the experts in the sector.

- The NBC recommends strengthening the commitment to health education, including enhancing the functions of some services, such as family counselling and mental health services; proposing adoption of the most appropriate measures to improve health information, for example with the use of easily understandable forms, with translations and graphics for those who are not schooled; calling for the provision of vaccination coverage for the age groups concerned; and also calling for the provision of appropriate and widespread awareness-raising initiatives and intervention in the territory, aimed also at preventive health care.

- It recommends a progressive increase in the intercultural competency of NHS workers, so that in their regular professional practice they are able to relate appropriately to immigrant patients, through an increase of knowledge on the socio-health problems of the countries of origin and also thanks to the involvement of intercultural mediators, in particular therapeutic settings; to this end collaboration should be promoted with those who, even in the private, social and voluntary sector, have gained specific experience in the field over time; the linguistic skills and professionalism of physicians and other migrant socio-health workers must also be enhanced, in the context of facilities with a greater migratory impact.

- It also recommends making provision, within university training courses addressed to future doctors and health professionals, for appropriate enhancement of *Medical Humanities* and the studies and research concerning consideration of the therapeutic relationship in an intercultural perspective.

- It recommends implementing information on epidemiological data related to the health of immigrants, as well as data on the economic contribution and the contributory capacity that they provide: this in order to increase critical awareness of the problem and avoid prejudices, unjustified fears and stereotypes about "immigration diseases", which can promote marginalization and hinder social integration.