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Migration and Health from a Public Health Perspective

Maurizio Marceca

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Abstract

One of the main dimensions related to migration is that of health; this correlation is dynamic by nature and complex. Health is strongly related to the social determinants of health (job, income, education, and housing). When not properly supported by appropriate inter-sectoral policies, migration can expose the most vulnerable socioeconomic groups to significant problems. The protection of the health of migrants is an important investment of the public health because it promises benefits to both migrant population and natives. An essential aspect is to properly analyze the health needs of ethnic minorities. Both quantitative and qualitative research is necessary, and the involvement of the target communities is important. Another important aspect is the education and training of social and health workers involved in the care of migrants (with a multidisciplinary teamwork and “transcultural” approach), and the organization of services that can effectively be used. Finally, it is also essential to carry out an evaluation of health outcomes of the migrant population and the impact of adopted health policies. Protecting the health of ethnic minorities is both a challenge for governments and a test of the quality of their health systems.

Keywords: Italy, migration, immigration policies, legal/regular/documented migrants, illegal/irregular/undocumented migrants, health, right to health, health needs, health inequalities, public health policies, public health system

1. Introduction

Since ancient times, migration has been practiced by our species. Some modern scientific technologies (in particular paleogenomic analysis on the haplogroups of mitochondrial DNA and Y chromosome) have enabled us to reconstruct approximate times, directions, and sequences of the movements of *Homo sapiens* across the planet. This migration, known as “Out of Africa II,” seems to have started some 70,000 years ago in North-Eastern Africa and is likely to have been caused by the search for better living conditions, for example, plentiful food, a better

climate, more comfortable and safe environments, an impulse which continues to drive migration today [1, 2].

In the modern era, human migration has been one of the primary forces shaping the nation as we know it today, for example, in the case of the USA or Australia. In other countries and within other times and modalities, human migration was among one of the main social changes of the last century. This is especially relevant to the European continent. Where in some countries (such as England, France, the Netherlands, and Portugal), immigration has essentially represented a “returning” movement induced by colonialism, especially since the end of the nineteenth century. In other countries in the contemporary era, this phenomenon arose mainly in response to the need for foreign labor—initially a semi-skilled and unskilled workforce—and was embedded within older (e.g., in the cases of South Africa, Argentina, Uruguay, Brazil, Belgium, and Germany), or younger (e.g., in the cases of Italy, Spain, Sweden, and Greece) migratory dynamics. Different countries, such as Italy and Spain, passed through distinct historical migratory phases: from being countries of emigration to countries of destination. In this case, these shifts took place after an economic boom and the resulting social growth after the second half of the twentieth century.

While the migratory phenomenon has been widely examined from historical, social, economic, and cultural perspectives, health and healthcare perspectives are understudied. This is a problematic oversight because health is one of the most important aspects of migration. This correlation between “health” and “migration” is in itself dynamic and complex. It is dynamic because it is extremely heterogeneous (there are many different migrant communities) and it is variable, in both the diachronic and synchronic sense: prospective and evolving immigrant generations will experience different socioeconomic conditions in their country of origin and in the destination countries, and they will ensue different possibilities of integration. It is complex—as discussed by an editorial of the medical journal “the Lancet” in 2006—because its primary dynamics influence different migrant communities in various ways. A possible interpretation of this variety and complexity is that of gender because of a multiplicity of health risks linked, for example, to potentially dangerous and violent conditions in the workplace, different discrimination and racism in the destination countries, and so on [3].

Since the 1970s, some epidemiological studies comparing mortality and chronic diseases, especially the cardiovascular ones, between immigrants and natives,¹ have revealed the effects of the environment (e.g., certain diets) and those of the socioeconomic conditions (e.g., income). These studies have contributed to the so-called social epidemiology, and continue today to fuel the scientific debate [4].

When contemplating how to ameliorate the health conditions of migrants, it is possible to adopt a logical framework which considers the various possible stages embedded within a migratory journey [5]. Schematically, the health of a migrant depends on his/her living conditions in the country of origin (pre-departure), on experiences during the travel and the even-

¹Throughout the chapter, the term ‘natives’ is used in a general sense: i.e. “people who were already living in that place.” Talking about Europe and the European Union, “native Europeans” are referred to; talking about Italy, “native Italians” are referred to.

tual intermediary stages of this travel (interceptions) and, lastly, on the living conditions in the destination country, the primary stage of interest in this analysis [6].

In relation to the pre-departure phase, we have to consider the geopolitical and socioeconomic conditions in the country of origin, as well as the personal and familiar position of the migrant (with a specific focus on the level of education and income). This approach allows for an easy localization of the so-called push factors, those factors which trigger the decision to migrate. Talking for instance the tragic state of affairs in Syria at this time, we can say that the situation of the war has produced an exodus of millions of people, many of them having a medium to high level of education and good economic resources. In considering the possibility of existing diseases in the country of origin, although it is possible to find people already affected by diseases in populations forced to migrate due to wars or persecutions (which is generally the case where international protection is concerned), it is usually rare in those populations migrating for economic reasons. Indeed, a good state of health is usually a fundamental prerequisite for a migrant, especially in the case of first-generation economic migrant. This is due to the fact that being physically active and psychologically “strong” (especially when considering the capacity of adaptability to a new context) are the main sources of strength, which will determine the success of the migratory endeavor. This reasoning, which has been verified by epidemiological data (e.g., the minor mortality rate of migrants in relation to the local population [17]), is at the basis of the so-called healthy migrant (or immigrant) effect. This theory posits a kind of self-selection of the healthy individuals prior to the departure from the country of origin. This is of course not a universal and systematic mechanism. However, it is nevertheless evident that youth, a predominant feature of the larger majority of people migrating for economic reasons, provides a protective barrier for one’s personal health. Moreover, within the logic of a larger non-nuclear family, it would make sense to allocate communal economic resources to those possessing good health and the capacities to face unexpected situations, generally the younger members of the family. Following this logic, these members would maximize the possibilities of migratory success, and, as a result, are most likely to return the support in the form of remittances from the destination to the origin country.

The phase of the travel can last from a few hours (e.g., a flight, or a ride on the bus or in a car) to many months. This diversity engenders a great variability in terms of health risks. Generally, a migrant who is in the condition to enter regularly and legally another country does not encounter any risks. Conversely, the travel of the so-called forced-migrant (seekers of international protection due to humanitarian and environmental threats) is full of latent dangers, which are usually unpredictable in their times and modalities. These dangers are usually minor if the person is able to pay the so-called human traffickers. In recent years, for example, the Mediterranean Sea has become a graveyard for thousands of people who tried to cross it through various makeshift means, or in overloaded and unsecure boats, leaving them at the mercy of the sea, storms, and ruthless “people smugglers.” The blog “Fortress Europe,” which compiled the accidents documented by the international press over the last 30 years, calculated that since 1988 to January 2016 27,000 people have died along European borders, with 4273 dying in the year 2015 alone. As news of shipwreck survivors has been extremely rare, it is possible that the real numbers of dead may be higher still [7]. According to the

International Organization for Migration, of the total number of 250,000 people who landed on the Mediterranean coasts in 2016 (data updated at the end of July), more than 3000 died (to be exact 3034) [8]. When people do not perish while travelling over land or at sea (e.g., dying of exposure in cold storages, or asphyxiating inside commercial trucks where people place plastic bags over their heads so that the border police would not find any CO₂ emissions), the extreme conditions of travel still place a person's health at high risk. For instance, extreme dehydration (when a migrant does not have sufficient liquid intake), or immersion in gasoline while travelling by boat (liquid usually mixed with urine which becomes a particularly aggressive irritant for the skin) often generates severe burns [9]. Other times, health risks are magnified by the intrinsic vulnerability of the migrant during travel, for example, in cases of pregnant women, infants, and disabled people.

Frequently, some "obligatory" interceptions occur when migratory routes are not agreed upon between countries of origin and destination, the circumvention of which then depends upon the contractual economic power and organizational skill of the migrant him/herself. These "obligatory" interceptions are generally dangerous for the life and the health of the migrant who risks exposure to various forms of exploitation and extreme violence. For example, a large majority of the migratory routes from Sub-Saharan Africa must pass through Libya, where many people are taken and imprisoned in inhumane conditions, held captive until a ransom is paid by the relatives of the migrant (who are contacted by phone with the desired demands). Many women face individual or collective rape, which may be repeated over time. Beyond the unintended pregnancies, the reason for which many female migrants start taking hormonal contraception before departure, there is also the serious risk of contracting sexually transmitted diseases. A less severe form of suspended migration, which is nevertheless a source of deterioration of the migrant's health, happens when, following the Regulation of Dublin III, the asylum seeker is kept in (or taken back to) the first country of entry in Europe [10]. The inability to arrive at the initially planned destination, a decision usually dictated by the intention to reunite with family members living in European countries, can have negative impacts on the health of a migrant. The same situation of the "undesired stop" can happen to economic migrants who are not allowed to cross a European border, especially when the politics and application of European norms are particularly rigid. Historically, different migratory "waves" organized their intermediary stops depending on various strategic or logistical opportunities. This is, for example, the case with a consistent portion of Polish emigrants in the 1980s and 1990s. Although they wanted to reach North America, they passed through Italy because there was a strong network of religious institutions sympathetic to the Polish people because at that historical moment the Pope was one of their fellow countrymen, Kairol Jozef Wojtyla.

The last migratory phase takes place in the country of destination. There, in most cases, new generations will be born, family reunions will happen, and newly arrived migrants will join preexisting communities. Here, the health of the migrant will be determined largely by the outcome of his/her social integration and by the success (or lack thereof) of his/her migratory project.

The most effective theory to analyze health dynamics of migrant communities in destination countries is using the "social determinants of health." This examines the impact that

fundamental socioeconomic and cultural factors have on the health of a person, for example, education, income, type of work, housing conditions, diet, access to water and hygienic services, the possibility to access sanitary services, the presence and strength of a social network (social cohesion) [11]. When the exposure of the migrant to these determinants (in particular the income) is positive, a kind of virtuous circle is activated, supporting and protecting the health of the person. For example, when employment is found quite rapidly, so as to become a stable source of income, the migrant is able to sustain a dignified living. If he migrated by himself, there is the possibility to bring his family to join him, pay for living expenses (e.g., food, children's education, public or private transportations, etc.). *Vice versa*, when the socioeconomic integration is difficult, and it is usually worsened by an inadequate knowledge of the language of the host country, the migrant will be exposed to physical and psychological risks and experience health inequalities [12]. Inadequate nutrition, precarious housing with poor hygienic conditions, and the emerging feelings of failure, solitude and anxiety, concerns about the family living far away, are difficulties that need to be dealt with. In these cases, it is important to remember that many migrants have undertaken significant debts to pay for their travel, debts from which they must extricate themselves precisely when the state of their settling is at its most delicate and precarious. In the end, the accumulation of all these difficulties and obstacles (sometimes exacerbated by exposure to exploitation, discrimination, violence, and racism) produces what is known as the "exhausted migrant effect." Whether the migratory project is successful or not, the objective criteria of sanitary protection are extremely important, in terms of both prevention and assistance in the host country. This usually depends on the concrete juridical recognition of the right to health and of its eventual limitations.

In other words, health and its promotion depend upon the capacity to express inter-sectoral protective and convergent policies. Beyond this, the health sector alone could play an important role in favoring and guaranteeing access to usable services.

As we will attempt to demonstrate in this chapter, the protection of the health of migrants (independently of their juridical status!) is a form of investment typical of a National Public Health System. This investment generally produces positive spillovers on both the direct subjects (migrants) and the local communities (natives).

2. Migrants' right to health at the international level

The ethical-legal perspective is inevitable when addressing the issue of migrants' health [13]. It is clear that the recognition of the protection of health as a universal right, unconditionally held by every individual without the constraints of meeting specific requirements (such as citizenship or residence permit), is the basis of policies and of any possible forms of protection at both global and local level.

There is an identifiable thread, connecting the different statements from various important institutions regarding the issue of immigrants' health expressed at an international level [14]. Some deal with this issue indirectly, for example, the various conventions, recommendations, declarations, action plans, which, from the 1950s until the present, have included different

categories of subjects (e.g., workers) and “vulnerable” populations (e.g., women, children, the disabled, the elderly, refugees, and displaced persons), and stress the need to avoid discrimination of these groups [13, 15]. Other documents deal with this issue, again indirectly, by considering health as one of the various dimensions that characterize international immigration and development.

Others identify this theme as a central and specific issue. Among them, and of particular prominence, is the Resolution of the 61st World Assembly of Health, which invites the Member States to promote and support various lines of intervention. Among these lines is an invitation “to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race” [16].

Focusing solely on the European context, it would be useful to recall, inter alia [17–19], three documents.

In September 2007, the Conference “Health and Migration in the EU: better health for all in an inclusive society” took place in Lisbon (during the period in which Portugal held the Presidency of the European Union (EU)). The Conference produced some very interesting Conclusions and Final Recommendations. It upheld the following assertions:

- immigrants represent a resource for the European Union; European migration policies have to be re-defined;
- universal access to healthcare assistance has to be seen as a prerequisite for European public health and is an essential element for its social, economic, and political development and for the promotion of human rights;
- immigrants’ health protection must not be seen solely as a humanitarian cause, but principally in terms of the need to reach the highest level of health and well-being for all in Europe.

The final messages of the Conference can be summarized as follows:

global problems require global solutions, and health and migration are two global phenomena which require urgent global responses of which the EU should assume a leading role, and the reduction of poverty and the promotion of the integration of immigrants are key initiatives which must be undertaken.

Given that the lack of access to qualified health care is a central issue for immigrants, the Conference recommended the prioritization of equal and culturally sensitive access for all immigrants. Strengthening cooperation with the aim of fulfilling essential health needs is crucial for preventing disease and ensuring better health everywhere in today’s globalized world context, and urgent political decisions should open the way to practical solutions [20].

Less than 2 months later, the Eighth Conference of the Ministers of Health of the 47 countries of the Council of Europe took place in Bratislava in November 2007, with the title “People on the Move: Human Rights and Challenges for Health Care Systems,” at which the “Bratislava Declaration on health, human rights and migration” was approved [21]. The Declaration, recalling other statements such as the European Social Charter, and demonstrating a systematic

interpretation of the binomial “health and migration,” set out 20 areas of duties “to address the challenges that human mobility generates for human rights within the health field and for health care systems...”

With reference to the right to health, the Charter stresses that:

We, the Ministers of Health of the forty seven member states of the Council of Europe [...],

ARE RESOLVED TO:

1. *Focus on ethical and human rights aspects when addressing health issues of people on the move through cooperation with other international organisations, including NGOs; [...]*

AND TO THIS END RECOMMEND TO [...]

2. *continue to promote policies incorporating the ethical, social and human rights dimension into health policies, taking account of specific needs of vulnerable groups, including migrants;*
3. *strengthen the Council of Europe’s role as a guardian of human rights and social cohesion by including the components of solidarity and intercultural dialogue in European health policies, encompassing migrants, refugees and other “people on the move”;*
4. *invite the European Health Committee (CDSP) to take into account, in its future work, the ethical and human rights dimension of migration including an international code of ethics in health care for “people on the move” [...] [21].*

Finally, in March 2011—due in part to the support of various NGOs [22–24]—the European Parliament approved a “Report on reducing health inequalities in the European Union,” exhorting the Member States to confront the inequalities in access to health care, including those faced by illegal/irregular/undocumented immigrants, especially pregnant women and children [25]. It emphasized that

“... health inequalities are not only the result of a host of economic, environmental and lifestyle-related factors, but also of problems relating to access to healthcare” (point P)

and that

“... in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for illegal / irregular / undocumented migrants” (point AD). Among other recommendations, the European Parliament called upon the Member States

“...to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare;

...to assess the feasibility of supporting healthcare for illegal / irregular / undocumented migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation” (point 5);

“...to promote access to high-quality legal advice and information in coordination with civil society organizations to help ordinary members of the public, including undocumented migrants, to learn more about their individual rights” (point 8);

and

“...to ensure that all pregnant women and children, irrespective of their status, are entitled to and actually receive social protection as defined in their national legislation” (point 22).

In summary, it would appear that, in light of the events of the last decade, a common understanding has developed at an international, and, more specifically, the European level, regarding the complex background and consequences of human mobility and health. This vision may be interpreted as being based upon the principle of the right to health, conscious of the significance of incorporating within government policies not only an ethical but also a social dimension, and paying special attention to the most vulnerable groups of immigrants. The perspective has to be culturally sensitive and inter-sectoral [14].

In spite of the clarity and completeness of this vision of the migratory phenomenon, when it comes to its implications it is necessary to emphasize the precariousness and the uncertainty of the processes of implementation at the local level, taking into account the non-binding nature of these pronouncements. More specifically, the European Union does not have any coercive influence upon the individual Member States in regard to the health protection of immigrants, due to the “principle of subsidiarity,” which implies that intervention by the European Community is only mandated when the goals of the planned action cannot be sufficiently achieved by the single Member States acting alone [26].

Moreover, it has been noted that the current economic and financial crisis regrettably poses a significant risk to the application of these statements regarding the right to health. An example of this problem is the restriction of health care for immigrants and, even more notably, the stigmatizing approach of labeling immigrants as a source of infectious risk for the native population, including health as a pretext for deportation to the countries of origin, as occurred around 2012 in Greece, a country that is the “symbol” of the current European crisis [27]. More generally, it must be recognized that the right to health and to health protection of migrants are adversely affected by demagogic and populist, if not openly racist, ideological orientations [4].

In several countries, the purported non-sustainability of healthcare costs for migrants is used to justify closure policies, which are more concerned with electoral response than actual policy reform. In reality, it is more often the case that immigrants, through the payment of taxes, contribute more to the socioeconomic well-being of their host countries than what they receive in terms of services, including publically provided health care [28]. In other countries, racist announcements are circulated to attract large groups of people who are drawn in by sensational and dramatic media coverage, and consequently frightened in adopting an “us versus them” mentality.

In modern and contemporary history, the phenomenon of human mobility has met, and continues to meet, obstacles and resistance that have obvious repercussions on the health promotion and healthcare provision. These complications are particularly related to defining and protecting boundaries, which consequentially draws on the idea of the Nation-State, to the perception of a threat to cultural, ethical, and religious values of the host society and to its socioeconomic stability, to fear, or to open hostility toward those who are different. This, paradoxically, is often done without distinguishing the different types of migrants, even

involving asylum seekers and refugees, which should be better protected by international conventions and laws.

2.1. General considerations regarding the approach to the health needs of migrant communities

Together with the importance to recognize the right of migrants to the protection of their health (the ethical-legal dimension) by various countries, the health of migrants' communities is linked to the level of efficiency regarding the interventions targeting them, the so-called techno-operational dimension. These interventions (which make up the "health service offer") should be consistent with the "health needs" and healthcare needs of the immigrants and with a verified clinical efficiency, which is valid from an appropriate scientific point of view.

The possibility of obtaining reliable data on migrants' health, based on health determinants and on the usage of sanitary services, and being able to correctly interpret these data, is an essential pre-condition to identify their health needs in order to offer appropriate and accessible sanitary services [19, 29].

Collecting the different levels of "demand for assistance" is not sufficient by itself, nor does it generally reflect the true health needs of foreigners. Aside from the fact that the demand for sanitary assistance can stem from people who usually have no medical or scientific knowledge, this demand can also be influenced by sociocultural and psychological variables. This implies that the demand itself is affected by the level of language competency, "health literacy," and the diversified knowledge of the sanitary system's organization (which determines the configuration of the "offer"). This is also evident for native groups, but in the case of immigrants, the influence can be even greater. For example, within immigrant populations, a higher level of inadequate usage of sanitary services has been recorded (both in the cases of over- or under-usage) [30]. When considering primary and secondary preventive care, the offer of sanitary services cannot be contingent upon the demand. In other words, when people are healthy (whether in appearance or in fact) they do not perceive any health needs, particularly if they lack available information and knowledge. But the preventive care culture varies from country to country, and normally it is weak or even absent in the countries of origin of most migrants. For example, it has been demonstrated that some groups of migrant women have minimal familiarity with oncological prevention, which is widely practiced in the receiving countries, such as screening for the presence of a carcinoma of the uterine cervix by performing the Pap test. It has been observed that, in the case of a positive test result, the carcinoma of a migrant woman is at a more advanced stage than that in a native woman, due to the delay of screening [31]. Therefore, it is important that sanitary systems implement "active offer" interventions, which is provided by the sanitary system and is free of charge for these so-called hard to reach groups in order to reduce or eliminate the greater risks they usually face. Another example, where better information and prevention would improve health outcome, relates to occupational health risks (especially occupational health hazards in the construction sector in the timber or leather industries). In this case as well, it

has been demonstrated by studies enquiries that migrant workers are more vulnerable than the local populations [19, 30].

In both examples and in the international context, the availability of data of a current health information system has made it possible to gather evidence that migrants encounter greater health risks than natives. In fact, using this system, it was possible to disaggregate reliable data relating to immigrants and compare them with the group of natives or with specific subgroups of immigrants. The publication of these data is the fundamental basis for expressing scientific evidence-based guidelines, diversifying them for different immigrant groups [32–34].

It is no coincidence that the Resolution of the 61st World Health Assembly cited above mentions in its invitations to the Member Countries the following aims: *“to establish health information systems in order to assess and analyse trends in migrants’ health, disaggregating health information by relevant categories”* [...] and *“to gather, document and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit and destination”* [16].

The possibility of conducting quantitative research, which could allow for an evaluation of the health needs of migrants, depends on the following:

- the local cultural sensitivity in relation to the importance of data/information; the availability of reliable databases (e.g., a national statistics institution);
- the activation and the maintenance of qualitatively good and reliable sources of sanitary information;
- the presence—in the abovementioned informative systems or in other “record-linkage” systems—of useful information to more appropriately interpret existing sanitary data (e.g., aside from the country of origin, citizenship, and nationality/ethnicity, also religion and language); and
- the identification and construction of valid and powerful indicators to be used internationally [35].

This need can clash with a scarce epidemiological culture or with techno-managerial difficulties (e.g., the unavailability of adequate computer systems), with institutional public concerns related to the right to privacy and the correct usage of sensitive data, or with resistance by health personnel to correctly and systematically register information. Although extreme caution on the part of competent authorities is understandable, it is necessary to convince the authorities that, in relation to the right to privacy and to the legal usage of sensible data, this information can allow for preventive care intervention, and thus protects the migrant communities. For example, the registration of a familial migratory history of third-generation subjects could pinpoint to psychological risk factors. Without collecting these data, these factors would not be highlighted. This transparency of data would permit certain targeted socio-sanitary interventions to be realized.

Another aspect of interest is the homogeneity of information registration to allow for a comparison of the data at the international level. Regarding this issue, there are some generally

well-consolidated data gathering practices concerning certain health variables and areas, for example, general or case-specific mortality rates, data on the frequency of transmissible or non-transmissible diseases, data related to hospital admissions or vaccination practices, and so on. There are other areas that are less “explored” due to lack or limits of specific information sources, for example, that of primary care or rehabilitation.

Importantly, the possibility of connecting certain health variables, such as suicide or psychological problems with socioeconomic variables, for instance education, income, residence, length of permanence, level of language, social networks and degree of social connection would be extremely useful. Unfortunately, this is often impossible to implement because of a lack of attention to the importance of social determinants of health. It would have great potential allowing research in the field of so-called social epidemiology to be conducted. It would reveal the existence of inequalities in relation to health and sanitary assistance and interpret their dynamics when considering migrant communities.

Aside from the continuous availability of databases and related health information systems, it can be useful to conduct occasionally “ad hoc” enquiries in order to evaluate health needs. For example, some enquires can help to evaluate self-perceptions of health within some groups of migrants, identified by nationalities or variables such as employment categories (e.g., caregivers for the elderly), initiate epidemiological enquiries in order to identify the health status in a certain context (e.g., jail), conduct research in relation to specific lifestyles (e.g., eating habits of teenagers belonging to certain migrant communities), or examine some characteristics of the usage of certain sanitary services (e.g., maternal and child health care).

Acknowledgment of the effectiveness of using a mixed methods approach (quantitative and qualitative) is also growing. Qualitative methodology often offers valuable insight into how to interpret the results of the quantitative data and vice versa. In the case of abortion, Italian standardized data established that the rates were three times higher in migrant women than in Italian women [36]. Conducting interviews with women belonging to prevalent foreign communities has established certain variables and sociocultural conditions, which were identified as motivating factors for abortion services [36].

An intrinsic strategic value of qualitative research is to strongly favor the involvement of migrant communities within the research, for example, through focus groups, structured interviews, or questionnaires. Indeed, despite the impossibility to generalize from single experiences, the direct expression of the health needs of the immigrants themselves offers helpful suggestions for decision makers. This information does not necessarily translate directly into specific interventions, but rather suggest more appropriate modalities in which to implement them.

2.2. General considerations regarding the definition of health policies and the organization of health services

According to the aforementioned 2008 World Health Assembly Resolution on the Health of Migrants, Member States have an obligation to implement on migrant-sensitive health policies and practices (see Box 1) [16]. One of the most significant lines which calls for action claims

that members should: *“devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery.”*

The 61st WHA Assembly calls upon Member States:

1. To promote migrant-sensitive health policies
 2. To promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality, or race
 3. To establish health information systems in order to assess and analyze trends in migrants' health, disaggregating health information by relevant categories
 4. To devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery
 5. To gather, document, and share information and best practices for meeting migrants' health needs in countries of origin or return, transit, and destination
 6. To raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues
 7. To train health professionals to deal with the health issues associated with population movements
 8. To promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process
 9. To contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals
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Box 1. Recommendations of the resolution of the 61st World Health Assembly (2008).

The value of this call for action is not only to identify existing discrepancies in delivering welfare health services and making these known to decision makers, managers, and professionals, but also to remind them that migrants may be one of the various population groups left vulnerable by those inequities. It is implied that interventions on behalf of the immigrant population should not exclude other groups of the population that can be similarly disadvantaged.

Together with this directive line of action, there is another one outlined in the Bratislava Declaration of 2007. This latter invites members to: *“Work toward overcoming the barriers to the enjoyment of the access to protection of health for people on the move through capacity building and awareness raising for health providers, policy makers, health management planners and health educators as well as other professions allied to health services delivery”* (see Box 2) [21].

Work toward overcoming the barriers to the enjoyment of the access to protection of health for people on the move through capacity building and awareness raising for health providers, policy makers, health management planners, and health educators as well as other professions allied to health services delivery

Support public health research to enhance and strengthen national and international surveillance and information systems and to strengthen and support evidence-based programs for the health of people on the move

Take steps to reinforce and incorporate the health dimension into development and cooperation policy following the principle of “health in all policies”

Promote migrants’ participation in program planning, health services delivery, and evaluation

Take steps to train and educate healthcare providers, policy makers, health management planners, and health educators, as appropriate, on addressing healthcare issues associated with population mobility and disparities in health services between geographical locations

Encourage host countries to consider the invitation of the Parliamentary Assembly in the Resolution 1509 (2006) to eliminate any requirement on health service providers and school authorities to report the presence of irregular migrants to the authorities

Box 2. The “Bratislava Declaration on health, human rights and migration” (2007) Extracted from the duties.

This reference to potential barriers is particularly important: aside from those regulations (as linked above to the right to health protection), immigrants can encounter bureaucratic, economic, organizational, lingual, psychological, and cultural barriers. Confronting these barriers can become a turning point in achieving full health protection for migrants and the promotion of equity in relation to their health [6, 14].

This change would involve promoting the so-called availability (functioning public health and health facilities, goods, services, and programs in sufficient quantity), “accessibility” (non-discrimination, physical accessibility, economic accessibility or affordability, information accessibility), “acceptability” (respect for medical ethics and culturally appropriateness, sensitivity to age, and gender), and “quality” (scientific and medical suitability) of health services [6]. Of course, ensuring that migrants are aware of their rights and of the nature and operation of the health system of the host country is fundamental, although not always sufficient. Proper information of all public health services should go hand in hand with continuous care for all the processes of integration and make the most of all meetings during which contact is being made with migrants. Aside from the formal channels (TV, radio, newspapers, institutional websites, and advertisements on public transport), information regarding health services should be spread by key figures of these communities (leaders, speakers, religious representatives, teachers in the community), and by schools. Important figures in healthcare systems are general practitioners, community nurses, obstetricians, pediatricians, and cultural-linguistic mediators.

Another strategic element is the adequate training and regular updating of the health, social, and administrative personnel of the health system, which is (or can become) a point of access to the migrants' community, in order to promote the so-called cultural competency and challenge discriminatory behaviors and attitudes [16, 20]. This training should take place in groups of small numbers (30–40 people) with various professional figures present at the same time (interprofessional education). There needs to be a systemic, complex, and multidisciplinary approach "built" on the educational needs outlined ahead of time with the collaboration of those operators toward whom the services are also addressed. If possible, it is useful to adopt types of education and training more engaging, such as training on the work site, education based on experience, working groups, or "role playing." Having acknowledged the peculiarity of the theme and its important communicative and relational implications, it is advisable to limit distance training. Where distance training is necessary, it needs to be supported by meetings and discussions.

Cultural-linguistic mediation in health is also relevant. First of all, it must be said that, from the linguistic perspective and, following the empowerment of the migrant and his/her community, the principal instrument of autonomy possesses a sufficient knowledge and capacity to speak the language of the host country. In this sense, a special effort should be made to encourage learning of the language. We consider basic language examinations necessary to receive some rights, in particular that of citizenship. However, there remains the fact that especially in the first phase of immigration, many migrants would still need people to mediate between themselves and the health system, whether this is in an administrative-bureaucratic organization, a clinical service, or consulting a healthcare professional.

Aside from the possibility of finding individuals to fill the specific role of cultural-linguistic mediator, we think they should not necessarily belong to the specific community of the patient, a viable option would be to draw upon professional figures who already work within the health services and are of foreign origin and create a connection between the patient and his/her required services. The utility of the linguistic-cultural mediator is beyond question. However, this person should not be identified as a "*deus ex machina*." It would be wrong (and even dangerous) to assign all the functions of welcoming, listening, interpreting, informing/explaining, and supporting to the sole figure of the cultural-linguistic mediator. From the perspective of inclusivity, it is essential to create the mediating function of the system so that it encompasses all services' operators, from the administrative desk to surgery. In other words, the cultural competence should be stimulated in all operators.

The development of policies and resulting actions (and even earlier, the analysis of health needs) cannot leave aside the necessary involvement of the migrants' communities and of the civil society organizations working with these communities (NGOs included), and at the technical-scientific level, the scientific societies, all of whom are involved in different ways. Such involvement should be ongoing, not occasional; requested and supported from within the organizations and their teams, for example, inside the "local observatories" or within "working groups" on migrants' health; and for allowing discussions between the different actors on equal footing. This "bottom-up" approach and network logic have been proven to increase efficiency in practice. This is so because the interventions necessitate

active collaboration between the recipients and the other stakeholders, making it more functional and consistent in terms of “accountability,” as well as answering a call for democratically managing of public resources.

In order to promote migrants’ health as part of the international agenda, the World Health Organization (WHO), in collaboration with the International Organization for Migration (IOM) and the Spanish Ministry of the Social and Health Policies, organized a global meeting on migrants’ health in Madrid during March 2010. From this meeting, the report “WHO-IOM. The way forward” [35] was produced.

In particular, this report presents an outline for an operational framework to guide action by key stakeholders, which suggests key priorities and corresponding actions in each of the following thematic areas:

- Monitoring migrant health
- Policy and legal frameworks
- Migrant-sensitive health systems
- Partnerships, networks and multi-country frameworks.

We are convinced that the recommendations provided in this report present the right direction in which to move forward. The central point is the cultural dimension.

2.3. A case study: health protection’s policies for immigrants in Italy

“The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent...”.
(*The Italian Constitution, 1948 - 32nd Article*).

Situated in the South of Europe in the center of the Mediterranean Sea, Italy is a country of more than 60 million inhabitants. It is one of the founding and current members of the European Union. For more than 100 years, starting from the second half of the nineteenth century, Italians have settled around the world, particularly in North and South America and Central Northern Europe. Since 1861, when the Kingdom of Italy was proclaimed, more than 24 million Italians have emigrated, a population size almost equivalent to that of the nation itself following unification. From no other European country, and for over such a period of time, has a constant stream of emigration occurred. According to estimates by the Italian Minister of Foreign Affairs, there are currently between 60 and 70 million people of Italian descent living outside of Italy (the so-called *oriundi*). The countries where they are most dominant are Brazil (with more than 27 million), Argentina (with almost 20 million), the United States (with more than 17 million), France (with four million), Colombia (with two million), Canada (with nearly 1.5 million), Peru (with 1.4 million), Uruguay (with 1.2 million), Venezuela (with one million), and Australia (with more than 900,000). While in the United States and in France Italian descendants make up around 6% of the total population, in Colombia, Canada, and Australia they are almost 4%, in Argentina and Brazil the “Italians *oriundi*” are estimated to represent around 47% and 13% of the total population, respectively.

Furthermore, the number who reside abroad, but still hold Italian citizenship (and have the right to vote in Italy), are estimated to be five million, of whom almost 85% are equally distributed between North and South America and Europe [37].

For the first time in 1973, a “positive net migration” was registered, and the number of immigrants in Italy was found to be higher, by a small percentage, than the number of emigrants. Since then, immigration in Italy has grown constantly, and sometimes exponentially, going from hundreds of thousands of people in the 1980s to the current presence of five million foreigners, equaling 8.3% of the total resident population [38]. Their distribution across the nation is uneven and largely determined by opportunities for work: almost 60% of the immigrants live in the north, 25% in the center, and 15% in the south. Because of the recent global economic crisis there was a decline of immigrants to Italy and an increase of people leaving Italy, this added to the growing number of Italians who migrated mainly to other European countries. Although the social perception of immigration, as broadcasted by the media, is one of “invasion,” according to accurate statistical predictions, new entries of foreigners into Italy (only a relatively small part remains permanently) cannot guarantee any demographic equilibrium of the Italian population (which decreased by 150,000 people in 2015) [39].

The geography of Italy (a peninsula with almost 7500 km of coasts, but less than 2000 km of inland borders, all in the North) has made it, together with Greece, a central position of the migratory fluxes passing across the Mediterranean Sea. The principal routes originates from Africa (Horn of Africa, North Africa, and a part of Sub-Saharan Africa) and from the Middle East and Asia (Afghanistan, Syria, Pakistan, and Bangladesh). In 2015, almost 154,000 people, a combination of asylum seekers and economic migrants landed in Italy [39]. As in 2014, the large majority of these migrants did not see Italy as their final destination, but countries in Central-Northern Europe such as Germany, France, the United Kingdom, and Sweden were their destinations. Due to the current European regulations, which draws upon the Schengen treaty (specifically with “Dublin III”), these people have the right to apply for asylum only within the country of entrance in Europe [10]. In the case that they reach a second country of the European Union and apply for asylum there, they are sent back to the first country were they arrived. The current situation is an acute crisis, mainly linked to the conflict in Syria. Italy's request to redistribute migrants across the different European countries has created strong tension within the EU. In fact, a bloc of countries from Central-Eastern Europe, where nationalist parties, sometimes of a xenophobic nature, have a stronghold, have refused to accept their share of the relocations as decided by the EU, and have physical barriers, such as barbed-wire fences and walls, as well as turning a blind eye to the high degree of violence by their armed forces, in order to reinforce their resistance [39].

A peculiar characteristic of the Italian situation is the diversity of the foreign communities; there are almost 200 of them, and the resulting variety of languages and sociocultural backgrounds. This distinctive feature has different spillover effects, for example, in creating the concrete possibility of using a cultural-linguistic mediator in providing public services.

The first systematic national law on immigration in Italy dates back to the early 1990s; previous laws only partially regulated immigration in some aspects, for example, in the work sector. This set of regulations was revised in 1998, and again in 2002. Without looking at any

of the complex technical-juridical aspects, it is evident that the core of these regulations has been conditioned by both the prevailing social feeling of the population during those years and the government's position at the time of the juridical revision. In analyzing the various laws and regulations, it is possible to discern that the image of the typical immigrant in Italy varies greatly. The images include that of the worker (being useful in the production sector), to that of a person who, apart from participating in the socioeconomic growth of the country, also has the right to have a family (or start family reunions' practices), participate in public life, and integrate into society.

As in the rest of the world, the possibility of entrance and integration into the new society in Italy for a migrant is strongly linked to the juridical environment, and to aspects such as the educational level, income, knowledge of the language of the host country, and the presence of his/her community. However, it must be noted that, unlike other countries, the set of regulations adopted in Italy made many immigrants vulnerable to instability regarding their status as legal immigrants. This is due to the fact that there were, and still are at present, certain difficulties in both getting a regularized permit to remain in the country and renewing it periodically. Reasons are that it is often impossible to provide proof of income, or are cases where a family member needs to be taken care of. Overall immigrants are more likely forced to turn to the "black" market, the informal labor sector, than native Italians. Sometimes, because of language difficulty immigrants find it hard to compete in the open market.

The principal distinction used, aside from the general one of "asylum seeker" and "economic migrant," is that of the "legal," "regular," "documented" and "illegal," "irregular," "undocumented," or even "clandestine" immigrant. The latter, including the "clandestine" immigrant, never received a residence permit to stay. On the semantic level, it must also be noted that the usage of the term "clandestine" is heavily charged with moral judgment. This is unlike other countries, such as France or the United Kingdom, where the lack of permit is the only characteristic highlighted without distinguishing within that category: "Sans papier" or "undocumented," which does not carry the negative connotation.

The ordinary person, with limited information, has great difficulty recognizing the variety of types or descriptions of migrants. Recent explanations have cleared up the difference between "asylum seekers" and the "economic migrant." However, paradoxically, the result was the legitimization of the former and the delegitimization of the latter, strengthening an incomprehensible stigma where emigrating to escape economic misery is not a justified (and thus legitimized) reason in comparison with escaping violence and persecution.

In the past 30–40 years, the social dynamics of integration have developed in nonlinear ways and today we have large numbers of second-generation immigrants (third generation of those communities who had arrived in Italy previously). The lack of reform in citizenship law is evident: unlike most other countries in the world, Italy does not automatically recognize any person born on its soil (*ius soli*) as a citizen. This originates from the past when it was prudent to favor Italian descendants with the rights of citizenship (*ius sanguinis*). In terms of citizenship rights, immigrants who are regularized as residents (legal, regular, documented) but not citizens have no right to vote (active or passive) if they are not EU immigrants. In relation to social integration, it is useful to see how, unlike other countries accepting immigrants where

the official language is internationally widespread (notably English, Spanish, and French), Italian is a language scarcely used outside of its homeland and quite difficult to learn. Italian public schools have played a fundamental role in improving integration by upholding every individual's right to be educated, regardless of race, nationality, or culture, and by opening its doors (without economic barriers) to the children of irregular (illegal, undocumented) immigrants. We have today in Italy more than 800,000 "foreign" minors registered in the Italian schools; more than half of them were born in Italy.

Following this overview of the context, history, and principal characteristics of the migratory processes in Italy, we turn to the policies pertaining to the health of immigrants.

The current regulations on the available healthcare services for immigrants date back to a comprehensive law, entitled "Single Text on Immigration" (D.Lgs. 286, articles 34th, 35th and 36th) which was approved in 1998, and successive regulatory provisions (mainly the DPR 394/1999, articles 42nd, 43th and 44th and the Circular n. 5/2000 of the Health Department) [14]. First of all, it must be emphasized that the "philosophy" of these deliberately "inclusive" health policies can be summarized in two major statements:

1. Equality of rights and obligations, regarding both health and rights to health care, of Italian citizens and foreigners who are legally present (with stay/residence permit, documented, regular migrants), with complete healthcare coverage by the National Public Health System.
2. Broad possibility of health protection and health assistance also for the undocumented (irregular, illegal) immigrants, especially for women and children, and in relation to infectious diseases [14].

These laws pose in fact Italy in an "advanced" position in the international scene: in no other country in the world, we understand, immigrants without a stay/residence permit have the right to be assisted without being reported to the police.² Undocumented, illegal, irregular immigrants have the right to receive the necessary treatment, even for prolonged periods of time, free of charge if they do not have the economic resources to pay for the services.

However, this "inclusive" health policy is based on the willingness of part of the local authorities to collaborate. The local authorities, that is, the 21 Italian regions and autonomous provinces, have over time acquired a fundamental role in the provision of social and health services for foreigners, and in maintaining its effectiveness. Indeed, as a result of the changes introduced in 2001 in the Italian Constitution by a Constitutional Law (article 117 of the Constitutional Law n. 3), the Regions and Autonomous Provinces are empowered to define regulations on health issues for all residents, including immigrants, while migration remains one of the issues in which the state maintains complete legal authority. The theme "health and immigration" seems ambiguously suspended between the "exclusive" legislation

²In Italy, "stay permit" and "residence permit" are two distinct situations. The possession of "Stay permit" (in Italian "permesso di soggiorno") means the institutional recognition of the legitimacy of the presence of the person on the national territory (and it is a condition that is associated first of all to the migrant); the "Residence permit" (in Italian "permesso di residenza") is linked to the stability of the life of a person in the place where s/he dwells. From an administrative point of view, the two are treated separately, although to get the second permit it is necessary to have already been granted the first permit.

of the state and the “competing” legislation of the autonomous regions and provinces. The complex process of decentralization named “health federalism,” which implies interconnection between the various institutional levels involved in the health system, results in uncertain pathways of responsibility, which can jeopardize the successful application of healthcare policies, preventing them from achieving their institutional mission (as may indeed also occur in matters of health care for Italian citizens) [14].

As an example of the ambiguity that is created between the migration policies and the healthcare policies, we can provide the introduction, of the crime of irregular entrance and stay through the approval of the law n. 94/2009, which is the so-called Security Package. During the parliamentary discussion about the Security Package, there was an attempt, by a notoriously anti-immigration Italian party, to repeal the provision that prohibits health and administrative personnel from reporting illegal immigrants who use health services. This was mainly motivated by ideological reasons. It represented a serious interference in the health sector, and could have posed a serious threat to immigrants’ right to health care. Although the proposal was abandoned, and therefore the prohibition of denouncement remains in effect, the introduction of illegal entrance and sojourn being a criminal act and punishable by the authorities has placed the health professionals (doctors, nurses, administrative staff, etc.) in a difficult practical, ethical, and deontological situation. According to one legal interpretation, a public officer should be obliged to make a denouncement to the public authorities if, during the exercise of his or her profession, the irregular, illegal, undocumented status of an immigrant comes to light. But this is contradicted by another law of the state, the aforementioned “Single Text on Immigration” [14], which sets out the rules on health care for irregular, illegal, undocumented immigrants. These two contrasting laws, regarding the prohibition to and, conversely, the obligation to denounce, have given rise to confusion, ambiguity, and the use of discretion. The regions, which had in part also taken a stance against the proposal for the repeal of the prohibition of denouncement, therefore had to provide prompt clarification of its validity. The Ministry of the Interior subsequently issued a circular confirming that the law on public security had not repealed the previous rules and that, as a consequence, doctors and other workers within the healthcare sector remained obliged to observe the prohibition on reporting irregular, illegal, undocumented immigrants seeking healthcare services, with some limited general exceptions (e.g., firearm injuries) [14].

As a demonstration of the ambiguity that has arisen between state jurisdiction (center) and regional administration (peripheral), we can mention the appeals presented by the Government to the Supreme Court, between 2009 and 2010, on the presumed constitutional illegitimacy of the regional laws on migration in three Italian regions (Tuscany, Puglia, and Campania). These regional provisions were contested by the government on the grounds that they exceeded the competences of the regions. According to the Italian government then in office, local provisions for the protection of the right to health care, if extended to illegal, irregular, undocumented immigrants, would be considered to affect the regulation of the entry and sojourn of such immigrants. These were matters for the exclusive competence of the state. However, the Supreme Court rejected, with regard to health care for immigrants, the government’s appeal in all three cases, reaffirming the “*irreducible nucleus*” of the right to health, even with reference to foreigners without a valid stay/residence permit. Indeed, this right to health

is “protected by the [Italian] Constitution as an inviolable aspect of human dignity” (Sentence No. 252 of 2001), in conformity with the view already expressed by the Court, according to which “the foreigner is [...] entitled to all the fundamental rights that the Constitution recognizes as owned by the person” (Sentence No. 148 of 2008) [14].

In February 2007, by means of Legislative Decree No. 30 of 2007, Italy implemented the European Resolution 2004/38/CE in relation to the right of European citizens and their families to move and settle freely within the territory of the Member States. The untimeliness of the measure, nearly 3 years after the European Resolution, and the concomitant entrance (1st of January 2007) of Romania and Bulgaria into the EU, created considerable confusion and widespread use of discretion within the health services. Not only were tens of thousands of “neo-communitarian citizens” immediately excluded from health protection, as they were unable to meet the necessary conditions in order to obtain health assistance (possession of the European Health Insurance Card or legal work and/or registered residency), but the directions later on provided by the central government were unclear and in some cases contradictory (Circular issued by the Ministry of Health on 3 August 2007, 19 February 2008, 24 July 2009, and 11 more in less than a year). For these reasons, the different Italian regions had provided very different answers, not only in relation to procedure but also with regard to possible levels of health care, especially with reference to the socially and economically disadvantaged.

This “pendulum of competences” generates a high level of risk in terms of creating inequalities, not only in the terms of access to health services but also in terms of the health profile of the immigrant population. As a result of the above considerations, at the end of 2008 an Inter-Regional Committee was established by the Health Commission of the Conference of Regions, in order to create a stable form of collaboration among the regions, as well as a form of negotiation between the regions and the state, on the issues of immigrants’ health and healthcare assistance, and to reduce the discretionary interpretation of national laws. After 2 years of work, the Committee produced the document “*Directions for the correct application of legislation for health care assistance to the foreign population by the Italian Regions and the Autonomous Provinces,*” which was first approved by the Assembly of the Regional Health Authorities and then ratified at national level [14]. Despite all these efforts, differences in the interpretation and practical application of the rules remain between the different Italian regions, often bureaucratic attitudes threaten to override the right to health care for immigrants. A recent advocacy action successfully exercised, in particular by the Italian Society of Migration Medicine - S.I.M.M. (the only Scientific Society in the world with this mission), is the recognition of the right to have a permanent pediatrician, chosen by the parents, for the children of immigrants without stay/residence permits.

3. Conclusion

Migration is a complex phenomenon and the determinants of health can help us to analyze the issue. The success of the migration project usually translates into better health and access to healthcare opportunities, which show the positive impact of the social determinants of health such as education, employment, income, and housing. These are not mechanical and

linear processes, nor immediate developments. The migration process may in fact represent a phase of stress and risks to mental and physical health, particularly accentuated in asylum seekers, refugee unaccompanied immigrant children, and those who are victims of trafficking and, more generally, victims of physical and/or psychological violence [40, 41]. Of particular importance, in addition to the individual resources of the immigrant (e.g., his/her “coping” mechanisms, ability to adapt to changes and unforeseen, adverse situations, presence of a social network) is the ability of the host society to welcome and integrate the newcomers.

A careful analysis of the health needs of the immigrant communities represents the fundamental precondition for identifying appropriate health and social policies. This involves a commitment to quantitative and qualitative research, possibly with the involvement of the same migrant communities. When not properly supported by appropriate inter-sectoral policies, immigrants will be exposed to hostile circumstances that leave them vulnerable to negative experiences which, in turn, influence their life chances.

Today, public health is facing the effects of these dynamics, in particular with respect to the prevalence of chronic diseases in the most disadvantaged populations. This involves the planning of interventions, possibly “community-based,” capable of reaching all the present populations, without discrimination, and in some cases the realization of interventions targeted at “hard to reach” groups.

As recommended by many international statements and by extensive medical-scientific literature of the field [3, 4, 6, 12–26, 31–35], it is important that countries recognize health as an unconditional fundamental right, guaranteeing health coverage both to regular, legal, documented migrants and irregular, illegal, and undocumented ones. This implies investment in the services: legal, organizational, and economic resources are needed, linguistic and cultural barriers need to be contested, and training and retraining of staff, aimed at obtaining a cross-cultural competence, requires professional planning. In order to maximize the chances of the effectiveness of such programs, a multidisciplinary teamwork and a “transcultural” approach is very important. Protecting the health of ethnic minorities is both a challenge for governments and a test of the quality of their health systems. One of the main international recommendations is to make health systems “migrant sensitive” [35].

As stated by Michael Marmot introducing a series of articles that recently appeared in an issue of the *European Journal of Epidemiology*:

“There are some politicians who would argue that to treat migrants well is simply to encourage others to come. Such a view argues, in effect, that individuals be treated as instruments of political policy. This view is immoral. It runs counter to medical ethics that state clearly that all individuals should be treated with dignity. One way to treat people with dignity is to understand and respond to health problems caused by their migrant status” [4].

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Author details

Maurizio Marceca

Address all correspondence to: maurizio.marceca@uniroma1.it

Sapienza University of Rome, Department of Public Health and Infectious Diseases, Italian Society of Migration Medicine (S.I.M.M.), Rome, Italy

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