Master Thesis

Elisa Rossetti

MANAGEMENT CENTER INNSBRUCK
Master "International Health Care Management"
Universitätsstrasse 15, A-6020 Innsbruck
Tel: +43 512 2070-3700
Fax: +43 512 2070-3799
www.mci.edu

Title page

THE ACCESS TO HEALTHCARE FOR ASYLUM SEEKERS IN ITALY: DISPARITIES BETWEEN LEGISLATION AND PRACTICE

Master Thesis

In partial fulfillment of the requirements
for the degree

„Master of Arts (MA)"

Master Program:
„International Health & Social Management"
Management Center Innsbruck

Supervisor:
Prof. Dr. Natascha Zeitel-Bank

Author:
Elisa Rossetti, B.A
1410360012

DECLARATION IN LIEU OF OATH

I hereby declare, under oath, that this master thesis has been my independent work and has not been aided with any prohibited means. I declare, to the best of my knowledge and belief, that all passages taken from published and unpublished sources or documents have been reproduced whether as original, slightly changed or in thought, have been mentioned as such at the corresponding places of the thesis, by citation, where the extent of the original quotes is indicated. The paper has not been submitted for evaluation to another examination authority or has been published in this form or another."

Table of Contents

List of figures

List of tables

Table of abbreviations

AIDA……..	Asylum Information Database
AMIF……..	Asylum, Migration and Integration Fund
ANCI……..	National association of Italian municipalities (Associazione Nazionale Comuni Italiani)
ASGI……..	Association of juridical studies on immigration (Associazione per gli Studi Giuridici sull'Immigrazione)
ASL……	Local healthcare unit (Azienda Sanitaria Locale)
ASRC……	Asylum Seeker Resource Centre
BMA……...	British Medical Association
CA……..	Consolidated Act on Immigration (Testo Unico sull'Immigrazione)
CARA……	Reception centre for asylum seekers (Centro di Accoglienza Richiedenti Asilo)
CEAS…….	Common European Asylum System
CESCR…….	United Nations Committee on Economic, Social and Cultural Rights
CFREU……..	Charter of Fundamental Rights of the European Union
CIE…….	Centre of identification and expulsion (Centro di Identificazione ed Espulsione)
CIR…….	Italian Council for Refugees (Centro Italiano per i Rifugiati)
CISV……..	Community, Commitment, Service, Voluntary work (Comunità, Impegno, Servizio, Volontariato)
CSC……...	Social Cooperative Camelot (Cooperativa Sociale Camelot)
CSDP……	Common Security and Defence Policy
D.Lgs…….	Legislative Decree (Decreto Legislativo)
EASO……	European Asylum Support Office
ECHR……	European Court of Human Rights
ECRE	European Council on refugees and exiles
EPIM……..	European Program on the Integration and Migration
ESC….....	European Social Charter
EU……..	European Union
FER……	European Fund for Refugees (Fondo Europeo per i Rifugiati)
FRA……	European Union Agency for Fundamental Rights (Fundamental Rights Platform)
GP……..	General practitioner
HUMA..……	Health for Undocumented Migrants and Asylum Seekers
ICCPR……..	International Covenant on Civil and Political Rights

ICESCR……	International Covenant on Economic, Social and Cultural Rights
ICMC…….	International Catholic Migration Commission
IOM……	International Organization for Migration
IRC……..	Italian Red Cross
MEDU……	Doctors for Human Rights (NGO - Medici per i Diritti Umani)
MS…….	Member State
MSF…….....	Doctors without Borders (NGO - Médecins Sans Frontières)
NAE….....	North African Emergency
NCC……...	National Coordination Centre
NCD……...	Non-communicable disease
NGO……..	Non-governmental organization
N.I.Ra.S.T….	Italian network for asylum seekers victims of torture (Network Italiano per Richiedenti Asilo Sopravvissuti a Tortura)
PTSD…….	Post-traumatic stress disorder
Sa.Mi.Fo……	Healthcare for forced migrants (Salute per Migranti Forzati)
SAS……	Civil Protection reception system (Sistema di Accoglienza Speciale)
SPRAR….....	Protection system for asylum seekers and refugees (Sistema di Protezione per Richiedenti Asilo e Rifugiati)
SSN…….....	National Healthcare System (Servizio Sanitario Nazionale)
STP code…..	Temporarily present foreigners code (Straniero temporaneamente presente)
TFEU…….	Treaty on the Functioning of the European Union
UN……..	United Nations
UDHR……	Universal Declaration of Human Rights
UNHCR…….	United Nations High Commissioner for Refugees
VI.TO…….	Victims of Torture (Vittime di Tortura)
UN DESA…..	United Nations Department of Economic and Social Affairs
UNDP……	United Nations Development Program
WHO……..	World Health Organization
WWII……..	Second World War

“È una questione di essere persone”

“It’s a matter of being human”

(Enzo Romeo, physician and Red Cross volunteer,
L’escludo, 2014)

Introduction

Much is discussed everyday about the so-called *European refugee crisis*, but the phenomenon is often just perceived as a migration inflow of thousands of people, without really focusing on who they are and what needs they have.

Asylum seekers are among the most vulnerable migrants, because they do not have reference points, not yet in the hosting country, not anymore in the country of origin. Most of the times they reach Europe illegally across the Mediterranean Sea, arriving to the *EU border countries*: Italy, Spain and Greece.

They face the journey in the framework of a highly organized human smuggling business that endangers their lives, as violence, torture, imprisonment, absence of food and water and precarious hygienic conditions are common.

Asylum seekers carry with them the traumas experienced both in their country of origin and during the journey, besides the culture shock, lack of information, loss of status and social isolation experienced in the country of arrival. Therefore, it is important to understand their personal histories and tackle properly their needs, including legal assistance and linguistic mediation, but most importantly healthcare.

The right to health is a fundamental human right recognized in international, regional and national legislation, according to which everyone is entitled to the highest mental and physical health status possible. However, practical, bureaucratic and even legal barriers often limit the asylum seekers' real access to institutional healthcare, and consequently their entitlement to health, across the European Union.

The here-presented thesis focuses particularly on Italy, because it is one of the main countries of arrival in the European Union and because it is an emblematic case of heterogeneous asylum practices, in terms of both healthcare provision and in consideration of the social determinants of health, which affect the health of asylum seekers as well. The cases of Rome, Milan, Mineo, Florence, Ferrara and Turin have been selected in the analysis to represent the heterogeneity across the country.

The period in consideration is the North African Emergency (2011-2013) that happened following the Libyan conflict and the Arab Spring.

This specific asylum inflow represented one of the \migration peaks in Italy and a turning point in the Italian asylum history, in terms of formulation of new laws and appearance of a changed asylum reception system after 2013. It was chosen also because, during the North African Emergency, the asylum seekers' population was rather homogeneous in terms of journeys, needs and history, therefore proper for the purpose of this research. Lastly, the author was personally involved in the North African Emergency as volunteer in one localized reception centre.

The main goal of this thesis is to analyse the implementation of European and national legislation concerning asylum and healthcare, as well as to identify the existing discrepancies between the legislation and the practice related to the healthcare access of asylum seekers in Italy. The social determinants' impact on health is also considered, with a special regard to housing and the Italian asylum reception system.

The research methodology consists of a systematic literature review, concerning both the legislative and the procedural aspects mentioned above, through the conjunction of scientific studies, demographic research, legal and policy-related published documents and reports written by NGOs operating on the field.
Therefore, the perspective considered is the one of human rights, represented and defended concretely by the operating NGOs and organizations, in response to the concrete healthcare needs of asylum seekers, particularly mental healthcare.

Part One provides a theoretical framework and classification of migration, describes the connection between migration, urbanization and health, defines forced migration and illustrates the asylum-related migration in the European Union.

Part Two analyses the European Union's role in asylum-related issues, mainly through the formulation of legislation, in theoretical compliance with the international human rights' codes, and the defence of external borders.

Part Three focuses on asylum trends and routes, legislation and procedures, reception systems and healthcare approaches in the Italian context, explaining the asylum seekers' needs and barriers in accessing healthcare during the North African Emergency. The role of NGOs and local associations is highlighted in all its importance as a complementary measure to the institutional healthcare responses, with a particularly focus on the already mentioned, selected cities.

Part Four aims at discussing the observed results, in terms of differences between the European and national legislations, the legislative and practical discrepancies in the Italian context, as well as the possible discordances between healthcare provision and the asylum seekers' needs, in particular considering mental health, and the NGOs and civil society's role during the Emergency.

Besides, it includes an analysis about some crucial human right controversies both at the European and Italian levels, that affect the asylum seekers' health and well-being, and it gives an overview of the developments after the North African Emergency, identifying the observed problems and suggesting recommendations for the future.

PART ONE

Migration and Health

1. Migration as a human characteristic

Mobility has always been a key feature of the human kind. It is a "*non-permanent move of varying duration*" (Bell & Ward, 2000, p.99). It implies a change in a personal condition, either social, employment-related, or geographical. **Migration** instead is the "*permanent change of usual residence*" (Bell & Ward, 2000, p.99).

Both derive from the necessity of change. The main difference is that migration refers to a collective phenomenon, while mobility underlines its individualistic nature. Mobility suggests regular, short-medium distance movements, while migration implies a thoughtful long-distance journey.

1.1 Objective and subjective classifications of migration

Migration is classified according to a set of objective parameters and subjective motivations (Baggio, n.d). The **objective framework** includes geographical, chronological, demographic-economic, political-legal and causal criteria (Table 1).

Objective frameworks	Sub-categories
Geographical classification	Domestic
	International (neighbour, transoceanic…)
Chronological classification	Temporary
	Permanent
Demographic-economic classification	Individual (gender, age, generation…)
	Collective (familiar, massive, national…)
	Employment (highly skilled, skilled, unskilled)
Political-legal classification	Regular
	Irregular
Causal classification	Voluntary
	Forced

Table 1 – Objective Classifications of Migration. Own illustration, based on Baggio, n.d.

Migration is domestic if it happens within one country, particularly from rural to urban areas. It is international if it involves cross-border movements, from short-distance (neighbour migration) to long-distance (transoceanic migration).

Besides, although "*migration is often seen as a permanent move*" (Skeldon, 2013, p.2), it can be a temporary condition too, generally for long periods (months, years).
The individual migration criterion could be based on gender, age, generation. More often, migration is collective, performed by a family (familiar migration), a crowd (massive migration), a population.
From the employment perspective, it reflects the migrants' skills, sectors and experience. They can be skilled, rural/seasonal, industrial, autonomous, subordinate or unskilled workers. Emerging trends are brain drain and technology migration: highly qualified workers leave their countries, with the prospect of permanent expatriation.
A further classification considers the legality of movements: regular (when authorized) or irregular (when the legislation is infringed). The migration's motivations relate to free choices (voluntary migration) or major external dangers (forced migration).

Closely related to the objective causal classification, the **subjective framework** includes the (most common) reasons for migration (Baggio, n.d). Voluntary migration is due to economic reasons, business activities, internships, job offers, healthcare provision, studies, tourism, pilgrimage, marriage, family reunification, spirit of adventure, wish of improving life-style, among others. Instead, natural disasters, conflicts, persecution, discrimination, political or economic instability, and human trafficking cause forced migration.

Overall, two complementary elements induce migration: the **push factors**, as repulsion from the home country and the **pull factors**, as attraction towards the destination country (UNDP, 2010) (Table 2).

Push factors	Pull factors
Poor medical care	Better access to medical care
Unemployment	Better working opportunities
Lack of opportunities	Better access to education
Poor living conditions	Better living standards
Political instability	Political stability
Persecution, violence, mistreatment	Security and personal freedom
Religious, ethnical, racial discrimination	Friends and family connections
Economic instability, poverty	Enjoyment, spirit of adventure
Natural disasters, extreme climate changes	Ambitions, experiences

Table 2 - Push and Pull factors. Own illustration, based on Baggio, n.d.

1.2 Urbanization and migration flows

Urbanization is both cause and consequence of migration. People migrate to industrialized areas to have access to better living standards, and while doing so, they contribute to the urbanization process.

The first historic example of a unique movement of individuals and families, based on the same "*economic decisions, made separately*" (*History of Migration,* n.d, p.8), was the middle 19th century's transoceanic migration, when 55 million people left Europe, mostly toward the USA. Unprecedented global migration flows characterize the twentieth and twenty-first centuries, following urbanization and economic growth. International movements towards high-income countries, like the United States, many European countries and Canada, result in the so-called "***global cities***".

In 2010, 95% of foreign-born in the USA lived in metropolitan cities, like Chicago, New York and Los Angeles (Singer, 2013, p.80).

Migration connects different cross-cultural communities, bringing innovation, economic growth and reciprocal benefits, but it can also cause conflicts and discrimination, increasing criminality and growing challenges about immigration policies and legislation (Schultz, 2014). Nevertheless, there is often no clear separation between the opposite effects and they result in a paradoxical coexistence. Besides, migration patterns are in **constant evolution** and difficult to monitor, as the biggest source of data inaccuracy regards those living, working and travelling illegally (Council of Europe, 2006, p.11).

The International Organization for Migration (IOM) estimates **740 million internal and 232 million international migrants globally** (2015, p.17).

In the European Union (EU), 3.4 million immigrants reached the Member States (MSs) and 2.8 million emigrated from a MS[1] during 2013 (Eurostat, 2015a).

Among the immigrants, "*there were an estimated 1.4 million citizens of non-member countries, (…), and around 6.1 thousand stateless people*" (Eurostat, 2015a, par 2).

The top EU destinations were Germany, United Kingdom, France and Italy.

Concerning the immigration's gender structure, there were more men (53%) than women (47%), and they were on average younger (median age = 28 years) that the local population (median age = 42 years).

Big differences in immigration nationalities persist between Western, Central and Easter Europe, as well as in each MS. In 2006, 21.38 million foreigners lived within

[1] These data include the migration flows between the EU and third-countries and within the EU itself.

the whole European Economic Area, of whom 12.5 million (58.2%) were Europeans, 3.6 million (17.1%) Africans and 2.5 million (11.8%) Asians (Council of Europe, 2006). However, these shares constantly change, due to time and new immigration patterns.

1.3 Migration and health in the urban context

Since urbanization goes hand in hand with migration, half of all international migrants worldwide resides in ten top highly urbanized countries, including France, Germany, the United Kingdom and Spain (UN DESA, 2013).

The consequent urban growth challenges the urban settlements, the access to social services and results in a "*poorly managed urban migration*" (IOM, 2015, p.3). In fact, migrants often face the urbanization-related problems the most, through restrictive immigration and inadequate labour policies, **limited access** to resources, services and opportunities, diffused poverty and the necessity to develop informal solutions.

A common problem is that "*population groups are spatially unequally divided within many European cities*" (IOM, 2015, p.59), preventing a solid socio-economic, cultural, and linguistic integration. These factors highlight the effects of migration and urbanization on health.

Health is "*a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity*" (WHO, 1946, Preamble).

Due to the so-called **healthy migrant effect** and the average young age, they tend to be stronger and healthier than locals (Domnich, Panatto, Gasparini & Amicizia, 2012) and their compatriots left behind (Chiswick, Lee & Miller, 2008).

However, over time, "*their initially positive health characteristics begin to deteriorate to levels similar to those of the host population, probably as a result of a combination of environmental and behavioural changes*" (Domnich et al., 2012, p. e7532-2), so immigrants can be even more exposed to health-related problems than locals.

> "*The triple threat consists of infectious diseases that thrive in poor and overcrowded urban environments, non-communicable diseases which are exacerbated by unhealthy lifestyles (…), and injuries and violence that stem from dangerous road traffic and unsafe working and living conditions*" (Schultz, 2014, p.5).

The **risk factors** include the spaces of vulnerability (locations frequented by migrants, such as informal urban settlements, railway stations, construction sites etc.); the temporal determinants (different health statuses connected to the migration's phases); and especially the **social determinants of health**, defined as "*conditions in*

which people are born, grow, live, work and age, and which are mainly responsible for persisting health inequities" (Schultz, 2014, p.6).

Migration is a social determinant of health itself (IOM, WHO & UNHCR, 2013), a change-bringing condition both for migrants and locals.
It is crucial to address the issue particularly for migrants in the urban context, where these populations meet. Many policy recommendations were developed to improve their health status, tackling the interrelated social determinants of health. The access to healthcare services and check-ups, water, sanitation and housing are important for an acceptable living standard and its implications on well-being. Education is essential to follow healthcare procedures and to understand cultural differences (for both migrants and locals), enhancing social inclusion and cooperation, so reducing unemployment and segregation as well (Figure 1).

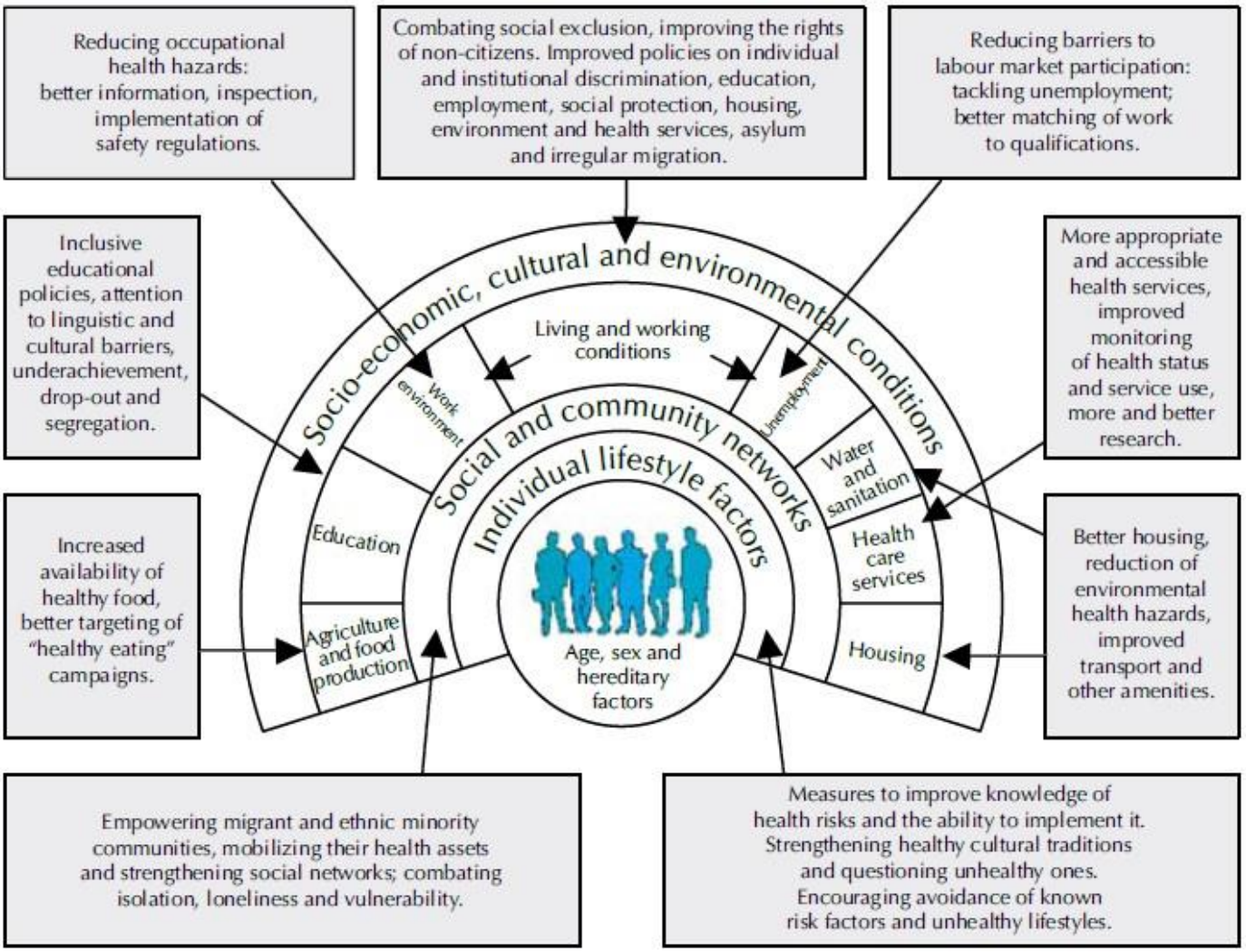


Figure 1 - Policy measures required to tackle the social determinants of health for migrants and ethnic minorities. Source: WHO regional office for Europe. (2010).

However, migration often relates to inadequate housing, immigration and social policies, which could lead to unemployment, poverty, discrimination, cultural shock, anxiety, depression, smoking, alcoholism, violence and drugs. These factors affect all migrants, but influence particularly the health status of the most **vulnerable** groups, such as women, children, elderly, unskilled, refugees, internally displaced persons, homeless and asylum seekers (Schultz, 2014).

2. Asylum seekers: a vulnerable migrant population

2.1 Classification of forced migration

According to the objective classification, the asylum-related migration is international, collective, often permanent, irregular and forced. There is still plenty of misunderstanding about its **definition**, often confused with other categories of forced migrants (Baggio, n.d):

- **Displaced person**: who had to leave his/her home, "*as a result of a natural, technological or deliberate event. (…) Displaced people include internally displaced (people, who remain in their own countries) as well as refugees (people, who cross international borders)*" (WHO, n.d, para. 2).
- **Exile**: a person forced by his/her country's authorities to leave it.
- **Deported**: a person subject to "*deportation, expulsion or forced removal – physically removing someone against their will from the state's territory and transporting them to their presumed country of origin, or habitual residence, or a country they have transited or to which they have agreed to be removed rather than being returned to their country of origin*" (Karamanidou & Schuster, n.d, p.2).
- **Refugee**: who, "*owing to 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*" (Convention relating to the Status of Refugee, 1951, Art. 1.A(2))
- **Asylum seeker**: a person seeking protection, meeting the definition of refugee, whose application is still under evaluation by the host country's authorities.

A transfer of status is possible: chronologically, asylum seekers are displaced persons or exiles, who will be either refugees, or deported, or **undocumented immigrants**, defined as "*foreign nationals who are not able to legitimise their residence or work or both in accordance with the rules of law of the specific country*" (Roskilde University and Working Lives Research Institute, 2008, p.9).

According to the Universal Declaration of Human Rights, "*everyone has the right to seek and to enjoy in other countries asylum from persecution*" (art.14, 1948).
Apart from the refugee status, **subsidiary and humanitarian protection** are provided to those asylum seekers, who fail in meeting the refugee definition, but have proof of economic or other founded reasons (subsidiary protection), or humanitarian motives (humanitarian protection) not to return to their country of origin or residence.

2.2 Asylum migration in the European Union

Developing countries host around 86% of the world's refugees, with Pakistan and Iran in the 2013 top positions (ASRC, 2013). However, around 1.2 million people become new asylum seekers worldwide each year (UNHCR, 2013).
The top two countries receiving asylum applications in 2013 were South Africa and Germany (ASRC, 2013).

The asylum seekers' current inflow towards the EU is the result of an **increasing pattern** in the recent past (2010-present), caused primarily by the socio-political instability in Syria, Iraq, Afghanistan, Maghreb, Somalia and Eritrea (Figure 2).
If the 350 thousand asylum applications in 2012 in Europe (83% of which in the EU) were 10% more than in 2011 (UNHCR, 2012a), more than 500 thousand (87% in the EU) were reported in 2013, an increase of 32% from 2012 (UNHCR, 2013).

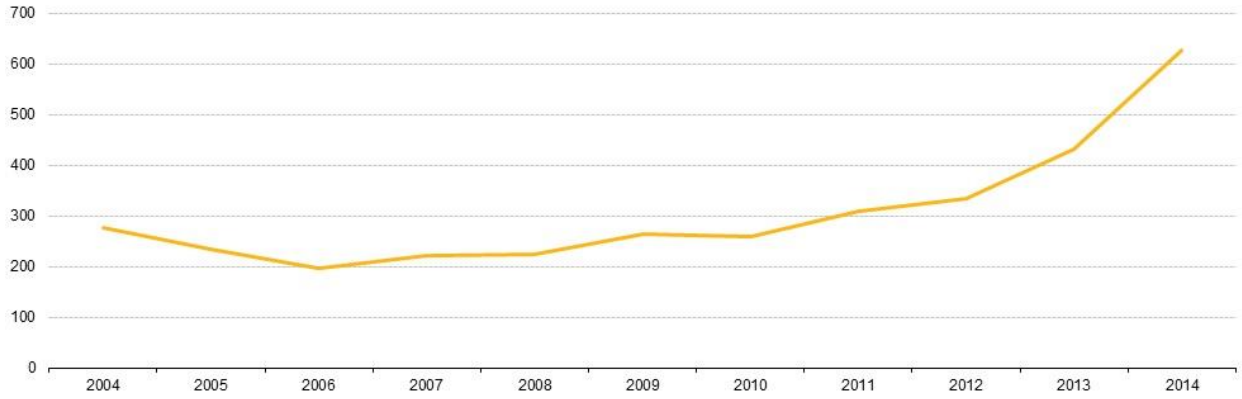


Figure 2 – Asylum applications (non-EU) in the EU-28 Member States, 2004–14 (thousands). Source: Eurostat

There were 1.8 million asylum seekers globally during 2014 (UNHCR, 2015a), almost **662.000** of whom (36.7%) registered their application in the EU+[2] (AIDA, 2015a) (Figure 3). This represented a further increase in comparison to 2013, followed by a raise of 86% in the 2015 first quarter compared to the 2014 same period (Eurostat, 2015b). However, the EU represents **only a portion** of *the world's largest movement of asylum seekers since the end of WWII* (Alfred, 2015).

Member State	Share in 2014 (%)	Number of applicants
Germany	30.6%	202,815
Sweden	12.3%	81,325
Italy	9.7%	64,625
France	9.7%	64,310
Hungary	6.4%	42,775
UK	4.8%	31,945
Austria	4.2%	28,065
Netherlands	3.7%	24,535
Switzerland	3.6%	23,770
Belgium	3.4%	22,850
Denmark	2.2%	14,715
Norway	1.7%	11,480
Bulgaria	1.6%	11,080
Greece	1.4%	9,435
Poland	1.2%	8,025
Spain	0.8%	5,615
Finland	0.5%	3,625
Cyprus	0.2%	1,745
Romania	0.2%	1,545
Ireland	0.2%	1,450
Malta	0.2%	1,350
Czech Republic	0.17%	1,155
Luxembourg	0.17%	1,150
Croatia	0.06%	450
Portugal	0.06%	445
Lithuania	0.06%	440
Slovenia	0.05%	385
Latvia	0.05%	375
Slovakia	0.04%	330
Estonia	0.02%	155
Total		**661,965**

Figure 3 – distribution of asylum applicants in the EU+.
Source: AIDA, Annual Report 2014-2015.

[2] Statistics from the EU+ zone include the 28 EU Member States, Norway and Switzerland.

Around 90% of the asylum seekers were first time applicants (AIDA, 2015a) and 45% of applications in the EU28 received a positive first instance decision, a refugee status (56% of cases), subsidiary or humanitarian protection. Out of refusals, only 18% received a positive final decision on appeal (Eurostat, 2015c).

The asylum seekers' **nationalities** in the EU are very diverse, by both geographical origin and destination distribution. The overall main countries of origin over the recent past (2010-present) were: Syria (19.5%), Afghanistan (6.6%), Kosovo (6.1%), Eritrea (5.9%), Serbia (4.9%), Pakistan (3.5%) and Iraq (3.4%) (Eurostat, 2015c).
An increasing trend regards in particular **Africans**, mainly from the Western sub-Saharan area and the Horn of Africa. They reach the EU border countries, like Italy, Greece, Malta and Spain, across the Mediterranean Sea, the EU's most used route for illegal entries and the least subject to rejections (Sabbati & Poptcheva, 2015).

Under age 14, the **gender distribution** is balanced, except from the unaccompanied minors (86% males). Until age 64 males are around 70% of the total, and only in the last age group, 65+, which accounts only for 0.8%, females are the majority (57%) (Eurostat, 2015c). Concerning **age**, 79% of asylum seekers are under age 35 and 54% are aged 18-34 (Eurostat, 2015c).

From the legal perspective, almost all the asylum seekers' migration journeys towards the EU are **irregular**. The detected irregular migrants'[3] crossing of the Mediterranean Sea were over 267 thousand in 2014 (Kuschminder, de Bresser & Siegel, 2015).
Other overland routes exist too, principally the Asian route, across the Middle East and Turkey, and the Western Balkan route. However, they are in continuous evolution and reshaping, due to each migration's uniqueness (Kuschminder et al., 2015).

The choice of reaching the EU, instead of a closer border country, is determined to a great extent by the "**European dream**", which embodies democracy, freedom, security, welfare, opportunities, life-style and reputation (pull factors). Instead, the push factors include individual, social, political, economic reasons in the home country, as well as some legal, bureaucratic or policy measures' effects (Kuschminder et at., 2015).

[3] Asylum seekers are included as a part of the broader category of irregular migrants.

PART TWO

The EU's role in asylum-related policies

3. Jointly achieved responses

The EU provides a responsive role to the asylum seekers' migration towards its territory, continuously developing joint policies and legislation. However, if the asylum bureaucratic and legal procedures are well developed, the harmonization of healthcare provision and reception conditions still lack coordination.

3.1 Frontex and the defence of external borders

Frontex, or the European Agency for the Management of Operational Cooperation at the External Borders, is an intelligence-based agency established in Warsaw.
It operates since 2004 with Europol, Interpol and others to fight illegal immigration, terrorism infiltration and human trafficking, relying on its Border Guard Teams.
It coordinates and assists the MSs' border management systems to protect the EU's external borders (air, land, sea), as a **joint surveillance** with common standards.
It contrasts irregular arrivals, organizes joint deportation operations, offers a unified training for border guards and provides rapid emergency response capabilities.
All operations are based on risk analysis and research, to make them "*uniquely tailored to the circumstances identified*" (Frontex, General, n.d).

Frontex also provides "*adequate information to allow for appropriate measures to be taken or to tackle identified threats and risks with a view to improving the integrated management of external borders*" (Council Regulation (EC) 2007/2004, Preamble, (6)). Therefore, all operations are evaluated and further recommendations forwarded to the **National Coordination Centres** (NCC), through periodical reports published on Eurosur, the information and data exchange-platform.

As a "*necessary corollary to the free movement of persons within the European Union and a fundamental component of an area of freedom, security and justice*" (Council Regulation (EC) 2007/2004, Preamble, (1)), Frontex implemented a number of joint operations in the **Mediterranean Sea** (Figure 4), such as Hermes, Aeneas and Triton.

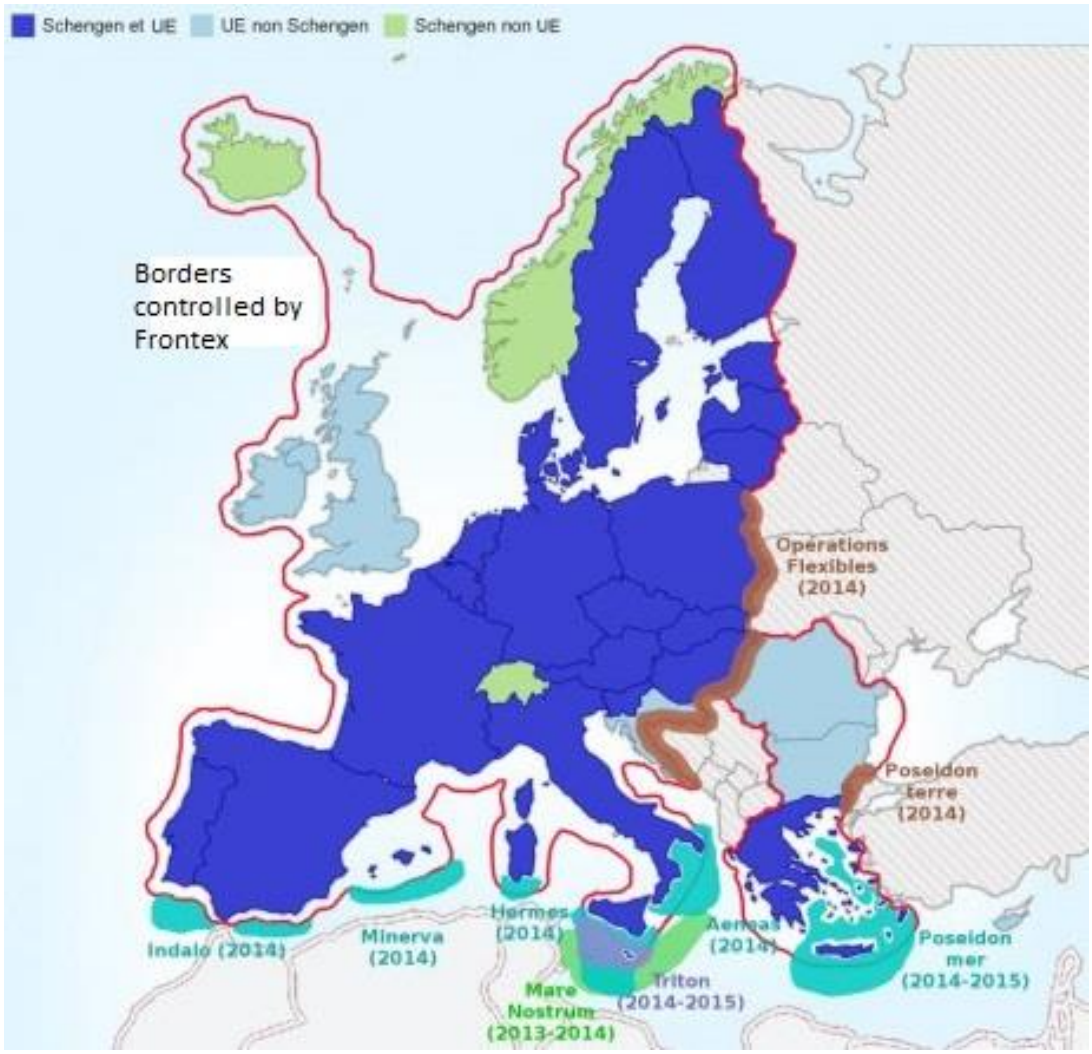


Figure 4 – Frontex defensive role of EU borders.
Source: La Tribune, Triton, Poséidon, Hermes : les opérations de Frontex en carte, 24.04.2015

Hermes operated fragmentally between 2009 and 2014, protecting the southern Italian coasts on its demand from illegal arrivals from Tunisia, Egypt, Algeria and Libya, amounting for a joint EU cost of 40 million Euros (Frontex, Archive of Operations, n.d.).

Aeneas operated on Italy's demand too, tackling departures from Egypt, Turkey and Albania between 2011 and 2014.

However, the African illegal migrants continued to set sail, resulting in a growing number of drowning and refoulements. Therefore, between 2013 and 2014, Italy launched the operation **Mare Nostrum** with search and rescue purposes, as a reaction to the Lampedusa tragedy's 350 deads.

As the operation was national, unpopular and expensive, the new Frontex joint operation **Triton** was implemented, replacing from 2014 Mare Nostrum, with a less humanitarian and more surveillance-related aim (European Commission, 2014).

3.2 The health-related human rights in legislation

The fundamental human rights equally concern all people, without discrimination, based on the fact of being human. The right to asylum, life, the freedom from torture and slavery serve as examples.

They are international, interrelated, indivisible and inalienable, and grant both rights and duties. It is a state competence to fulfil and protect fundamental rights, but all individuals should respect them.

The modern concept of human rights developed after WWII, when the United Nations (UN) adopted a number of international legislations (OHCHR, What are human rights?, n.d). The integration of human rights into national legislation follows, therefore, a top-down direction (Figure 5).

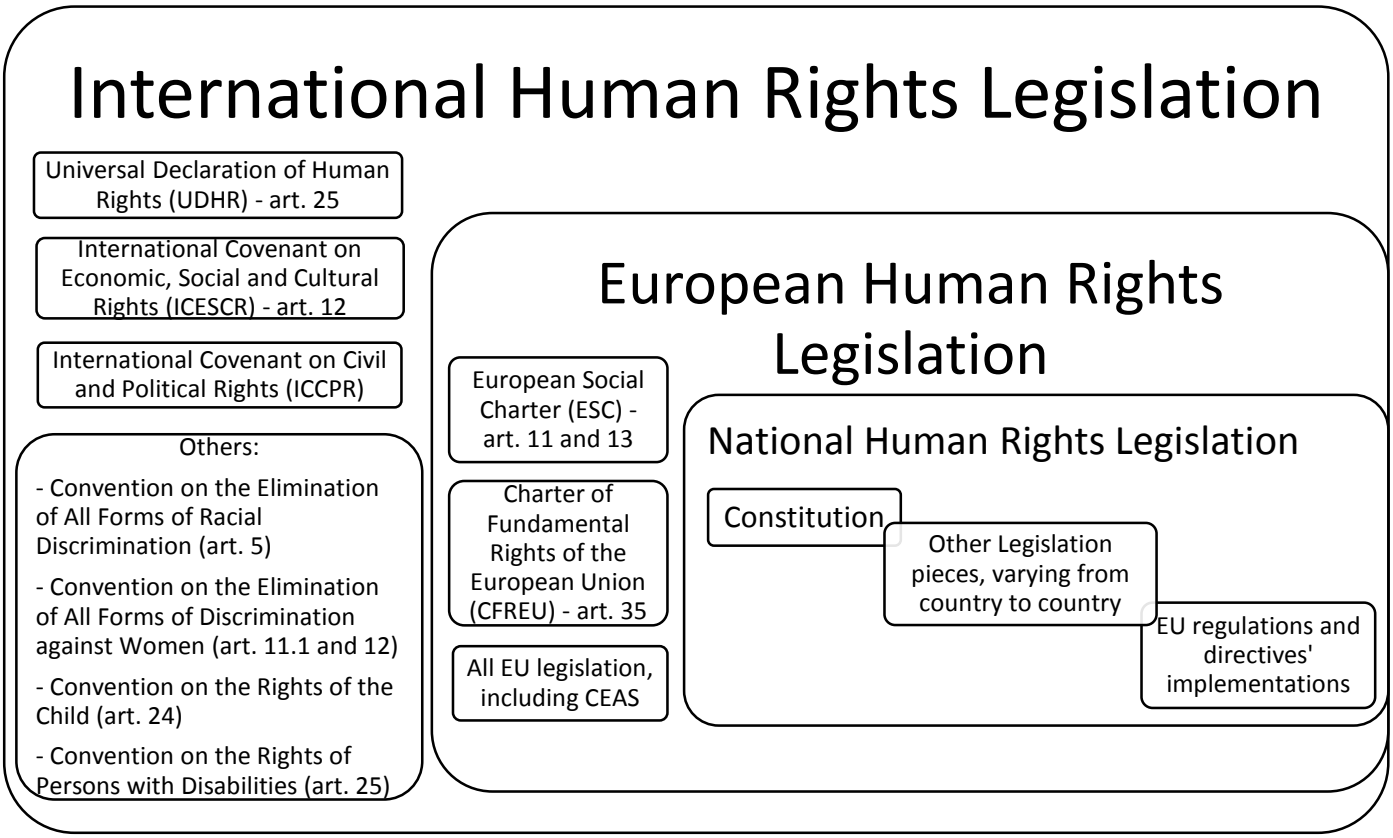


Figure 5 - Overview on the right to health in Human Rights Legislation at three levels. Own illustration.

The main international codes forming the **Universal Bill of Human Rights** are the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Civil and Political Rights (ICCPR, 1966a) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966b).
Since the EU complies with these and human rights are inalienable and universal, human rights in EU legislation apply to asylum seekers too.

The **right to health** is crucial for the dignity of the person. The UDHR states:

"*everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services*" (art. 25).

The dependency of all other rights on the right to health is evident, where the right to health does not refer to healthcare merely, but to all socio-economic circumstances that enable a person to a healthy life, considering the social determinants of health and the individual biological features too (CESCR, 2000).

The ICESCR also recognizes the "*right of everyone to the enjoyment of the highest attainable standard of physical and mental health*" (12.1).
Other international codes referring to the right to health are the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5, 1965), the Convention on the Elimination of All Forms of Discrimination against Women (art. 11.1 and 12, 1979), the Convention on the Rights of the Child (art. 24, 1989) and the Convention on the Rights of Persons with Disabilities (art. 25, 2006), among others.

Particularly, the **state obligations** to fulfil the right to health are:
"(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (ICESCR, art. 12.2).

The last point highlights the four conditions necessary to assure medical service: **availability** (the healthcare system's functioning), **quality** (scientific and medical appropriateness), **acceptability** (ethical and cultural appropriateness) and

accessibility (related to geography, physicality, affordability, information and based on the non-discrimination principle) (CESCR, 2000).
The non-discrimination principle is underlined explicitly as basis for the application of the ICESCR itself (art. 2.2 and 3).

All EU legislation complies with the Universal Bill of Human Rights. The right to health is explained in the revised **European Social Charter** (ESC, 1996) and principally in the **Charter of Fundamental Rights** of the European Union (CFREU, 2001).

The CFREU is the main European human rights legislation and states:

"*everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*"
(art. 35)

It protects the right to health, in compliance with the international legislation, however it leaves a large margin of freedom to MSs in healthcare provision, as it is clear in the Qualification Directive for asylum as well.

The ESC, like the CFREU, is a human rights European legislation encompassing the EU territory, as it was drafted by the Council of Europe.
It is the most complete code on human rights and serves as a point of reference to EU law (particularly the Treaty on the Functioning of the EU) and the CFREU. However, while the CFREU is legally binding in the EU since 2009, the ESC is not (Council of Europe, the European Social Charter, n.d).
The ESC guarantees the socio-economic human rights, focusing particularly with vulnerable populations, non-discrimination and health.
Article 11 grants everyone the right to protection of health, in particular "*to prevent as far as possible epidemic, endemic and other diseases, as well as accidents*", supported by the right to social and medical assistance (art. 13).

The Court of Justice of the EU, the European Court of Human Rights (ECHR) and the Fundamental Rights Agency are the three institutions responsible for judging or monitoring the protection and implementation of the fundamental human rights in the EU's territory.

3.3 The Common European Asylum System

The main achievement concerning asylum was the legislative procedure started in the 1950s towards the application process' unification.

The adopted **Geneva Convention** relating to the Status of Refugee (1951) was limited at first only to post-Second World War Europeans.

The 1967 Protocol excluded the Convention's geographic and temporal limits (art. I.3), making it the main internationally unified code on asylum practises nowadays. The mandatory **principle of non-refoulement** was included (art. 33.1), prohibiting forcible return to any dangerous territory for the refugee's life and freedom, health and well-being alike. The United Nations High Commissioner for Refugees (UNHCR) is responsible for intervention, as guardian of the Convention (art. 35 of Convention and art. II of Protocol), its principles and the refugees' personal dignity.

The **European Refugee Fund** enhances financial solidarity during sudden disproportional influxes, like the North African Emergency (NAE), or aims at improving reception infrastructure and services. Since 2014, the **Asylum, Migration and Integration Fund** (AMIF) also supports the EU financial cooperation to strengthen the CEAS and ensure its efficient legislative implementation.

In emergency circumstances, the **Directive on Temporary Protection** (2001/55/EC) is an exceptional measure to provide immediate protection for one year (art. 4), without granting asylum, together with a residence permit (art. 8), access to employment (art. 12) accommodation (art. 13), education (art. 12, 14) and family reunification (art. 15). The directive also underlines the MSs' responsibility for temporary protection beneficiaries to "*receive necessary assistance in terms of social welfare and means of subsistence, (…) the assistance necessary for medical care shall include at least emergency care and essential treatment of illness."* (art. 13.2).
It also considers vulnerabilities, stating:

> "*Member States shall provide necessary medical or other assistance to persons enjoying temporary protection who have special needs, such as unaccompanied minors or persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence*." (art. 13.4)

However, the directive's mechanism, including the promoted solidarity spirit in reception among MSs, was never concretely enforced.

Considering the right to asylum (CFREU, art. 18) and the planned adoption of asylum-related measures (Treaty establishing the European Community, art. 63), the Treaty on the Functioning of the European Union (TFEU) finally established a **Common European Asylum System** (CEAS) (art. 78).
Created in 1999 after the Tampere meeting, when asylum policies were largely a national competence, it aims at diminishing the treatment differences between MSs. As these were not completely harmonized yet, the CEAS is still undergoing developments today, legislating over asylum procedures, MSs' responsibilities and reception conditions.

In 2008, the **Policy Plan on Asylum** was published, adopting three pillars for the CEAS: harmonisation of the protection standards as alignment of all Member States' asylum legislation; supportive and effective practical cooperation among MSs; and increased solidarity and sense of responsibility inside and outside of the EU towards the asylum-related migration flows (European Commission, 2008).
The Treaty on Friendship, Partnership and Co-operation between Libya and Italy in 2008, with the participation of the EU, was part of the cooperation with non-EU countries, "*with the goal of improving the management of refugee flows and enhancing protection capacities in the regions from which many refugees originate*" (European Commission, external aspects, para. 1, 2015a).

Based on the Policy Plan, there are five main revised legislative codes to the CEAS (Figure 6).

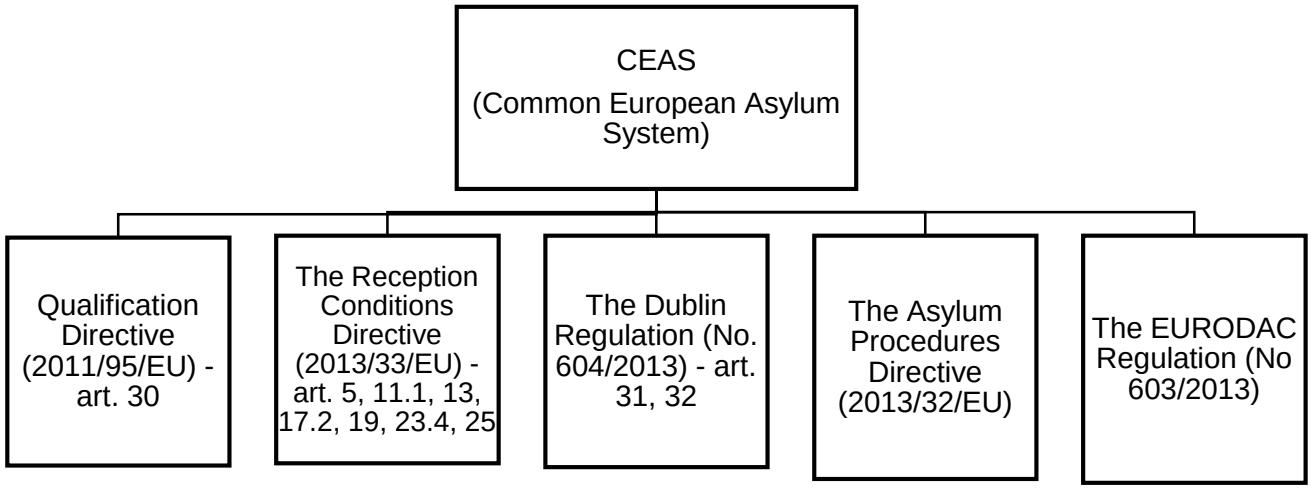


Figure 6 – Overview of the CEAS and its healthcare legislation. Own illustration

- **The Qualification Directive** (2011/95/EU) establishes the standard requirements for international protection (art. 2(a)), harmonizing the process in the EU. It also clarifies the access to minimum rights and integration measures for international protection beneficiaries.

  Article 30.1 ensures them with "*access to healthcare under the same eligibility conditions as nationals of the Member State that has granted such protection*", including both physical and mental healthcare provision to vulnerable groups, "*such as pregnant women, disabled people, persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence or minors who have been victims of any form of abuse, neglect, exploitation, torture, cruel, inhuman and degrading treatment or who have suffered from armed conflict*" (art. 30.2).

- **The Dublin Regulation** (Regulation (EU) No. 604/2013) forms the Dublin System jointly with the EURODAC Regulation. Its goal is to "*determine rapidly the Member State responsible [for an asylum grant], so as to guarantee effective access to the procedures for granting international protection and not to compromise the objective of the rapid processing of applications for international protection*" (Preamble, (5)). It is based on the Qualification Directive and the prevention of multiple-country applications, by the same applicant (asylum shopping). The responsibility is usually assigned to the first MS entered, but the solidarity principle in EU cooperation persists in exceptions.

  The Regulation provides legal and procedural transparency of transfer, deportation and detention conditions and crisis-management mechanisms, but healthcare is only mentioned for the purpose of information exchange between MSs, in case of transfer of a person in need of healthcare provision (art. 31, 32).

- **The European Dactyloscopy** (EURODAC) Regulation (Regulation (EU) No 603/2013) established an EU database for comparison of fingerprints of unauthorised entrants to the EU territory, better monitoring their movements and prevention of asylum shopping and terrorism, while facilitating EU MSs in judging asylum requests. No data is shareable with third countries (art. 27).

- **The Asylum Procedures Directive** (2013/32/EU) aims at faster and fairer decisions on asylum, harmonized with the same minimum standards, to provide the same chances everywhere. The right to remain in the country pending the examination of the application (art. 7) and to legal assistance and representation

(art. 15) are defined, as well as the access to procedures, application examination and personal interviews.

The only reference to health regards the consultation possibility with a professional when doubts arise on the applicant's ability to be interviewed (art. 14.2b) or his/her age (art. 25.5), and the eventual assessment of signs, proving persecution or serious harm suffered (art. 18.1).

- **The Reception Conditions Directive** (2013/33/EU) aims at harmonizing adequate reception standards, based on the Qualification Directive.

  It includes housing and food (art. 2(g)), education (art. 14), employment (art. 15), information (art. 5), detention (art. 8, 10, 11) to meet the asylum seekers' needs and maintain the functioning of the applications' procedure.

  Healthcare provision shall be ensured by MSs, including at least emergency care, treatment of illness and mental disorders (art. 19), information provision (art. 5) and adequate living standards to protect physical and mental health (art. 17.2). The directive also mentions public health-based medical screenings (art.13), mental healthcare and rehabilitation services for traumatized minors (art. 23.4) and applicants in detention (art. 11.1), besides medical and psychological treatment for victims and torture and violence, by appropriately trained professionals (art. 25). The cost for such services is left to the discretion of the MSs (art. 17.4, 17.5).

Since 2010, the **European Asylum Support Office** (EASO) operates as an independent specialized body to help the EU MSs fulfilling European and International asylum legislation and enhancing the CEAS's implementation, through exchange of information and best practises. Nevertheless, disparities among the MSs are still present, due to the newness and the practical difficulties of the described legislation.

3.4 Unified approaches in healthcare provision

Despite of the unified legal-procedural framework for asylum, none is provided for concrete healthcare provision.

In fact, even if the right to health is recognized across the EU, the protection and improvement of human health is a **national competence**, with only partial support and coordination by the EU (art. 6, TFEU). The Qualification Directive also considers the access to healthcare to be guaranteed by each MS individually (art. 30.1).

One of the main determinants granting healthcare access is **legal status**, whether asylum applicant or refugee (WHO Regional Office for Europe, n.d).
Therefore, the Qualification Directive states that healthcare access should be granted under the same conditions as citizens (art. 30.1) for refugees.
Instead, for asylum seekers, the Reception Conditions Directive only sets a minimum level of healthcare provision (emergency care and essential treatment of illnesses and of serious mental disorders, art. 19.1).

Most EU countries comply with these directives, but in practice, as the national healthcare systems operate **differently** and independently, the asylum seekers' effective access to healthcare is still fragmented (HUMA Network, 2009) (Table 3).
If France and the Netherlands grant access to adult asylum seekers to all healthcare and treatment types free of charge, Greece only does that in case of lack of resources, if not full payment for HIV treatment.
The Czech Republic grants everything under co-payment and Slovenia under full payment, with the exception of emergency care, ante-post natal care and treatment for infection diseases, if a public health threat arises.

Concerning pregnant women and children, only Spain and Portugal grant the same conditions and entitlements in healthcare as the local population, while all other countries are highly different.

Unaccompanied children enjoy no-discrimination in all EU countries considered[4], except from Germany, Poland, Romania and Slovenia, which offer the same entitlements, under different conditions and pregnant women instead go through different conditions in Belgium, Germany, Greece, Poland and Romania (HUMA Network, 2010).

[4] Austria, Bulgaria, Croatia, Denmark, Estonia, Finland, Hungary, Ireland, Latvia, Lithuania, Luxemburg and Slovakia were excluded from the study.

NO ACCESS | ACCESS FULL PAYMENT | ACCESS CO-PAID | ACCESS FREE OF CHARGE | NO LEGAL PROVISION

	ACCESS TO HEALTH CARE					ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
BELGIUM	If they request first the "*réquisi-toire*"[23]	If they request first the "*réquisi-toire*"	If they request first the "*réquisi-toire*"		If they request first the "*réquisi-toire*"	If they request first the "*réquisi-toire*"	If they request first the "*réquisi-toire*"	If they request first the "*réquisi-toire*"
CYPRUS	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.[24]	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.			If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.
CZECH R.[25]								
FRANCE[26]								
GERMANY	If residence above 48 months otherwise only if "illness or acute pain" and if get in advance the "*Krankenschein*"	If residence above 48 months otherwise only if "illness or acute pain" and if get in advance the "*Krankenschein*"	If residence above 48 months otherwise only if "illness or acute pain" and if get in advance the "*Krankenschein*"		If residence above 48 months otherwise if they get in advance the "*Kran-kenschein*"	If residence above 48 months otherwise if they get in advance the "*Kran-kenschein*[27]	If residence above 48 months otherwise only if "illness or acute pain" and if get in advance the "*Krankenschein*"	If residence above 48 months otherwise only if "illness or acute pain" and if get in advance the "*Krankenschein*"
GREECE	If lack of resources.	If lack of resources.	If lack of resources.		If lack of resources.	If lack of resources.		
ITALY						[28]		
MALTA	One legal provision generally entitling them to "state medical care and services" and a non-legally binding policy document applying to asylum seekers and undocumented migrants in detention centres[29]							

	ACCESS TO HEALTH CARE					ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
NETHERLANDS								
POLAND						[30]		
PORTUGAL						[31]		
ROMANIA[32]								If the disease creates an imminent danger to life.
SLOVENIA								If needed to prevent the spread of an infection that could lead to a septic state.
SPAIN [33]	If obtain "*empadronamiento*" and thus the health card" [34]	If obtain "*empadronamiento*" and thus the health card"	If obtain "*empadronamiento*" and thus the health card"			If obtain "*empadronamiento*" and thus the health card"	If obtain "*empadronamiento*" and thus the health card"	If obtain "*empadronamiento*" and thus the health card"
SWEDEN	If care "cannot be postponed"	If care "cannot be postponed"	If care "cannot be postponed"	If care "cannot be postponed"		If treatment "cannot be postponed"		If disease included in the list provided by law
UK	If included in a NHS list by a general practitioner.	If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner			If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner

Table 3 –Differences in access to institutional healthcare for adult asylum seekers in 16 EU countries. Source: HUMA Network, 2010

The reason for this **fragmentation** is not only the lack of a common EU strategy, but the great differences in administrative and bureaucratic procedures within different healthcare systems.

Despite of the healthcare access identified by the HUMA Network, regional and local differences exist too, and in general EU countries do not often comply with the fundamental human right to health (2010) nor the values of solidarity, equity, cooperation and responsibility agreed in the Tallinn Charter (2008).

The single country's geographic location, its migration history, the political attitude and the public's prejudice on the issue often **influence further** the asylum seekers' access to healthcare, especially restrictive in detention or deportation conditions and concerning public health. In fact, the scarce resources' allocation in the healthcare systems often impede the reduction of health inequalities, through the full access to healthcare, including prevention care.

The restriction to emergency care and essential treatment only could cause the accumulation of health problems, leading to wider health inequalities and each time more expensive treatments (HUMA Network, 2009).

Some general **recommendations** were developed by the WHO European Office, which calls for the equitable access to "*culturally appropriate vaccination services and information*" (part.5, para. 2), within the framework of the European Vaccine Action Plan 2015-2020 and for a universal, high-quality and uninterrupted health coverage, with no discrimination or legal status preconditions.

Concerning **public health** (which is a shared competence between the EU and its MSs), it furthermore recommends health checks for both communicable and non-communicable diseases, to protect both the foreign and resident populations and it advocates for preparedness and coordination among different countries and social sectors, to answer quickly to outbreaks, still respecting the personal dignity and right to health.

The HUMA Network demands universal healthcare access to all people living on its territory, with no legal status or financial discrimination, underlining that immigration policy must not constrain health policies (2010).

In fact, healthcare access limitations are often linked and performed within the broader fight against illegal immigration, and the healthcare assistance to asylum seekers is often related to the national health-related priorities too.

The **medical screening programs'** goals are to check the asylum seekers' health status and to protect the locals' safety.

Screening for infectious diseases, the most common across the EU, seems more related to public health concerns, while mental health screening, the least frequent, aims more at ensuring the asylum seeker population's exclusive well-being (Norredam, Mygind & Krasnik, 2005).
In regards to infectious screenings, WHO proved no evidence of benefits as opposed to costs and only anxiety produced in asylum seekers and prejudice fostered in communities (n.d).
It is not only screenings producing tensions and affecting the migrant population's health, but the healthcare access conditions as well, both nationally and at EU level. In fact, the lack of a unified approach multiplies the information-related barriers and the human rights break, especially when migrants (not yet asylum seekers) are moved to one country to another, in compliance with the Dublin Regulation.

For example, the bilateral **readmission agreement** between Italy and Greece applies to those migrants, who irregularly cross the sea to apply for asylum in Italy. The healthcare implications caused by the readmission to Greece are reported by MEDU, as dangerous for the migrants' well-being and contrary to the protection of human rights (2013a). While in Italy the healthcare access for undocumented migrants is free or co-paid and basic assistance is provided at ports, in Greece it is prohibited by law, except from emergency care (HUMA Network, 2010), together with low sanitary conditions and xenophobic persecutions.

3.5 On-going response formulation

New recommendations from international organizations, like UNHCR and WHO, as well as from a number of NGOs are constantly developed to increase the effectiveness of the EU's response to the asylum seekers' inflow, with a specific focus on the compliance with human rights and the adequacy of reception conditions.

One of them is the **UNHCR 10-Point Plan of Action**, aiming at helping states, especially in the Mediterranean basin, to deal with mixed migration movements, where economic migrants and future asylum seekers coexists, intervening in protection and reception, data collection and analysis, long-term solutions for refugees and differentiated procedures for different needs.
Particularly, the first and main point of the plan regards the crucial cooperation among key partners on the issue. This refers to cross-border European cooperation, but also to the consideration of migration-related issues as shared competence with non-EU

countries, as well as with international, national and local NGOs and associations and involving the participation of the civil society alike (UNHCR, 2012b).

Within the EU, a **European Agenda on Migration** was set in December 2015 with the goal of increasing mutual trust and solidarity between MSs and improving the migration management with the same perspective in the EU and cooperating with non-EU countries that migrants cross or come from.
The main short-term priority is to stop the human smuggling and tragedy in the Mediterranean Sea, while fighting at the same time illegal immigration.
Therefore, Frontex's funding is being increased, new operations will be implemented at sea and further support granted to the EU's border countries, to better register the migrants within the EURODAC system.
Besides, the European Commission proposed a new European Border and Coast Guard Agency, with a stronger mandate, to replace Frontex and increase the anti-terrorism and criminal infiltration to the EU through the launching of Common Security and Defence Policy (CSDP) operations to identify and destroy boats in the Mediterranean (European Commission, 2015b).

Furthermore, the EU also aims at opening a multi-functional pilot centre in Niger in cooperation with UNHCR and IOM, to better supervise migration flows and offer re-settlement arrangements and humanitarian assistance to transiting people (European Commission, 2015c).
The medium and long term goals are to dismantle smuggling organization in the non-EU countries, strengthening the CEAS structure and legislation, increasing the solidarity and joint efforts of EU MSs, unifying better return policies and systematically monitoring the common legislation's implementation, through a stronger action of EASO, Frontex and Europol directly in the national reception systems (Hotspot method) (European Commission, 2015d).

Concerning the respect for human rights, the EU developed a still broad and flexible **Action Plan on Human Rights and Democracy for 2015 to 2020**, to protect the fundamental rights worldwide, since the Strategic Framework on human rights and democracy was designed in 2012.
As "*human rights are universally applicable legal norms*" (Council of the European Union, 2012, p.3, para.2), their protection is crucial for the EU, indirectly including the right to health and explicitly mentioning the focus on vulnerable populations.

However, nothing is said about concrete healthcare provision to asylum seekers, within the EU. In fact, the EU's strategy for the future years concentrates primarily on political, economic, security and border-protection issues, without tackling healthcare and other social services directly.

The number of proposals to amend or create new EU legislation is very high, and EU communications or MS individual interests foster continuously the discussion and direction of the EU's response formulations.

PART THREE

The Italian reception system

4. Asylum seekers and health in Italy

After having described the EU asylum situation, the specific case of Italy is exposed. Italy is among the main countries of arrival, due to its strategic geographical position.

4.1 Arrival trends

Italy received 9.7% of EU asylum applications in 2014 (Figure 3, p. 11).
The trends have been gradually **increasing**, apart from the 2011 peak, due to the Libyan conflict and the Arab Spring: in 2010 the arrivals were approximately 10 thousand, 62.6 thousand in 2011, 13.2 thousand in 2012, while 42.9 thousand in 2013 and 170.1 thousand in 2014 (Ministero dell'Interno, 2015a).

The inflow caused by the Maghrebine instabilities, between 2011 and 2013, was named "**North African Emergency**" (NAE) and granted extra humanitarian protection to 24 thousand people.

Over 50% of requests are approved yearly (Nufer and Trummer, 2013), as refugee (15%), subsidiary (33%) or humanitarian status (14%) (AIDA, 2013a).

The Mediterranean Sea is the main route of arrival, which is why 70% of asylum seekers are male and 84% aged 18-34, while only 7% are minors (Eurostat, 2015c). Nationality falsification is common during the journey (De Bruycker, Di Bartolomeo & Fargues, 2013) and the migrants' majority reach Italy only as a transit country towards Northern Europe, where they aim at seeking asylum.
Irregular migrants and asylum seekers rely on the same entry routes to the host country, with different migration purposes, creating a **mixed migration**.

The asylum requests were 9.7 thousand in 2010, 37 thousand in 2011, 22.5 thousand in 2012, 60 thousand in 2013, and 219 thousand in 2014 (UNHCR, 2015b).
As the asylum requests follow the same trend of irregular arrivals via sea (Figure 7), it is clear that many manage to remain undetected, making it impossible to draw the irregular migrants' profile (ICMC, 2011).

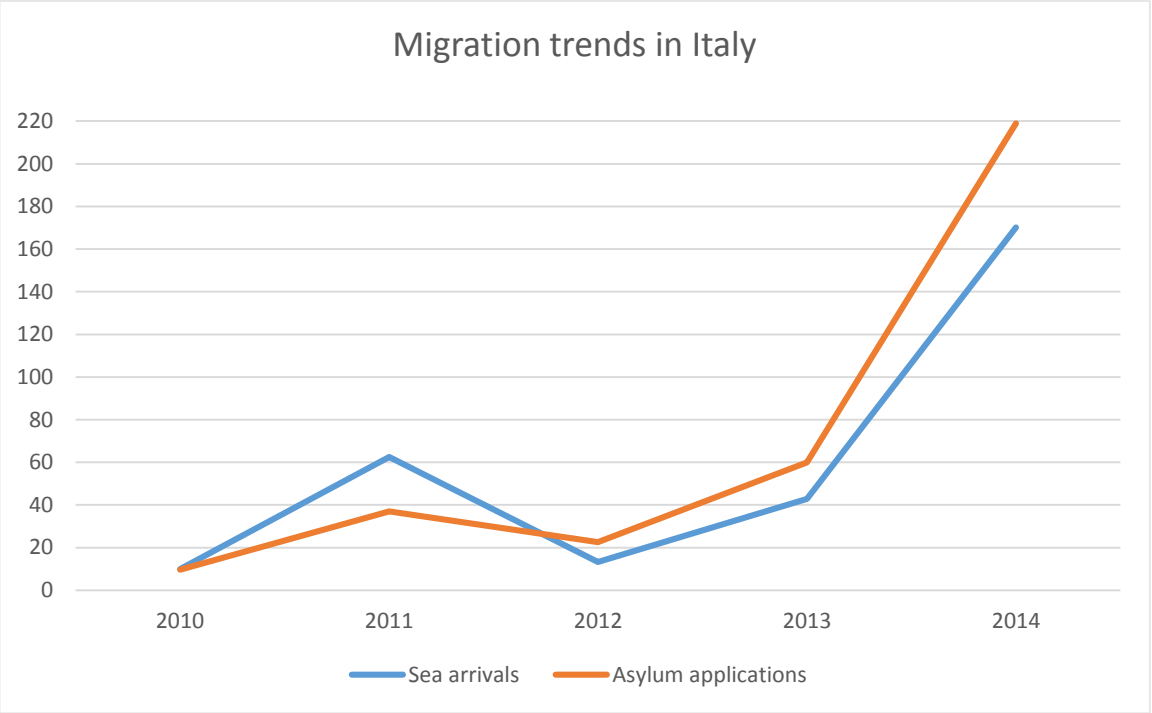


Figure 7 – Comparison of trends in migration arrivals at sea and asylum requests between 2010 and 2014 in Italy. Own illustration, based on national and UNHCR data

Since the early 1990s, the EU restrictive amendments of visa policies encouraged African migrants to reach Europe irregularly across the **Mediterranean Sea**, making it the main irregular entry route in use (Kuschminder et al., 2015).

Between 2009 and 2011, the Treaty on Friendship, Partnership and Co-operation on immigration and organized crime between Libya and Italy reduced the arrivals by 90%, due to joint Italian-Libyan "pushback" operations to **Libya**, which represented a serious disrespect to human rights and the principle of non-refoulement.

With the interruption of diplomatic relations with Italy, the agreement lost validity and irregular migrations re-started, incentivized by Kaddafi's traffickers, as a reaction to the imposed embargo conditions by Italy and the EU (ICMC, 2011).

The raise in African irregular migrants to Italy is also a consequence of the Spanish stricter surveillance, since 2000 (Barros, Lahlou, Escoffier, Pumares & Ruspini, 2002).

In particular, the peak of arrivals in 2011 included 5.000 from Turkey and Greece, and 56.000 from Libya and Tunisia (UNHCR, *Key facts and figures,* n.d).

The asylum applicants' main nationalities were indeed from **Africa** (Table 4).

2010	%	2011	%	2012	%	2013	%	2014	%
Ex-Yugoslavia	18	Nigeria	19	Pakistan	15	Nigeria	13	Nigeria	16
Nigeria	14	Tunisia	13	Nigeria	10	Pakistan	12	Mali	15
Pakistan	9	Ghana	9	Afghanistan	9	Somalia	10	Gambia	13
Turkey	8	Mali	7	Senegal	5	Eritrea	9	Pakistan	11
Afghanistan	8	Pakistan	6	Tunisia	5	Afghanistan	8	Senegal	7

Table 4 –Five main citizenships of asylum seekers in Italy. Source: author's creation, based on the official statistics from the Italian Ministry of Interior - National Commission for Refugees.

4.2 African and Mediterranean migration routes

"*Concepts such as country of departure and transit are extremely fluid because routes are constantly changing*" (AIDA, 2015a, p.25).

The **West African migration route** connects the Western sub-Saharan area (Senegal, Mali, Ivory Coast, Gambia, Ghana, Burkina Faso, Cameroon, Togo, Nigeria etc.) to the Maghreb region, while the **East African route** connects the Horn of Africa (Ethiopia, Somalia, Sudan, Eritrea) to Egypt or Libya (MEDU, 2015a).
A third route, used by Syrians, Afghans, Iranians, Pakistanis and Iraqis through Turkey is an alternative.

Once at the North African Coast, the migrants cross the Mediterranean Sea towards Spain, the Canary Islands and France using the **Western Mediterranean Route**, directed to Greece, Cyprus and the Italian Adriatic coast through the **Eastern Mediterranean Route** or approaching Malta and southern Italy following the **Central Mediterranean route**.
The latter is the main route to reach Italy, the islands of Lampedusa, Linosa, Pantelleria, Sardinia and Calabria (ICMC, 2011), extensively used during 2011-2013, in the NAE framework (Figure 8).

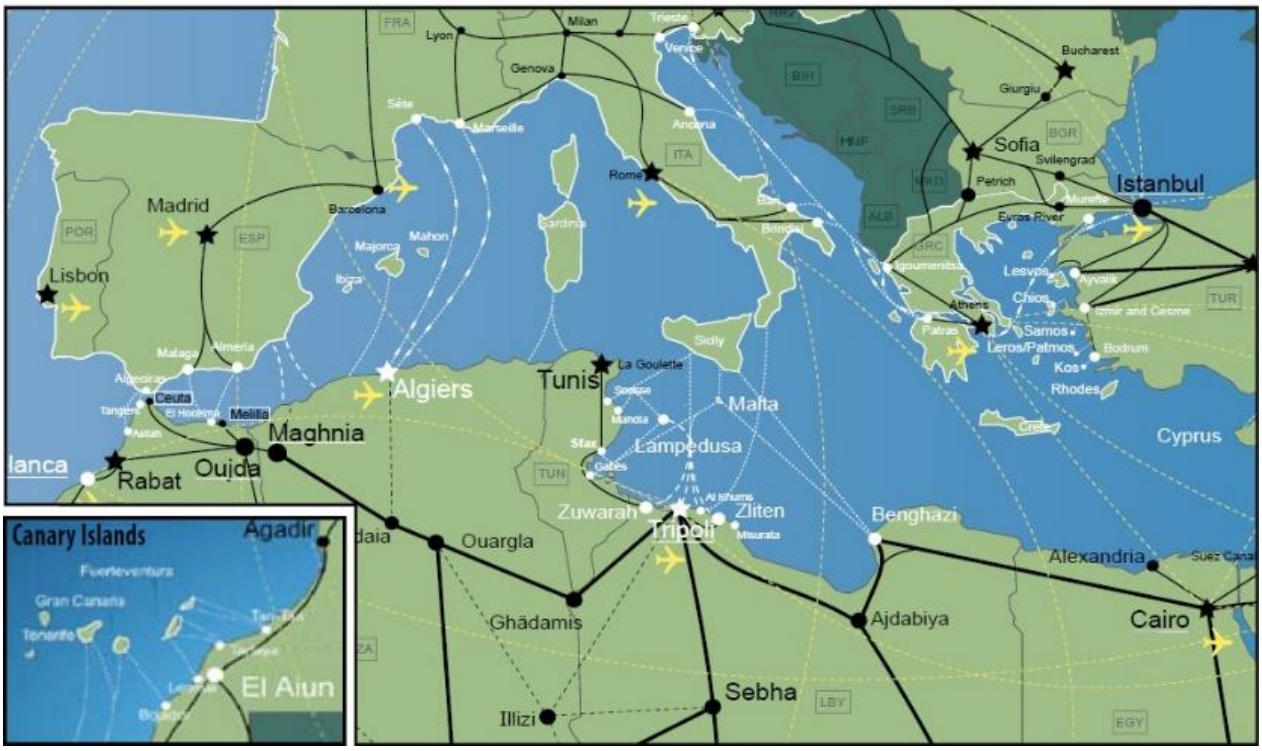


Figure 8 - Irregular Migration Routes in the Mediterranean. Source: ICMC Europe, 2011

The same route of migration was defined 2014's **deadliest** one in the world, with over 3500 dead or missing people over 212.000 arrivals (UNHCR, 2015b).

With the Italian operation Mare Nostrum end and its replacement with the EU operation Triton, the probability of dying during the journey rose from 1 in 50, to 1 in 23 (Amnesty International, 2015).

Commercial ships, fishermen and international organizations, like Médecins Sans Frontières (MSF) and Migrant Offshore Aid Station, are active in rescue operations since 2006 (De Bruycker et al., 2013).

4.3 Human smuggling and violence

In 86% of cases migrants board in Libya (Tripoli or Benghazi), within the framework of the organized human smuggling business (MEDU, 2014a).

It includes different "services", from transportation to public officers' corruption, at high prices that force migrants to stop during the journey to gather the money for the next phase. In fact, human smuggling regards the journey's all segments, including crossing the Sahara, entering Libya and reaching fortress Europe (MEDU, 2015a).

The travelling conditions are **dramatic**. Kidnapping, forced labour, imprisonment, financial extortion and extreme speed sum up to violence, sexual abuse, high temperatures, unstable sanitary conditions and lack of food and water, leading to psychophysical illness or death. Violence in Libya and Niger is particularly brutal, with **no consideration of human rights** (MEDU, 2015a).

According to MEDU, all participants in a research about the NAE were victims of some kind of abuse, by soldiers, police officers, human smugglers, Libyan businessmen and civilians. Racism is also present (MEDU, 2015a).
The main forms of mistreatment included blows, deprivation of food and water, hanging and burning tortures, attendance at others' violence or murder, sexual harassment or abuse. Specifically, 68% had scars or fractures and 62% received psychological assistance in Italy. **Psychological diagnosis** included anxiety (20), major depressive disorder (17), post-traumatic stress disorder (PTSD) (13), night terror (8) and insomnia (3).

According to another research, 62% reported exposure to at least one traumatic event and 18% confirmed torture. Generally, 37% experienced psychological symptoms during the previous week, showing a positive correlation with experienced traumas (Loutan, Bollini, Pampallona, Bierens de Haan & Gariazzo, 1999).
Overall, a systematic review in high-income countries confirmed the prevalence of torture above 30%, with psychological and physical consequences (Kalt, Hossain, Kiss & Zimmerman, 2013).

4.4 Exposure to illness

Migrants are vulnerable also once in the host country, in this case represented by Italy. Social isolation, loss of status, cultural shock, poverty, discrimination, uncertainty about the future, lost contacts with family members result in serious health concerns, especially a further drop in **mental health**. They are 10 times more likely to develop PTSD compared to the local population, with a considerable impact on concentration, memory, sleep, emotional and physical reactivity (SPRAR, 2010).
However, two-thirds experienced other problems than PTSD (Norredam et al., 2005). These are generated by the adaptation to new social norms, environment, bureaucracy and language, and could further cause somatic problems, such as loss of appetite, headache, diffuse pain, but also angriness, aggressiveness, substance abuse (WHO, 2010).

Asylum seekers are **more exposed** to illness also because they often arrive from conflict or poor areas, where the access to healthcare is very poor.
Statistics show that one in six present serious **physical problems**, including hepatitis, tuberculosis, HIV/AIDS, parasitic diseases and body pain (Norredam et al., 2005). However, the focus here is misleadingly put on communicable diseases, as a public health threat and stereotype.
Most frequently, their health problems at arrival are hypothermia, injuries and burns, gastro-intestinal sicknesses, diabetes, hypertension and respiratory infections, especially concerning vulnerable individuals.
Indeed, the overcrowding, exhausting journeys, poor hygiene and contaminated food and water increase the risk of communicable diseases, like measles and food-and-waterborne diseases. However, there is **no scientific association** between asylum migration and communicable diseases (WHO Regional Office for Europe, n.d).

Non-communicable (**NCD**) and chronic diseases and **psychosocial disorders** are more frequent (Bischoff, Schneider, Denhaerynck & Battegay, 2009), including diabetes and hypertension. However, the exposure to NCDs increases in the host country, consequent to the journey, the violence suffered, the difficult adaptation to the new environment, drug abuse, alcoholism, psychosocial disorders, different weather conditions, but also interruption or inadequacy of care (WHO Regional Office for Europe, n.d), in case of resettlement or transfer during the asylum procedure.

5. Legal and bureaucratic functioning of international protection

The national legislation on international protection was formulated over the last three decades. Since 2014 substantial changes were made, including a different asylum procedure and reception system. Since these reforms were done after the here-considered NAE, they will only be mentioned briefly.

5.1 The national legislation on asylum

The Italian Constitution recognizes the right of requesting asylum to everyone, who cannot exercise his/her democratic liberties in the country of origin (art. 10).
In 2011, refugee status was granted only in 13% of cases, besides subsidiary protection (24%) and humanitarian protection (24%) (ANCI, Caritas italiana, Cittalia, Fondazione Migrantes, SPRAR, UNHCR, 2014).
The reason for not granting asylum status is the requests' nature, often based on

economic or political instability or human rights' violation, which are not contemplated as reasons for *persecution* in the Geneva Convention (Ammirati et al., 2015).
The interpretation itself of **persecution** is flexible. The Italian legislative decree (D.Lgs) 251/2007 identifies it as:

- physical or psychological violence;
- discriminatory legislation, conduct by public officers, judiciary decisions;
- judiciary sanctions due to undertake military service, when this could represent human rights' violation;
- actions specifically against children or a particular gender (art. 7.2).

Therefore, **subsidiary protection** is granted when the requirements for the refugee status are unmet, but serious risks prevent the return to the home-country (D. Lgs. 251/2007, art.2(g)). The *serious risks* are death warrant, torture or other inhuman treatment, or the threat to life, within armed conflicts (D.Lgs. 251/2007, art.14). Instead, **humanitarian protection** is granted when international protection (refugee and subsidiary) is refused (D.Lgs. 25/2008, art. 32).
During the NAE, it was only valid for one year, while subsidiary protection for three and the refugee status for five (art. 23). The D.Lgs 18/2014 increased international protection to 5 years.

Italy faces the need of alternatives to refugee status since **1991**, when the Albanian Emergency happened, followed by the Yugoslavian, Somali, Kosovan, African inflows (Ammirati et al., 2015).
Italy's reaction was always to declare the state of emergency, relying on Law 225/1992 (art. 5), with practical consequences in the administration of asylum applications and the reception's quality (ASGI, 2013).

The international protection legislation in Italy is highly **fragmented and revised** (Figure 9).

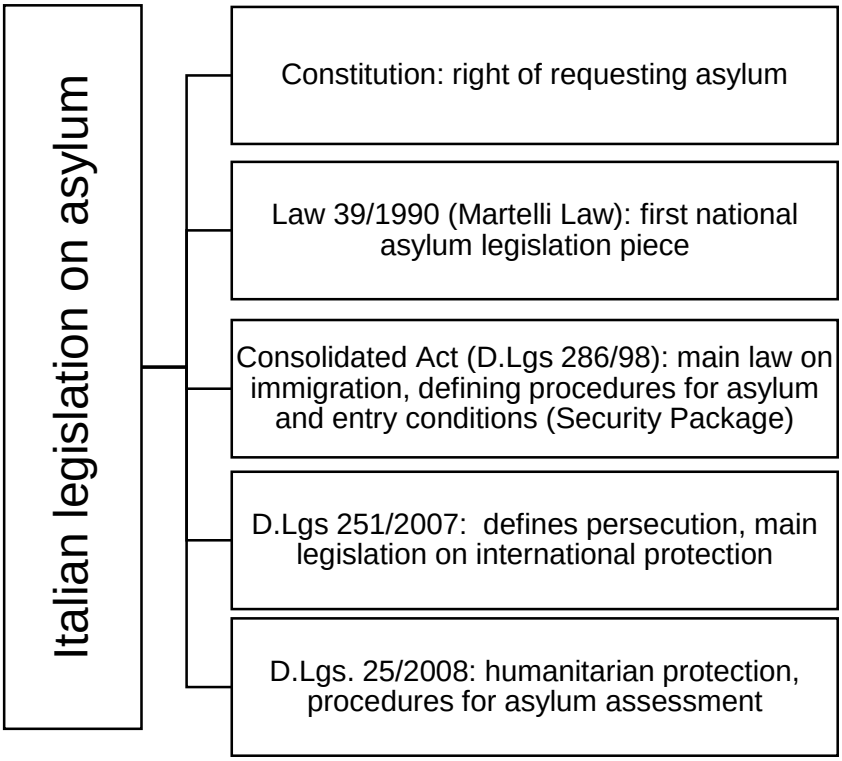


Figure 9 – Overview of the main Italian legislation pieces on asylum, at the moment of the NAE. Own Illustration.

Before 1989, only the Geneva Convention was ratified (Law 772/1954).
The D.Lgs 416/1989 and its amendment with law 39/1990 (Martelli Law) introduced the concepts of universal refugee status, entrance conditions, reception centres and border protection for the first time.

The main law on immigration is the **Consolidated Act** (CA), D.Lgs 286/98, modified in particular by laws 189/2002 (law Bossi-Fini) and 94/2009 (Security Package).
It clarifies the conditions and modes of entry and expulsion, the documentation, rights and duties. The principle of non-refoulement is maintained (art. 19.1) and the victims of human trafficking receive access to special assistance programs (art. 18), also in relation to the new D.Lgs 24/2014 on trafficking and protection of the victims, as implementation of the Directive 2011/36/EU.
Contrasting illegal immigration are state priorities, introduced by the Security Package, which increased the detention duration for illegal immigrants to 180 days (art. 14.5) and later to 18 months (D.Lgs 89/2011, art. 14.1bis).
Information portals at the official entry points are established (art. 11.6) and more importantly, the CA allows the adoption of extra measures for temporary protection

when exceptional events occur (art. 20).

The implementation of EU directives is ongoing since 2004.
The **D.Lgs. 251/2007** is the main international protection legislation (ASGI, 2012), as actuation of the first qualification directive 2004/83/EU.
It was the first organic national law on the juridical conditions of international protection beneficiaries, defining the conditions, approval, rejection or interruption of the beneficiary status, the applications assessment based on individual judgment, taking into account vulnerabilities (art. 19.2). The rights and duties are underlined and shared with the applicants in informative brochures (art. 21).

After the NAE, the approach to international protection radically changed.
The D.Lgs 09/2013 increased the reception system's accommodation capacity and the D.Lgs 18/2014 implemented the new qualification directive 2011/95/EU, modifying the D.Lgs 251/2007, with more attention to unaccompanied minors (art. 22), and introducing the National Coordinating Working Group on unplanned migratory flows, involving all authority levels, the UNHCR and the civil society.
The asylum application[5] procedures and the number and competences of the Territorial Commissions were changed too.

5.2 The National Reception Plan for the North African Emergency

The NAE was the Italian reaction, based on the CA (art. 20), to the huge inflows of African migrants between 2011 and 2013. It is an emblematic case of subsidiary and humanitarian protection's application and the reason for the vast reform of the asylum reception system after 2013 (Ammirati et al., 2015).
Initially, Italy violated the principle on non-refoulement, but on 12th April 2011, it officially declared the **emergency status**.
In early 2011, the majority of asylum seekers arrived were Tunisian and were granted subsidiary protection. However, the next inflows from Libya regarded Sub-Saharans, whose requests followed the regular refugee procedure and were rejected in **60%** of cases.

[5] The reception procedure in use since 2014 consists of a" first aid assistance" in reception hotspots at the point of entry, followed by a "fist reception" in regional or interregional centres, where the identification process takes place. The "second reception", with the longest duration, is attributed only to the System of protection for asylum seekers and refugees (SPRAR). If neither first nor second reception centre spots are available, special centres are temporarily used. (Ministero dell'Interno, 2014).

In fact, resulting safe country citizens, the human rights' violations and years lived in Libya were ignored. As almost all appealed to a second judgement, the government decided to grant everyone a humanitarian protection, to avoid additional costs and social tensions (ASGI, 2013).
The NAE was extended until the end of February 2013, under the Ministry of Interior's responsibility. Reception centres were then closed and the 16.800 refugees still living there (except 2.500 vulnerable people) were given 500 euros as an incentive to leave, holding an Italian residence and work permit and a Schengen travel document (Nufer and Trummer, 2013).

Apart from the extended period, the NAE was largely managed by the **National Civil Protection agency**. It activated a working group, involving the representatives of regions, provinces and municipalities to draft the **National Reception Plan**, which entered into force on 15th April 2011, as a jointly responsible cooperation between the State, the Civil Protection, regional and local authorities and reception providers (Protezione Civile, n.d).
The Plan implemented a **modular reception model** to grant room, board and assistance to a maximum of 50.000 migrants, distributed in all regions, in relation to the resident population.
It was enforced differently in the regions, considering the actuation phases achieved, migrants allocated already and different assistance conditions, according to the Regional Reception Plans derived from the national one.

A new reception service was created, to cope with the emergency quickly, under regional responsibility (Protezione Civile, 2011). Many NGOs and inexperienced hotel owners (also in remote areas) participated, under a payment of daily 46 euros per asylum seeker. However, they often lacked the assistance component, nor legal, nor linguistic and many benefits listed in the legislation (Nufer & Trummer, 2013), including difficult integration possibilities (Cooperativa Sociale Perusia, 2013).

In July 2011, a **monitoring and coordinating group**, formed by IOM, UNHCR, the Civil Protection and the Ministry of Interior was created to support the regions and verify the homogeneity of minimum assistance standards.
However, due to the reception centres' quantity, the monitoring group did not prove itself very efficiently (Protezione Civile, 2011).

5.3 Reception centres

The reception under respectable living conditions is a juridical obligation of MSs, including the rights to information, life, healthcare, family unification and communication with relatives, lawyers, UNHCR, associations (ASGI, SPRAR & UNHCR, 2013). In the NAE's first months, the few reception facilities used were concentrated in Sicily, in an overcrowded and collapsing environment.

Later, three main reception centre types were used: **reception centres for asylum seekers** (CARA), the **protection system for asylum seekers and refugees** (SPRAR) and the newly established **Civil Protection reception system** (SAS), besides the **centres of identification and expulsion** (CIE) (Cooperativa Sociale Perusia, 2013) (Figure 10).

Figure 10 – Distribution of reception centres in the Italian regions, during the North African Emergency. Source: SPRAR, 2012

CARAs were nine centres aimed at the so-called “first reception”, established with the D.Lgs 25/2008. They have large dimensions, outside urban centres and host hundreds of asylum seekers.
They guarantee the total freedom of movement, carry out the identification procedures at arrival and provide the first healthcare assistance. The permanence in the CARAs should not exceed 35 days, when asylum seekers are moved to the “second reception” system, the SPRAR (art. 28).
In reality, the permanence in CARAs can last for the whole asylum procedure, as SPRAR are usually full (ASGI, SPRAR & UNHCR, 2013).

The **SPRAR** was formed by 151 territorial projects, activated by 128 local entities in 19 regions. Before 2000, asylum seekers and refugees were not granted accommodation. Therefore, the SPRAR, created in 2001, was the first public diffused reception system (Cooperativa Sociale Perusia, 2013).
All its local projects are coordinated from a Central Service in Rome, which aims at informing, promoting, supporting and monitoring the different local entities in charge. The “second reception” includes not only food and board, but also information, legal and social orientation, alphabetization ad linguistic courses, healthcare and psychological support, cultural mediation, education for minors, socio-economic integration courses and other services.
They have small-medium dimensions and are located in urban contexts, to encourage social integration (Cooperativa Sociale Perusia, 2013). However, the SPRAR had a reception capacity of only 3000 spots (450 to vulnerable people and 50 to mentally ill), so many asylum seekers were excluded.

The **SAS** consisted of a highly heterogeneous network of facilities, selected on the grounds of immediate availability: flats, hotels, tourist resorts, abandoned gyms, schools, hospitals. These centres did not receive concrete and homogeneous directives in the National Plan, resulting in very different ways to provide services (Cooperativa Sociale Perusia, 2013).

CIEs were 13 centres hosting those illegal immigrants, who did not apply for asylum or committed crimes and were to be expulsed from the national territory, for a maximum period of detention of 18 months (Ministero dell’Interno, 2015b).

Unaccompanied minors cannot be hosted in CARAs and CIEs, so an appropriate SPRAR or dedicated centre must be identified, where he/she will remain until reaching legal age. As the admission timing to the SPRAR are very long, priority is given to vulnerable groups (minors, single parents with minor children, elderly, pregnant women, disabled, victims of torture or abuse).

5.4 The asylum application pathway

Italy's methods to identify asylum seekers and vulnerable groups on arrival, in order to differentiate their pathways, are often not implemented evenly (ICMC, 2011).

The Naval Coast Guard (*Guardia Costiera*) and the Tax and Customs police (*Guardia di Finanza*), under a national search and rescue mandate, perform the **interceptions at sea**. Once they reach the nearest port, the rescued migrants pass under the provincial police authority's responsibility (*Questura*).
Since 2006, the **Praesidium project** created by the UNHCR, IOM, Save the Children and the Italian Red Cross (IRC), is present in some southern regions, to improve and protect the migrants, providing healthcare and legal assistance at arrival (IRC, n.d).

In fact, all migrants arriving illegally are charged with the **illegal entry crime**, suspended if they ask for asylum. Sometimes, the asylum claim is judged only considering nationality, other times linguistic mediation is unavailable, leading automatically to non-asylum claim (ICMC, 2011).
At official entry points, after the asylum claim or nonage declaration, **NGOs** are allowed to intervene and asylum seekers are officially allowed in the country. Otherwise, migrants are immediately returned to the country they came from or to **CIEs**, with no possibility to identify vulnerabilities and victims of trafficking at this point.

After admission, they can access information and legal assistance at the **Information Portals**, and social and healthcare assistance in the centres of first aid by NGOs, like IRC, Caritas and the Italian Council for Refugees (CIR).
Here, the police and CIR also conduct the **identification procedures** and individual interviews within 48 hours to identify vulnerable groups and minors. If age doubts arise, a wrist x-ray medical screening is performed.
The Civil Protection Agency and the IRC distribute basic items, conduct the first medical screenings and provide emergency healthcare, while in some unofficial entry points, especially Lampedusa, MSF provides medical assistance in a mobile clinic.

However, the NGO first aid centres are only three nationally, therefore most migrants, especially at non-official entry points, procedures are not standardized: migrants receive immediate social and healthcare assistance and are transferred to the closest structures, with no assessment of their vulnerabilities and needs (Figure 11).

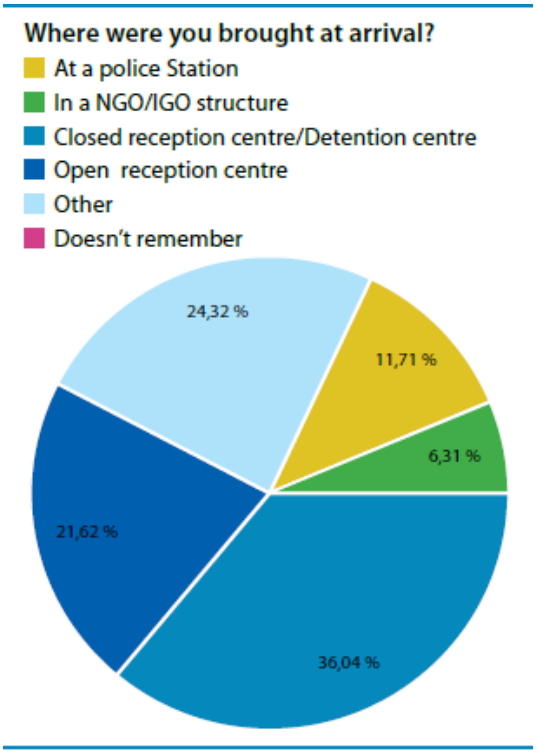


Figure 11 – Reception at arrival.
Source: ICMC, 2011

The following **registration process** can take place within 8 days from arrival, and consists of an asylum form to fill in with the help of interpreters or information leaflets. However, often interpreters are absent and the leaflets distribution does not take place, or often Sub-Saharan asylum seekers are illiterate (ICMC, 2011).
Therefore, the legal assistance of NGOs is fundamental, but their presence depends on the **willingness** of local authorities. The legislation does not guarantee the presence of legal advisors during the registration process.

The asylum forms are then sent to the **Territorial Commissions** in charge of their assessment, a process than can take up to a year in practice, instead of the theoretical 30 days (ICMC, 2011). A public security official, representatives from UNHCR and the local authority and a prefecture body official form the Commissions.

The **first hearing** can be followed by a positive answer, refugee status, subsidiary protection or the request for a humanitarian protection.
In case of a negative answer, the failed asylum seekers can **appeal** to the civil tribunal. Rarely, a second instance appeal before the court of appeal and a final appeal before the cassation court happen too (AIDA, 2013a).

Interviews conducted in Italy with migrants between 2010 and 2011 highlighted their **reception perception**. Some stated having been beaten by police officers.
Concerning information at arrival, 38% stated not having received any. Registration was done at arrival in 59% of cases, while the rest within one week.
Social support was received by 68%, legal service by 45%, medical assistance by 60%, psychological support by 21%, cultural mediation by 56%, and 14% of interviewed stated having received no support (ICMC, 2011).
However, assistance was sometimes provided later than at arrival (Figure 12) and its quality varied in relation to the reception centre types and the presence of NGOs.

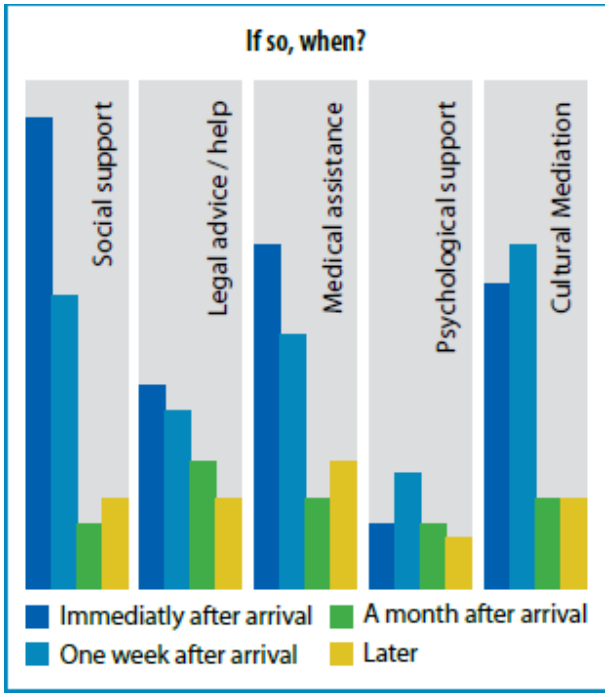


Figure 12 – Time distribution of assistance received.
Source: ICMC, 2011

The standardized procedure that should be followed for arrivals at official entry points is schematized in figure 13.

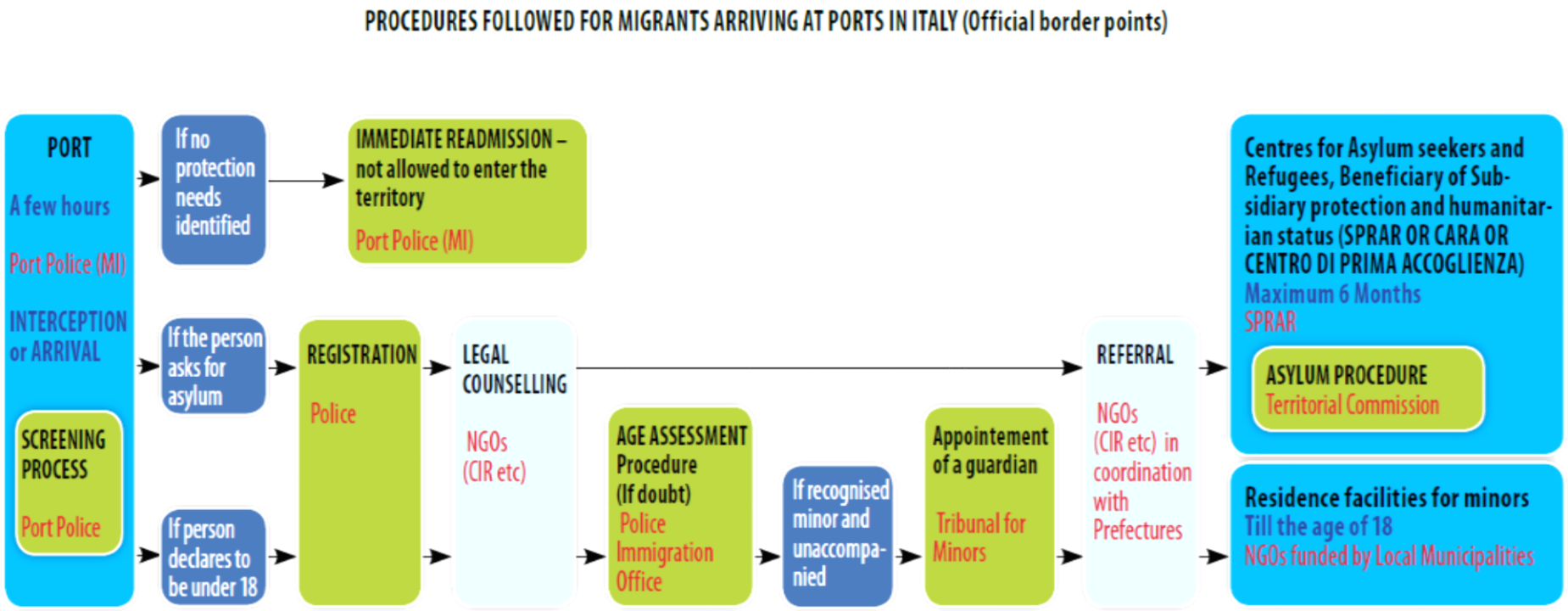


Figure 13 – Procedures followed for migrants arriving at ports in Italy. Source: ICMC, 2011

6. Healthcare provision

Healthcare in Italy is complex. The right is recognized to asylum seekers as to nationals, but a number of barriers limits its actual access, resulting in a human rights paradox, overcome by NGOs and localized projects (Abbondanti, 2013).

6.1 Legislation on the access to the National Healthcare System

The tax-based Italian Healthcare System (Servizio Sanitario Nazionale, SSN) is grounded since 1978 on the principle of **universal coverage** and managed as a **share responsibility** by the state, regions and provinces.

The Italian Constitution recognizes healthcare as right for the individual and interest for the community (art. 32). In correlation with the equality principle (art.3), everybody, without discrimination should have access to healthcare.

The basic benefit package, under the registration to the SSN done at the **local healthcare units** (Azienda Sanitaria Locale, ASL) and the health card obtainment, includes either free-of-charge or co-paid (ticket) care, excluding aesthetic surgery, male circumcision, physiotherapy and special vaccinations (HUMA, 2009).

The **CA** is the main legislation on the right to healthcare for asylum seekers (part V), highlighting its mandatory provision by all local sanitary facilities and the equal condition of international protection beneficiaries to nationals (art. 34.1b).

Asylum seekers must **register to the SSN**, which is a free of charge procedure and allows the free choice of a general practitioner (GP) and a paediatrician, special medical assistance on their request, midwifery and gynaecological visits, and free hospitalisation (AIDA, 2013a).

The ASL provides non-registered asylum seekers with the **STP code** (“temporarily present foreigners code”), allowing them to access emergency care and urgent treatment for renewable six months (HUMA, 2009) until they register to the SSN.

In fact, the registration can be done once a residence permit is provided, and sometimes asylum seekers do not register at all, due to linguistic and administrative barriers (Abbondanti, 2013).

Concerning the costs, asylum seekers are entitled to **free** healthcare in the first six months of their asylum claim, when they are not allowed to work. Afterwards, the ticket payment exemption persists only if they are registered to the unemployment office (CA, art.43.4).

Therefore, also in this case, the healthcare access is granted under the **same conditions as nationals** (Table 5).

Type of healthcare	Access conditions
Emergency care	Access free of charge (under registration to the SSN)
Primary Healthcare	Access free of charge
Secondary Healthcare	Previous authorization by GP and co-payment (ticket around 16 EUR). Exceptions: linked to age, income and type of illness, including work-related disability (above 2/3), partial blindness, deaf-mute, rare illness, early diagnosis and screening, HIV prevention and services against epidemics provided by law
Hospitalization	Co-payment (ticket around 45 EUR), with same exceptions as for secondary care
Ante and post natal care	Access free of charge
Medicines	Free of charge or co-paid: 0% for Category A (severe diseases); 50% for Category B and 100% for Category C. Exceptions: Children, people above 65 and persons with specific chronic diseases.
HIV screening	Free of charge and anonymous
HIV treatment	Free of charge
Treatment of other infectious diseases	Access free of charge for treatment of "exonerated pathologies" in outpatient special departments.
Children healthcare	Access free of charge for children below eighteen years. Vaccination: Some are compulsory, others recommended.

Table 5 – The healthcare services and the access conditions for each of them for asylum seekers, as equal to nationals in Italy. Own illustration, based on HUMA, 2009.

Within the SPRAR, it is the reception centre manager's duty to register the asylum seekers to the SSN (D.Lgs 140/2005, art. 10.1). The **cooperation** with hospitals and health services is high in 83.8% of cases (SPRAR, 2012).

In the centres for unaccompanied children, the unconditional access to healthcare and psychological services are available to overcome possible traumas (ICMC, 2011).

The asylum seekers living in CARAs have access to the healthcare services and personnel in place, for emergency or continuous care (Presidential degree 303/2004, art. 10.1). These centres' dimensions prevent the individual assessment of vulnerabilities.

Therefore, the reception services for vulnerable groups, in cooperation with the ASL, identified in the legislation (D.Lgs 140/2005, art.8), have in reality a difficult implementation. The internal projects by the IRC or NGOs remain marginalized and dependent on diminishing financial resources (FER, 2011).

Only a few cities, including Rome and Milan, have psychological and psychiatric programs (Nufer & Trummer, 2013).

Besides, proper **housing** is decisive for vulnerable groups.

However, SPRAR only reserves 50 places to people with mental conditions and torture survivors, making waiting periods very long, while CARAs are not suitable, because of their mass-hosting nature (Nufer & Trummer, 2013).

If asylum seekers can theoretically access mental health treatment as nationals, they only practically benefit from projects implemented by NGOs and private entities (AIDA, 2013a).

The registration to the SSN in the CARAs is often problematic, leaving the asylum seekers with the STP code for the whole length of their stay and causing an additional barrier for their healthcare access (FER, 2011). In CIEs, due to the juridical condition of the persons to be expelled, the same happens.

During the NAE, the accommodation and healthcare provision situation in CARAs and CIEs concerned over 7000 people (Figure 14).

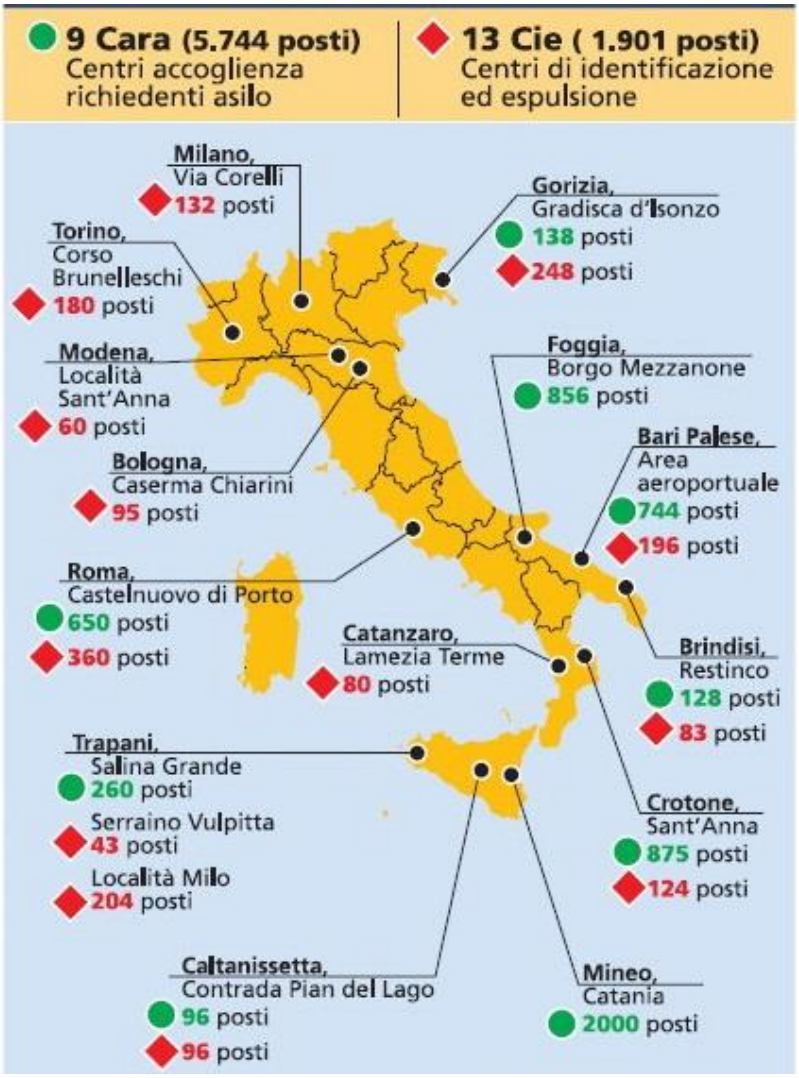


Figure 14 – CARA and CIE centres national distribution map. Source: Mollica, 2012

The situation is also heterogeneous depending on **regions**.
In fact, immigration is a national competence, while the healthcare provision is a shared competence with regions (Constitution, art. 117).
In Lazio, for example, the registration lasts for three months only. In Sicily the ticket exemption lasts for the duration of the asylum request assessment, while in Piedmont special "healthcare information points" were established during the NAE to provide further assistance and simplify the registration process to the SSN (FER, 2011).

The **administrative decentralization** is the reason why asylum integration and healthcare promotion are performed locally, causing disparities across the country. Because of the fragmented nature of the SSN itself into local units, responses to the problem (also concerning housing structures) are multiple, involving public and private providers and NGOs, as a delegation by the Ministry of Interior Affairs.

This heterogeneity lead to a 4-years long research and round-table discussion on the **Pact between the State, Regions and autonomous Provinces** (2012).
The document aims at overcoming the current multi-faceted response to the immigrants' (including asylum seekers) healthcare needs, gathering in a single document all healthcare dispositions and clarifying the existing procedures, in order to improve the efficacy and simplify the process (Abbondanti, 2013). The regional authorities have adopted the Pact, so it is binding (D.Lgs 281/1998, art. 4).
However, due to its recency, there is still space for improvements, in the direction of a uniform approach.

6.2 The violation of human rights and healthcare access barriers

The asylum seekers' healthcare **needs** can be physical, concerning communicable and not-communicable diseases, or mental, regarding trauma and violence.
Gender-specific needs relate particularly to women's health and female genital mutilation. Age-specific and disability-related needs are less discussed, because the prevalence of them is very low (The UK Faculty of Public Health, 2008).

Due to their clear juridical condition and the healthcare parity to nationals, asylum seekers enjoy a better assistance than other groups, at least theoretically.
In fact, the first barrier to the healthcare access is the **uneven legislative application** within a regionally fragmented system (Abbondanti, 2013).

The complex and constantly renewed **bureaucratic procedures** in a foreign language hinder the asylum seekers, who cannot often count on external help, especially if outside reception centres or in remote areas, with a reduced access to specialized care (FRA, 2013).

Africans emerge as the most discriminated, facing indirect **racism and limitations**, as sometimes priority was assigned and a better treatment provided in relation to socio-economic status and personal relations (FRA, 2013).
Many NGOs, such as MEDU and Caritas denounced the SSN institutional discrimination against asylum seekers (MEDU, 2014a).

Even if the level of social support and medical assistance at arrival was high in Italy, complains concerned its quality and continuity during time (ICMC, 2011).

The main barriers are **linguistic and cultural**, due to the heterogeneity of nationalities and the general foreign language illiteracy of Italians (Abbondanti, 2013).
They have an impact on psychotherapy, which is only successful in the mother tongue (FRA, 2013) and induce a lower use of specialized care, vis-à-vis emergency care, which does not tackle properly their healthcare needs.
Cultural mediators and translators with medical knowledge are rare, so the adopted communication strategy either relies on informal interpreters (family and friends), which can raise ethical and cultural issues, or non-verbal communication, which limits the efficiency (FRA, 2013).

Asylum seekers are sometimes not aware of needing professional help, as the perception of **medical appropriateness**, medical **mistrust** and the personal pride to ask for it are very culture-specific (WHO, 2010).
For example, gynaecology is a sensitive topic, due to cultural, gender, religious and linguistic reasons, as well as mental health services.

The **lack of information** about own entitlements sum up to the eventual ticket payments, reasons why there is a "*long and honourable tradition of service provision by NGOs (such as charities and church organizations)*" (WHO, 2010, p.16), with a better understanding and trust of the target population.
In fact, due to the high costs for private services, such as gynaecology, dentistry and ophthalmology, asylum seekers rely on the long-waiting listed public service instead (FRA, 2013).

Besides the communication difficulties compromising the treatment, which asylum seekers do not ask clarifications about, and the widespread medical illiteracy, there is a **cultural shyness** towards the staff and the complaint possibility about eventual discrimination, despite of the active NGO "Tribunal for Patients' Rights" (FRA, 2013).

Healthcare providers perceive this behaviour as a **lack of respect**:

"*for us it's difficult to understand if these guys really have problems: they do not talk, do things we cannot understand, so we don't know how to deal with them*"[6]
(*La denuncia di un infermiere*, 2016, para. 6).

GPs report further difficulties during consultations: absence of professional translators, lack of medical history knowledge, long duration of sessions, lack of information about their eligibility for medical services, cultural sensitiveness, other patients' attitude, lack of resources, including staff, time and funds, and the asylum seekers' non-attendance to medical procedures, like immunisation programs (BMA, 2004). Doctors sometimes give up, affecting negatively prevention programs too (FRA, 2013).

Therefore, a better **training** is needed, in terms of unified procedures and information, intercultural dialogue and specialization on particular needs and diseases, such as tropical dermatology (Abbondanti, 2013), because only if information is provided to both parties, social integration and proper healthcare assistance can be performed.

Overall, the asylum seekers face a **vicious cycle**: hailing from areas with poor healthcare access and hygienic attention, exposed to health threats and violence during the journey, they arrive to Europe with a high well-being vulnerability, which is worsened by a poor health-related assistance and the raising of mental health issues. Social discrimination influences the sense of exclusion and difficulty in creating a routine, which in turn affects again the psychophysical vulnerability of asylum seekers.

Therefore, a violation in human rights exists, contrary to legislation (Figure 15).

[6] "Per noi è sempre difficile capire se effettivamente questi ragazzi abbiano realmente problemi: non si esprimono, fanno cose che noi non capiamo per cui non sappiamo nemmeno come inquadrarli".

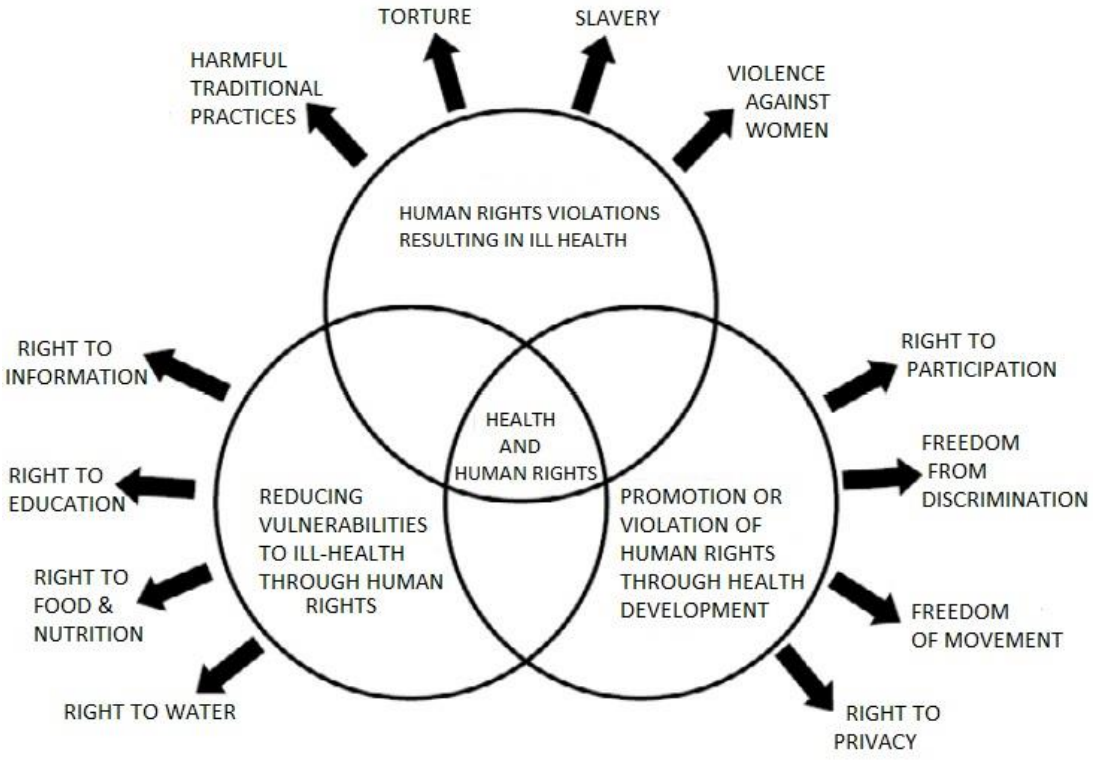


Figure 15 – Linkages between health and human rights. Source: IOM, WHO, UNHCR, International migration, health and human rights, 2013.

This situation gives authorities and healthcare decision-makers preoccupations about the right approach to their psychophysical needs, because they often relate to each asylum seekers' flow, in constant change, the very long legislative and bureaucratic durations and limited resources.

Especially in relation to mental healthcare, it is not enough to provide room and board, as it often happened during the NAE (Nufer & Trummer, 2013).
Any focus on alleviating pain, stress and rebuilding self-confidence, **dignity and hope** to victims of torture and generally asylum seekers, is crucial.
Besides the medical assistance, all interventions in the social, economic, legal and relational fields are beneficial, as the asylum seekers' needs are complex, including material needs, psychological comfort and socialization (SPRAR, 2010).

6.3 The role of NGOs and localized projects in healthcare provision

Rome, Milan, Mineo, Florence, Ferrara and Turin were selected (Figure 16) to represent the healthcare heterogeneity, with a special focus on torture, affecting estimated one third of asylum seekers (CIR, 2014).

Figure 16 – Geographic position of the selected cities in the Italian context.

The support of **NGOs, parishes and over 300 local associations** aims at filling the gap between the individual needs and the incomplete healthcare practices.
The healthcare access was guaranteed in most of SAS and SPRAR during the NAE, through the Caritas' intermediation mainly.
However, in CARAs and CIEs there is no standardized patient management. Due to the CIEs' "closed" nature, the ASL personnel access depends greatly (HUMA Network, 2009). Contrary to their purpose, during 2011, CIEs hosted 200 asylum seekers, who were arbitrarily considered as rejected refugees and could make an asylum claim only once inside (CIR, n.d).

In CIEs, the healthcare provision is **discretionary** on the managing authorities, often limited to primary care. Break-out attempts, self-harm and suicide were frequent, as protest gestures, psychological discomfort or attempts to be transferred.
Therefore, mutual stereotypical hostility between patients and doctors influenced the visits, and psychoactive drugs were administered on average to 50% of detainees

(MEDU, 2013b).
The IRC manages the **CIEs** in Milan and Turin since 1999, while the Roman one, the biggest in Italy (354 spots) was managed by the Auxilium Cooperative during the NAE. Only estimated 1.1% of detainees were asylum seekers (MEDU, 2012a).
A detainee in Rome stated:

"*We cannot even have a comb. The heating sometimes works and sometimes doesn't. We suffer because we don't know how long we are to be held here and there is no one to offer comfort and aid. When you are ill and you see the doctor, he never takes you seriously*" (MEDU, 2013b, p.15)

During 2011, there were 156 cases of self-harm in Turin (MEDU, 2013b).
In Milan, Caritas operated to determine vulnerabilities, but MEDU denounces the rare transfer of patients to ASL facilities (2013b).
In Rome, after a first visit, six doctors, four psychologists and a gynaecologist provide primary healthcare (MEDU, 2012a). However, specialist care is ignored, as an authorization is needed to enter the CIEs (Chiodo, 2016) and only a few NGOs operate in the centre (MEDU, 2012a).
In Turin, the healthcare assistance is limited to ambulatory care and an isolation area for severe diseases. Detainees are transferred for specialized care to a close hospital and treated by the ASL (MEDU, 2006). However, there is no assistance to mentally ill and victims of torture, besides the Tatep Association, that occasionally is granted access to the CIE and the Sert Association, focusing on drug addicts (FER, 2011).

At the **southern harbours**, MSF and IRC provided medical assistance, within local projects, like *Praesidium* (*Presidio nella terra di nessuno*, 2015). The civil society's contribution is crucial to provide a human-faced reception and a first contact especially with children (Lo escludo, 2014, A. Praticò, boy-scout).

NGOs helped also those asylum seekers, who did not receive any institutional accommodation, living in **illegal settlements**, as an accommodation proof was necessary to fully access the SSN. The time-lapse between asylum claim and accommodation was in Turin two months, while in Milan one year (FER, 2011).
In squats, as undocumented migrants, they are limited to emergency care (HUMA Network, 2009). Only 5.7% of homeless are asylum seekers, 98% of whom are not registered to the SSN and 86.5% facing at least one healthcare problem in the last month (MSF, 2016).

In **Torino** there are four occupied buildings, hosting 1400 people (MSF, 2016). CISV is the mail local volunteering entity, providing accommodation and social inclusion activities to asylum seekers, with a special focus on vulnerable women (CISV, 2015).
The municipality of **Milan** arranged some reception centres for undocumented migrants or refugees on route towards north, hosting around 43.000 people yearly (MEDU, 2014a).
In **Rome**, the Community of Sant'Egidio and the Astalli Centre provide assistance and accommodation. However, this has implications over time on the ASL acceptance of asylum seekers that formally reside in another area (FER, 2011). The refugees, asylum seekers, undocumented migrants and refused asylum seekers living in precarious settlements are around 2.500, especially Sub-Saharans (MEDU, 2014b).
MEDU and the association World Citizens adopted a mobile clinic approach to provide medical assistance and information, reporting insufficient hygienic conditions and overcrowding (MEDU, 2014a), underlining how its target population is emarginated from specialized care (FER, 2012).
Between 2011 and 2012, MEDU's project *A camper for rights* did the same in **Florence**, where 250 marginalized asylum seekers and refugees lived in two occupied buildings, including those, who left the NAE deliberately (30%).

Mineo (Catania) only have a CARA, the biggest one in Europe (2000 individuals), since 2011. The healthcare provision is managed by the IRC and UNHCR.
At arrival, asylum seekers undertake medical and psychological screenings to identify vulnerabilities. Hematologic and x-ray exams are performed only in special cases. The available services in the centre are nursing, ambulatory care, paediatrics, gynaecology, dermatology, dentistry, an infectiology laboratory and an ambulance, managed daily by twelve nurses, five doctors and one sanitary director, supported by one cultural mediator (FER, 2011).
Around 80 ambulatory visits are performed daily, mandatory to the patients through the personal badge-functions deactivation for all other services (MEDU, 2015b).
Due to the ASL's lack of resources (Caltagirone), the CARA's healthcare services are as independent as possible: the registration to the SSN is not done and even the STP code is released only in few cases. This situation prevents the activation of integrated rehabilitation pathways for vulnerable groups.
The identification itself of such cases is based at arrival on a questionnaire, culturally inappropriate and medically insufficient (MEDU, 2015b). A team of only one psychiatrist and six psychologists cannot manage the 800 vulnerable asylum seekers

at Mineo (MEDU, 2015b). Only the most serious cases are brought to Caltagirone, while a pharmaceutical therapy is recommended to the others (MEDU, 2015b).

In the **Ferrara** province, there were 500 asylum seekers and beneficiaries in 2012 (Abbondanti, 2013). The local SPRAR and SAS included the healthcare access to the ASL under the centres' managers' responsibility.
The project *Beautiful Mind* supported 80 victims of torture with rehabilitation, aiming at reaching a progressive personal autonomy. Since 2012, the project evolved into the project *Beyond Borders*, with a broader targeting (single parents, unaccompanied minors, pregnant women, etc.) (MEDU, 2012b).
Among the local associations, the Cooperativa Sociale Camelot (CSC) co-manages the Centre of Integrated Service for Migration, including two SPRAR centres and an information point (Abbondanti, 2013). It is responsible for the SSN registration, first screenings and connection to the ASL in the SPRAR network and other projects, such as the *Asylum Land* project, providing healthcare orientation to asylum seekers and the *Fellowship Program* about HIV/AIDS surveillance.
The CSC also organized **training courses to the ASL staff** concerning mental illness and healthcare access for asylum seekers, as also the NAGA in Milan, the CIR in Rome and the Frantz Fanon and Mosaic associations in Turin. In a still ongoing project in Ferrara, mediators are called to support and integrate the healthcare pathways of foreigners, including asylum seekers, in the public hospital.
The CSC also signed a protocol with the local authorities and the ASL, concerning the procedures for the correct medical assistance and certification of torture and abuse victims. As manager of the reception centres, it performed psychological analysis of trauma itself (Abbondanti, 2013).

Since 2011, Ferrara hosts a reception centre for **psychologically vulnerable groups**. Retired doctors and psychologists perform individual and group activities, following an integrated rehabilitation method (Abbondanti, 2013).
The project *Far from Violence*, aims at supporting victims of torture in twelve different cities, including Ferrara, Milan and Rome, since 2009. During 2010 and 2011, the project supported 89 people, financed partly by the European Refugee Fund (FER, 2011). However, the main problems are exactly the ad hoc financial supports and the lack of training of professionals.
The Astalli Centre in **Rome** offers healthcare assistance to asylum seekers in its ambulatory, managed by volunteers and drugs distribution, by volunteer pharmacies

(Centro Astalli, n.d), while in **Milan**, the association NAGA offers primary care and orientation about the SSN, free of charge.
Yearly, there are 15.000 ambulatory visits, 70 psychological and ethno-psychiatric consultations and 500 gynaecological visits performed (NAGA, n.d.).
NAGA is committed to the human rights' defence, organizing institutional meetings, to spread normative dispositions concerning healthcare and formulate legislative bills. It reaches squats with a mobile clinic dayly, providing healthcare to marginalized populations and participates in the Far from Violence project with its centre Naga Har. The centre targets asylum seekers and refugees since 2001, as a place of listening, reception and support to victims of torture, relying on a mixed medical and social therapy, including sports, arts and crafts. The most severe problems concerning mental illness are referred to the ASL (Nufer & Trummer, 2013).
Psychological assistance is provided by other associations too, such as the social cooperative Terrenuove in Milan (FER, 2011), the *Invisible Injuries* project, run by Caritas, and the *Sa.Mi.Fo*, adopted by the Astalli Centre, in Rome, focusing on mental health and trauma, in cooperation with the ASL, since 2006 and nowadays part of the *Far from Violence* project.

In the **Roman CARA**, an interview is used to detect vulnerabilities, in order to involve psychologists and ASL if necessary (FER, 2011).
The project *N.I.Ra.S.T* is a positive example of cooperation between the CIEs, CARAs, SPRAR and SAS and institutions, like the ASL Rome, CIR and UNHCR, since 2007. It supports asylum seeker victims of torture forwarded by the different centres, through a medical-psychological pathway in the cities that host the ten Territorial Commissions[7]. In 2010, 288 victims were assisted, of whom 101 in Rome (FER, 2011).
During the NAE, the CIR's project *VI.TO* was also active in Rome, targeting the rehabilitation of 600 victims of torture. Besides, it focused on awareness campaigns, prevention and research activities (CIR, 2014).
In **Turin**, the Frantz Fanon association offers since 1997 a service of counselling, psychotherapy and psycho-social support to immigrants, asylum seekers, refugees and victims of torture, supporting over 100 people annually.
Since 2013, it operates independently from the ASL, receiving patients from all reception centres around the region and relying on cultural and linguistic mediators

[7] Turin, Milan, Gorizia, Rome, Caserta, Foggia, Bari, Crotone, Siracusa and Trapani

(Associazione Frantz Fanon, n.d).

The Mosaic association instead, initiated by both immigrants, refugees and Italians in 2007, focuses on the promotion of refugee rights and social awareness on forced migration, organizing events and including concrete inclusion activities and support to refugees, asylum seekers and their families.

In cooperation with UNHCR, Amnesty International, ASGI, the Frantz Fanon Centre and others, Mosaic provides help in the fields of legal practices, employment orientation and other social aspects that influence the well-being and integration of foreigners in the local territory, such as events and summer camps for children to create new friendships, learn the language and better integrate. It also participates in the regional coordination working groups on asylum, since 2008 (Associazione Mosaico, n.d).

Table 6 provides an overview about healthcare provision in the discussed cities.

	Reception centres	**Main active NGOs**	**Projects**
Ferrara	SPRAR, SAS, centre for psychologically vulnerable groups	Cooperativa Sociale Camelot	Beautiful Mind, Asylum Land, Fellowship Program about HIV/AIDS Surveillance, Far from Violence
Florence	Illegal settlements	MEDU	A Camper for Rights
Milan	CIE	IRC, Caritas, NAGA, Social Cooperative Terrenuove	Far from Violence, N.I.Ra.S.T
Mineo	CARA	IRC, UNHCR	
Rome	CIE, CARA, SPRAR, SAS, illegal settlements	Auxilium Cooperative, Community of Sant'Egidio, Astalli Centre, MEDU, World Citizens, CIR, Caritas	Far from Violence, Invisible Injuries, Sa.Mi.Fo, N.I.Ra.S.T, VI.TO
Turin	CIE, illegal settlements	IRC, Tatep, Sert, CISV, Frantz Fanon and Mosaic associations	N.I.Ra.S.T

Table 6 – Overview of the role of NGOs in healthcare assistance in the selected cities. Own illustration

PART FOUR

Interpretation of results

7. Discussion on observed discrepancies

The socio-economic integration into a new urban context is fundamental for the asylum seekers' health and life. However, migration is a social determinant of health itself and often influences it negatively, due to cultural, linguistic and geographical segregation, particularly related to the access to healthcare.

7.1 The European and national legislation match

The international human rights legislations, like the Bill of Human Rights, recognize to everyone the entitlement to physical and mental health and the State's duty to provide all conditions for accessing preventive, curative and palliative care, without discrimination.

In compliance with this, the CEAS legislates over the right to health in the EU. The Qualification and the Reception Conditions Directives guarantee to asylum seekers the healthcare access under the same conditions of nationals, including at least emergency care, treatment of illness and mental disorders and emphasizing the assistance to vulnerable groups. Considering the social determinants of health, such as housing, education and employment, the EU improved its approach towards migrant health since the **middle 2000s**.

However, as healthcare is a national competence, a concrete EU strategy is inexistent and every country performs differently. Criteria such as legal status and a residence permit hold play a crucial role on healthcare access.

The WHO and UNHCR formulated **recommendations** for a unified approach, but the ongoing EU response development does not tackle healthcare directly, focusing on asylum identification, reception and assessment and border-control instead.

The Italian legislation on asylum is young, fragmented and revised, in constant development, causing bureaucratic and administrative **confusion**.

There is no single, organic, unified legislation at the national level, concerning the healthcare provision and access to asylum seekers. However, the right to health is

recognized, in compliance with the international fundamental rights and the CEAS.

Since 2004, the EU Directives are implemented into the national legislation, even in a more **beneficial** way than required (Ammirati et al, 2015).
The mandatory registration to the SSN for asylum seekers includes all related rights, the free-of-charge services during the first six months, or the release of the STP code for emergency care before the registration itself.
Therefore, even if both EU and Italian legislation on the issue are rather abstract and healthcare remains a national competence, there are **no identifiable discrepancies**.

7.2 The national legislation and practice match

As most inflows into Italy are labelled as emergencies, due to the lack of a permanent national strategy in place, the NAE lead to the formulation of a National Reception Plan that implemented in practice a mixed extraordinary reception system.
Since **housing** is an important social determinant of health, its impact on the asylum seekers depended on fate. SPRAR centres focused on the individual well-being and integration, SAS centres often lacked assistance, while CARAs and CIEs lack a patients' management standardization.
In the words of MSF:

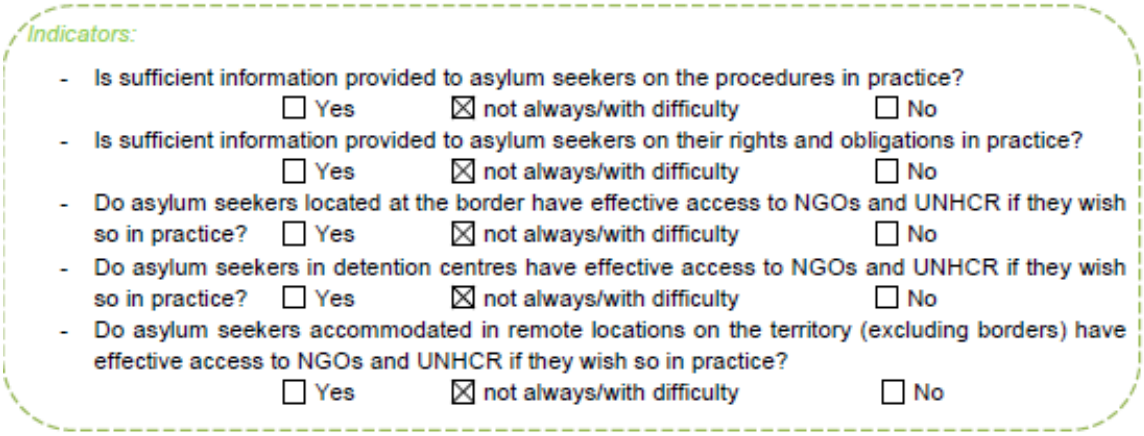
"The care received in the centres appeared to be strongly dependent on the attitude and willingness of the medical staff working in each centre. Patients often received a placebo instead of adequate medication"

(HUMA Network, 2009, p. 92).

The extension of the asylum applications' assessment from the theoretical 30 days to over one year and the high number of asylum appeals for a second judgement lead to a **shortage** of institutional reception spots.
This way, the limbo status of asylum seekers hosted, waiting for an answer, worsened their health (ASGI, 2014), while those not granted with a reception spot settled down in the urban illegal settlements.

The healthcare access of asylum seekers living in **squats** is institutionally almost inexistent, in absence of an accommodation certificate that would allow the registration to the SSN. Therefore, the association *Citizens of the World* highlights how the registration itself is not an assumed right in practice (FER, 2012).

The asylum pathways at arrival and the healthcare provision across Italy were also **heterogeneous**, depending on the point of arrival, the geographic reception location and also the responsible officers' personal predisposition. It was the reception centres managers' duty to provide healthcare assistance and create networks of ASL and local NGOs. The permission to NGOs to meet and operate with the target population often depended on the local authorities too (Figure 17).


Indicators:

- Is sufficient information provided to asylum seekers on the procedures in practice?
  ☐ Yes ☒ not always/with difficulty ☐ No
- Is sufficient information provided to asylum seekers on their rights and obligations in practice?
  ☐ Yes ☒ not always/with difficulty ☐ No
- Do asylum seekers located at the border have effective access to NGOs and UNHCR if they wish so in practice? ☐ Yes ☒ not always/with difficulty ☐ No
- Do asylum seekers in detention centres have effective access to NGOs and UNHCR if they wish so in practice? ☐ Yes ☒ not always/with difficulty ☐ No
- Do asylum seekers accommodated in remote locations on the territory (excluding borders) have effective access to NGOs and UNHCR if they wish so in practice?
  ☐ Yes ☒ not always/with difficulty ☐ No

Figure 17 - Information for asylum seekers and access to NGOs and UNHCR. Source: AIDA, 2013a

As mentioned, the Italian legislation on healthcare is existent, compliant with human rights and EU legislation, but still fragmented and vague.
Therefore, its practical, uniform implementation is difficult, as regions enjoy a high degree of independence in the SSN as well.

The asylum seekers' entitlement to health was concretely **limited** by many barriers, such as lack of information (Figure 17), cultural and linguistic mediation, resulting in a **human rights paradox**, where the legislation does not match with practice.

Discriminatory treatment in clinical practice is rare, but the healthcare system is still not able to address the patients' needs, leading sometimes to mutual mistrust with asylum seekers and unequal treatments and stereotyping, that health professionals are hesitant to recognise (FRA, 2013).
Bureaucracy also limits the healthcare access, as the impossibility of ticket exemption for unemployed asylum seekers after the sixth month too.
Housing precariousness prevents the sanitary regularization and the renewal of documents in other police stations than the one referent to the ASL of registration interrupts the healthcare coverage as well (MEDU, 2012b).

"What is written on the paper does not correspond to what actually happens to people (…) It really depends on the specific areas: within the same region, one town may act in a way, and the neighbour performs differently. So, basically [the healthcare access] is not guaranteed on the national level, there is no control on making this right due in the whole country and it is really depends on chance, on the common sense of operators and public officials. (…) After all, you are a person equal to all others on a territory that is defined as State and it is not possible that the answer you receive could be two hundred different ones. Therefore, if you get two hundred different answers, I would say that the State does not monitor eligible rights, and they become a matter of chance. It could happen that someone with a good heart grants it to you, but then it is not a universal right anymore"[8]

*(*Cristina Molfetta, Turin, FER, 2012, p.66-67*)*

In this light, **MSF** (2016) condemned national and local authorities, asking for:

- Better living conditions and human rights' respect for asylum seekers living in informal settlements, through the requalification of spaces or alternative living solutions and better healthcare assistance;
- Reformulation of the conditions for the registration to the SSN, independent from the residence proof and universal, granting access to a GP only based on auto-certification of current accommodation address;
- Promotion of the registration to the SSN immediately after the asylum claim, to avoid the STP code's improper use;
- Improvement of the public healthcare service, through the constant presence of cultural-linguistic mediators, staff training and informative courses;
- Improvement of the asylum procedures and the reception system's hosting and assistance capacity;
- Activation of a constant supervision of squats, for a quick identification of vulnerabilities and diseases and reference to socio-sanitary services.

[8] "Quello che c'è scritto sulla carta non corrisponde poi a quello che effettivamente succede alle persone (…) dipende proprio dal territorio specifico, magari all'interno della stessa regione, una cittadina fa una cosa, quella vicina ne fa un'altra, quindi diciamo così: non è garantito a livello statale, non c'è un controllo perché questi diritti siano esigibili su tutto il territorio ed è molto affidato al caso, al buon senso dell'operatore, al funzionario che sta dietro lo sportello. (…) comunque alla fine tu sei una persona uguale ad un'altra su un territorio che si dice uno Stato e non è possibile che la risposta che tu ricevi possa essere duecento risposte diverse. Quindi se ricevi duecento risposte diverse mi verrebbe da dire che lo Stato non vigila sul fatto che quello è un diritto, ma diventa una casualità. Potrebbe essere che qualcuno per suo buon cuore te lo concede, ma non è già più diritto".

7.3 The responses' match to the asylum seekers' healthcare needs

The solution to this chaotic situation consisted particularly in two measures' implementation.
One is the **Pact between the State, Regions and autonomous Provinces**, trying to unify the healthcare provision guidelines. The round table discussion for its formulation started in 2008, underlining that the procedure disparities were rooted in the system even before the NAE. The Pact represents an improvement, but it was signed only in December 2012, a few months before the NAE's end.
The other measure is the **role of NGOs** in complementing the institutional response, overcoming barriers and defending the right to health.

NGOs play an important role at the entry points and harbours, reception centres and illegal settlements. Sometimes they are organized as independent services, in specific locations, where asylum seekers are referred to. Their contribution is crucial to build a network for not only healthcare, but a pathway to integration.
The civil society is in the first line of the reception, support and inclusion actions:

"That's what remains in your heart in the evening: anguish, because sometimes you cannot help feeling an infinite sadness, but also happiness for having made one more person smile"[9] *(*Bruna Mangiola, Lo escludo, 2014, 04:51*)*

The asylum seekers' healthcare needs are **accumulated** from the home country lifestyle, the journey's dangers and the changes and asylum-related stress at arrival. Contrary to public opinion, contracted communicable diseases are a marginal phenomenon and most commonly the asylum seekers' face other needs, non-communicable and chronic diseases and especially mental illness.
The reception system in Italy and the EU lacks a multidisciplinary and empathic approach to tackle the asylum seekers' needs and vulnerabilities, which often remain undetected or underestimated. Once again, the reception framework is sometimes unsuitable and constitutes a risk factor to their conditions.

Besides, asylum seekers face the difficulty in accessing **information**, one of the fundamental elements granting actual access to healthcare (FRA, 2013). Without information, they do not acknowledge their rights and are unable to tackle their needs.

[9] "È quello che la sera ti rimane: l'angoscia, perchè certe volte ti viene una tristezza infinita, però la gioia di aver fatto sorridere una persona"

The importance of **mediation** to understand the patients' needs and to overcome cultural and linguistic differences is a fundamental aspect of providing healthcare, without generating mistrust and misunderstandings (FER, 2012).
For this reason, NGO services are accepted by the target population, because they understand better their needs and difficulties.
The Qualification Directive, which Italy refers to, states:

> "*in order to enhance the effective exercise of the rights and benefits (…) by beneficiaries of international protection, it is necessary to take into account their specific needs and the particular integration challenges with which they are confronted*" (Preamble, 41).

Institutional healthcare services exist in a limited number, especially concerning vulnerabilities. Therefore, the complementary response of the SSN and NGOs **together** is able to address the asylum seekers' needs better by providing an improved healthcare, aiming at overcoming all barriers explained.

However, the **capillarity** of little and independents projects makes it impossible to assess their match with healthcare needs from a national perspective, and leaves space for improvements.

MEDU asks authorities to systematically affirm the right to health, independently by conditions such as knowledge of the language, housing, legal status and to improve the assistance to vulnerable groups (MEDU, 2012b).
Underlining **human dignity**, it asks for smaller reception centres, where psychological risks are reduced, personal relations improved and professionals always present. It also suggests the implementation of networks between social, sanitary, psychological, legal and economic services for a multidisciplinary approach to the asylum seekers' needs (MEDU, 2015a).

7.4 A specific field: mental health

Almost one third of asylum seekers, especially victims of torture and trauma, have mental healthcare needs. They are more likely to develop psychological problems, like anxiety, insomnia, PTSD, which affect negatively their concentration, memory, emotional and physical well-being, originating from pre-migration and migration traumas. Post-migration traumas also exist, related to the limbo status, future

uncertainty, loss of reference points and social isolation.
The international and EU legislations recognize the **right to mental health**, with the Reception Conditions Directive including mental healthcare within the minimum standards delivered by MSs. However, CIR (2012) denounces the absence of a monitoring mechanism in the CEAS, about the actual provision in a unified way.

The Italian legislation includes psychological and physical violence in the definition of persecution, which asylum is based upon. The CA ensures the protection of victims through the access to special assistance programs.
Nevertheless, this is derived from EU Directives and the actual guarantee of minimum standards is **lacking**, as well as a national healthcare integration and rehabilitation strategy, with clearly defined roles, evaluation, coordination methods between the public services and ASL (FER, 2011). Psychological assistance is the most limited among all (Figure 12, p.40).

The localized mental healthcare **projects** are performed as isolated experiments, dependent to a great extent on limited financial funds, without a common coordination. Sometimes they are very successful and compensate for the national deficiencies with a multidimensional assistance approach, in order to rebuild their personal identity, self-trust, support them across the asylum application (CIR, 2014) and reduce their sense of invisibility (FER, 2011).

The reception system does not perform adequately in this regard, as SPRAR only reserves 50 places to people with mental conditions, SAS are emergency facilities sometimes set in remote areas, while CARAs and CIEs are overcrowded, degrading environments, preventing social inclusion and serenity.

The **identification** itself of such cases is based on often culturally inappropriate and medically insufficient questionnaires (Figure 18).

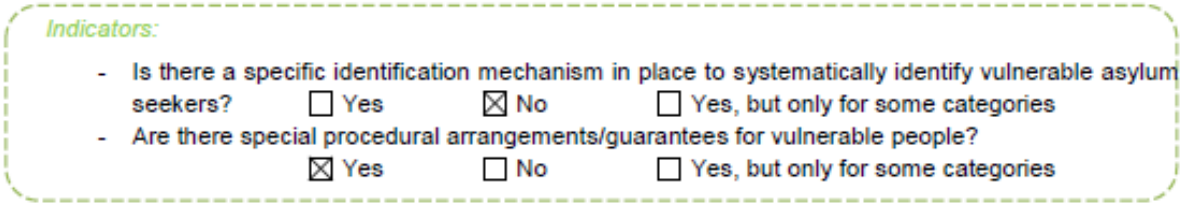


Figure 18 – Guarantees for vulnerable groups of asylum seekers. Source: AIDA, 2013a.

Culture has a crucial role in the expression of individual suffering and its significance within the community (CIR, 2014). It is very difficult to target mental health in a culturally appropriate way, as asylum seekers come from many different countries.
However, its neglect could lead to unexpected and aggressive behaviours, tensions and misunderstanding with the others hosted, operators and health workers, jeopardizing the whole reception centre's functioning (Provincia di Parma, 2011).

It is important to create an atmosphere of **mutual trust**, with transparent information about mental health rights, programs and linguistic mediation, in order to facilitate the identification of problems, stimulate dialogue and personal acceptance by the asylum seekers of needing help.
Instead of excluding them in mental institutions, it is better to **welcome** them in open centres, based on professionalism, quality and reciprocity with the outside world (SPRAR, 2011). Besides the medical assistance, all interventions in the social, economic, legal and relational fields are beneficial.

Therefore, the **multidimensional approach** characterized all chosen localized projects described, such as the *Invisible Injuries* of Caritas, *Sa.Mi.Fo* of the Astalli Centre and *N.I.Ra.S.T* of CIR and UNHCR.
However, the therapeutic, rehabilitative and assistance-related responses vary greatly depending on the local ASL systems and operators availability (Provincia di Parma, 2011). Even if they match perfectly the asylum seekers' needs, these projects are **not nationally unified** and do not match the inexistent legislation.

Maieutics was a cross-European[10] project aiming at elaborating minimum standards for a common interdisciplinary (legal-psychological) approach to grant the appropriate international protection to victims of torture and violence, starting from the identification of vulnerabilities and traumas.
The EU and therefore the MSs already present specific measures for vulnerable groups and victims of torture, but no standard methods to identify them (CIR, 2012), which can affect the asylum requests assessment.

Italy should therefore urgently define national guidelines and integration programs, establish adequate reception centres for victims of trauma and torture and promote

[10] The project was developed by a partnership of institutions based in Italy, Greece, Romania, the Netherlands and United Kingdom.

the registration to the SSN (FER, 2011). Besides, it should guarantee the freedom from detention and the access to a professionally specialized staff on trauma and torture (CIR, 2012).

8. Human right controversies

Outstanding critics were made concerning the freedom of movement and the rights to life, proper housing, health, personal dignity and non-refoulement. They are debated in the framework of the borders control, the CEAS and the Italian asylum system.

8.1 Frontex and the CEAS

Since 1988, at least 27.382 people died crossing the Mediterranean Sea, 13.318 of whom in the Strait of Sicily and 2.105 only during 2011-2012 (Del Grande, 2016).
The Policy Plan on Asylum aims at:

> *"ensur[ing] access for those in need of protection: asylum in the EU must remain accessible. Legitimate measures introduced to curb irregular migration and protect external borders should avoid preventing refugees' access to protection in the EU while ensuring a respect for fundamental rights of all migrants."*
> (para. 2, p.3, 2008)

Opposed to the Policy Plan, health and protection are ignored by Frontex and the **legal responsibility** of human rights violation is passed over to MSs, while Frontex defends its merely coordination role (European Policy Centre, 2014).

As Arias Fernàndez, Frontex CEO, stated, "*Mare Nostrum and Triton are not the same. Triton originated to control borders, not for rescue and assistance purposes*"[11] (MEDU, 2014a, para. 14).

An evident example was a 72-passengered boat from Tripoli towards Italy in 2011, which was not rescued, despite of the presence of Italian, Libyan, Maltese authorities, NATO, military and fishing vessels in the area, leading to the death of 63 people (Council of Europe, 2012).

[11] "Mare Nostrum e Triton non sono la stessa cosa. Triton nasce per controllare la frontiera non per operazioni di ricerca e soccorso".

Besides, the ECHR also judged Frontex in 2012 with the **Hirsi case law** (ECHR, 2012), about refugee boats intercepted by Italy in the Maltese search and rescue zone in 2009 and returned immediately to Libya, in violation of non-refoulement, effective remedy, health and prohibition of inhuman treatment (UNHCR, 2012c).
As the ECHR underlined the need of respecting human rights in the sea and Frontex's operations falling within the scope of the CFREU, the European Parliament created, among others, the Frontex Fundamental Rights Officer. It aims at increasing a better legal certainty of action, transforming Frontex's operation *"from pure border management (…) into a broader mandate including the promotion of human rights"* (European Policy Centre, 2014, p.1), a paradox criticized by many NGOs.

The European Council on Refugees and Exiles (ECRE) **denounces** the failure of respecting asylum and fundamental rights legislation, the British Refugee Council underlines the lack of democratic accountability and surveillance of the MSs participation in Frontex operations, while UNICEF talks about crime against humanity (ECRE et al., 2007).
The Astalli Centre and Migrantes association **recommend** legal and safe entry routes, focusing on vulnerable groups especially, resettlement, family reunification (Migranti, ancora naufragi, 2016).

Both ECRE and UNHCR criticized the **CEAS,** as a controversial framework, for impeding the asylum seekers' arrival and lacking an efficient healthcare protection.
The **Dublin System** increased the pressure on border countries, instead of harmonizing the reception solidarity and the rates of positive asylum assessment vary greatly among MSs, sign that the Qualification Directive is also not fully applied.
The Dublin Regulation's hierarchy of criteria, according to which asylum claims must be submitted in the country of arrival, apart from humanitarian and family reunification exceptions, is not always respected.
The use of **force** is applied for dactyloscopy, by police and public officers. Therefore, often asylum seekers tend to escape to remain undetected and reach family and friends in other countries.

MEDU denounces the **wrong application** of the Dublin Regulation as a territorial inequality of asylum claims and lack of solidarity and cooperation within the EU, as well as the lack of assistance and protection, as violation of human rights (2014a). Besides, the illegal immigration fight and the transfer of asylum seekers are

characterized with the use of long-term detention methods, which are having a very negative impact on their health, preventing their access to healthcare services and worsening their possible conditions of mental illness.
The daily episodes of xenophobia, racism, discrimination and even violence faced have the same deteriorating effects on asylum seekers (AIDA, 2013b).

8.2 Italian institutional healthcare discrimination and CIEs

Italy ceased its push-back operations towards Libya in 2009, a development appreciated by UNHCR, as well as the rescue efforts and the Mare Nostrum operation later (UNHCR, 2012c). MEDU still calls for a new joint operation different from Frontex, aiming at searching and rescuing migrants at sea, in compliance with the human rights protection (MEDU, 2014a).

It also asks for **better reception conditions**, specifically in Rome, where the most vulnerable migrants are left behind, underlining the uselessness of epidemic alarmism and the realism of a young population's low health conditions, due to terrible living conditions, inhuman treatment and degrading journeys (MEDU, 2014a).

According to **law 94/2009**, the healthcare staff is obliged to report the illegal entry crime for all undocumented migrants accessing the healthcare system, which diametrically contrasts the CA's prohibition to do so (art. 35.5). Therefore, fear and mistrust prevent undocumented migrants (including asylum seekers living in squats) to seek healthcare (Epicentro, 2015).

The ticket payment also precludes the healthcare access to most asylum seekers after the 6th month, as it is linked to the occupational status, especially since the new D.Lgs 142/2015 reduces the period to 2 months.
Unemployed asylum seekers have right to free healthcare, but as they are often registered as unoccupied, they lose this right.
Associations and NGOs, including UNHCR, Migrantes, Caritas, MEDU, MSF, Astalli Centre, NAGA, CIR and Emergency, wrote a **letter** in December 2015 to the Ministry of Healthcare, asking for a revision of the ticket exemption criteria, granting free healthcare to all vulnerable groups, in defence of the right to health in the Constitution (art. 32) and as such (ASGI, 2016).

Italy was **condemned** by the EU Commission in October 2012 for infringing the CEAS legislation pieces, in particular concerning accommodation and asylum procedures (Nufer & Trummer, 2013).
The continuous emergency declarations and the idea that municipal administrations would voluntarily join the national reception system and related responsibility to such extent to guarantee its good functioning are **non-realistic** (Ammirati et al., 2015).

Besides, the **detention conditions** in CIEs were also denounces, for being unable of safeguarding decent living conditions, responding to healthcare needs and for their insular nature, preventing accessibility to aid organizations, NGOs and journalists. The latter raised concerns about the defence of human rights inside of CIEs, causing the public campaign *LasciateCIEntrare* ("*let us in*!") since 2011 (MEDU, 2013b).

UNHCR detention **guidelines** were also formulated, making clear that asylum seeking is not a crime, and therefore detention is forbidden under international law.
Detention is accepted under human and dignified conditions, only as a measure of last resort for the purposes of national security, public order and protection of public health, in case of epidemics, justifying individual confinement (UNHCR, 2012d).

9. Post-NAE developments

After the NAE, a different approach to asylum arose, developing new laws and guidelines and especially a greater awareness and active participation of the civil society about the issue.

9.1 Legislation and guidelines

All main directives forming the CEAS were revised **after the NAE**.
However, despite the Action Plan on Human Rights and Democracy for 2015 to 2020, the European Agenda on Migration did not revise the approach to asylum in terms of fundamental rights and healthcare provision, but focuses instead on procedures and border-protection. As Hammerberg said:

"When preventing migrants from coming has become more important than saving lives, something has gone dramatically wrong" (Amnesty International, 2011, par.11)

The Italian asylum legislation was also amended after the NAE with new procedures and reception systems, protecting more unaccompanied children and family reunification (AIDA, 2015b). The SPRAR system was enlarged, still too slowly compared to need. Suspicions arose, that local political interests prevented such an experienced and efficient system to develop further (ASGI, 2013).

Administrative-bureaucratic **slowness** and some regions' refusal to host the continuously arriving migrants prevented the spread allocation system, as a percentage of regional populations, according to the 2011 National Reception Plan, continuing the unequal reception condition, especially regarding Sicily (Figure 19).

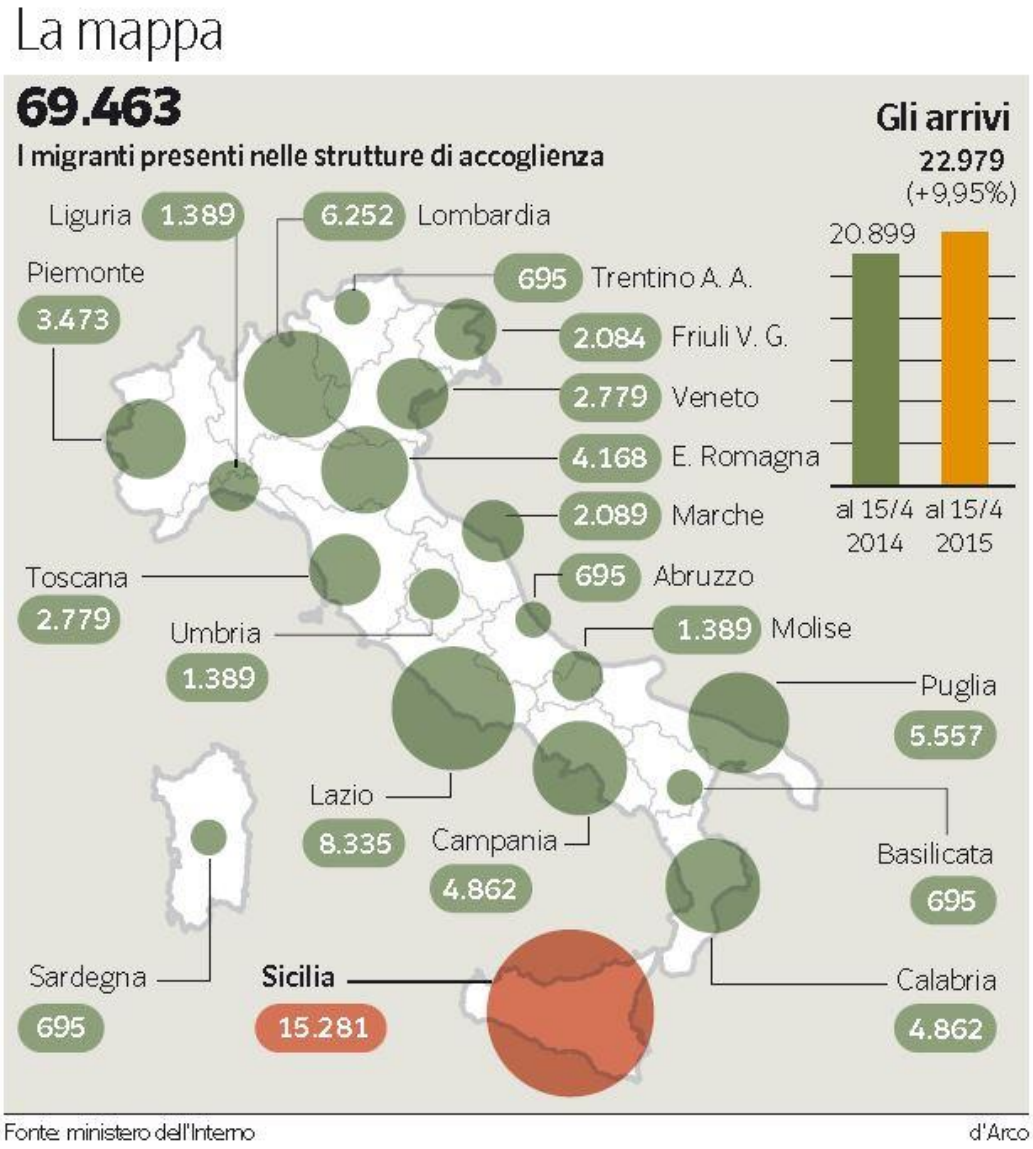


Figure 19 – Distribution of asylum seekers in the regional reception centres. Source: Ministry of Interior, 2015

However, the healthcare legislation remained unchanged, as it is among the best ones, in theory. The problem lays in its practical implementation, still nowadays.
If the legislation entitled asylum seekers to healthcare under the same conditions as nationals, many barriers prevented this right's enjoyment in reality.

When **144.000** migrants reached Italy, in 2015, an evolution in the reception system was necessary, not only due to practical motives, but for health-related reasons too (*Migranti, OIM*, 2015).

Therefore, a **National Charter on Good Reception** was signed in May 2016, aiming at overcoming the emergency declaration situation and converging the asylum seekers rights to healthcare, good living conditions, protection and their social utility for the community (doing voluntary or manual jobs). The SPRAR was chosen as reception model, providing quality, transparency and adequate services, with the goals of inclusion and sustainability (Biella, 2016).

9.2 The civil society's actions and reactions

The NAE ended with **90%** of asylum seekers receiving humanitarian protection, after two years of inactivity and wait.
As financial funds terminated, the reception system was closed, and many moved to France and Germany, while others ended up homeless. Only a small portion had found a job, learnt Italian and integrated properly (ASGI, 2013).

Reception conditions are crucial as social determinants of health, because they define the **environment** asylum seekers live in and their chance to integrate socially.

The capillary presence and role of parishes in assisting asylum seekers is part of a deeper Catholic **hospitality** value, rooted in the Italian society and responsible for many of the SPRAR and SAS centres.

"*If we all learn to invite one of this guys to dinner, at home, as I have been doing for a while, maybe we would understand Pope Francis, when he tells us about welcoming a stranger, because it's him offering so many emotions to me, not vice versa*"[12] (Signora Anna, Piazza Pulita, 2016, 01:21).

[12] "Se tutti imparassimo ad invitare uno di questi ragazzi a cena, a casa nostra, come faccio io da molto tempo, forse avremmo capito veramente cosa ci dice Papa Francesco, perché ci dice di accogliere l'altro, perché sono loro che regalano a noi, non noi che regaliamo a loro."

Other integrative **good practices** include the reception in small villages, like the Sicilian Sutera, where there are many empty houses and job offers (Tondo, 2016) or the diffused reception system in Piedmont, where asylum seekers are hosted within local volunteer families, a project that was inserted in the SPRAR system and implemented elsewhere too (Sala, 2015).
Pavia also accepted 15 asylum seekers in its university, providing them the opportunity to study and improve their lives (Ghezzi, 2016).

However, **42%** of Italians is against helping asylum seekers, based on prejudice, fear and jealousy (Demos & Pi, 2015).
Especially when the foreigners' proportion is higher than locals, social tension increases, as in the Piedmontese village of Zimone:

"*These people are always walking around, at any time of the day and night, I don't think it's ideal*"[13] (Anonimous, Biella Cronaca, 2016, 01:36)

The appearance of intolerance, xenophobic and authoritarian political movements happens across the whole EU, leading to the inability to overcome internal discords and create an efficient, common migration policy (Ammirati et al., 2015).
The trends towards cultural closure and racism are materialized through the creation of agreements, walls, fences, that not only block migrants, but also represents a failure of the Schengen Area (*Migranti, ancora naufragi*, 2016) and the Quotas system (AIDA, 2015a).
The implications on **healthcare** are evident, as inequalities persist among regions and MSs and human rights are not always respected, in the framework of weak European homologation efforts, attention to asylum seekers' needs and readmission agreements, like between Italy and Greece.

Equal healthcare access to everybody living in the EU, without discriminations of legal and economic status should be granted, in complete independence from immigration policies (HUMA Network, 2009).

[13] "C'è sempre tutta questa gente che gira a qualsiasi ora del giorno e della notte, non credo che sia proprio l'ideale!"

10. Conclusion

The aim of this thesis was to analyse the asylum seekers' access to healthcare during the Italian North African Emergency, identifying the possible discrepancies between the legislation and the practical healthcare provision, and its reasons.
In fact, the right to health is a fundamental human right recognized at international, regional and national level, but, as discussed, rarely respected.

At the European level, the CEAS is the main legislation framework concerning asylum, but it focuses mostly on the asylum procedures' harmonization and the joint border control, leaving healthcare as a national competence. Therefore, visible disparities exist across the EU, where the healthcare access of asylum seekers depends greatly on the national legal entitlements and the financial component of healthcare provision.

The on-going developments in EU legislation, especially the European Agenda on Migration (2015), concentrate on a better cooperation among the Member States to manage migration flows, to strengthen the CEAS structure and legislation and especially to fight illegal immigration and human smuggling.

However, trying to stop migrants, and among them, asylum seekers from arriving to Europe is useless and ethically wrong. Migrations have always characterized human beings, throughout history. Different EU countries independently and through joint efforts have been trying to prevent their arrivals over the last decades, but it has not worked, not in Spain and Greece, nor in Hungary and Italy.
The short-term effect could be to decrease the inflows' numbers, but it is impossible to detain desperate people from escaping death, torture, war and hunger, in the long run. The only rational option would be to give them realistic alternatives in their home countries for the long-term. As this is often not possible, the best solution is to make the arrivals more organized and orderly, working out in advance a concrete resettlement plan throughout the EU, based on experience and the asylum seekers' needs. Unfortunately, the European Agenda on Migration does not consider healthcare concerns, especially regarding vulnerable groups and victims of torture, who represent around 30% of all asylum seekers.

In Italy, the fragmented legislation on asylum includes the access to healthcare under the same conditions as nationals. The common practice of dealing with inflows as

emergencies lead to the extraordinary formulation of a National Reception Plan for the North African Emergency, when a mixed reception system was implemented.

As social determinants of health have a great impact on the asylum seekers, in particular the heterogeneity of reception centre types and non-standardized asylum application pathways created enormous disparities across the national territory. Besides, differences existed between the legislation and real healthcare provision too, as the National Healthcare System is mostly managed at the regional level.

The main cause were the barriers preventing asylum seekers accessing healthcare, such as the lack of information about own entitlements and the lack of orientation about the healthcare system's functioning, linguistic and cultural differences, long waiting lists, precarious accommodation, bureaucratic and financial issues.
The provision of some specific types of care, like psychological support and mental healthcare, the inclusion activities and assistance projects were often lacking institutionally and provided instead by NGOs and local associations, with the participation of the civil society.

After 2013, the Italian developments focused on the asylum process and reception system's reformulation, as a more individualistic approach concerned with assistance and integration services. However, healthcare provision and geographic distribution inequalities across the country are still problematic, as the emergency-tradition persists.

In fact, every asylum migration flow is different, and managed differently, following constantly evolving patterns and involving different reasons, populations and healthcare needs each time.
For this reason, a limitation of the present thesis is that it cannot be simply extended to other asylum inflows, as each is unique. Besides, asylum flows are difficult to monitor, leading to the impossibility of accurate statistical analysis. As there is no unified healthcare approach, it is also difficult to draw general performance assessments at the national level, and local realities always need to be considered singularly in the Italian context.

Healthcare systems should be able to develop a unified strategy to identify and quickly react to the different asylum inflows and migrants' needs, but often the needed regulations and policies are formulated slowly and resources are scarce.

Therefore, the main recommendation is to reduce the bureaucratic component of the healthcare system and its dependency on migration policies, in order to allow a quicker response development. Besides, trainings about asylum-related healthcare issues and needs should be performed more frequently and address the entire healthcare staff.

To overcome linguistic and cultural barriers, mediators with healthcare knowledge should be always present and involved in the asylum seekers healthcare provision.
In fact, a patient-centred service for asylum seekers, more attentive to individual needs and stories, would reduce the risk for non-communicable diseases, psychological disturbs and reduce the public healthcare expenses in the long-run.
It would also put an end to the institutional discrimination asylum seekers often face, still supporting public health, as screenings and monitoring visits would be carried out, in compliance with the non-discrimination principle and the Tallinn Charter's commitment to "*make health systems more responsive to people's needs, preferences and expectations*" (2008, Preamble, p. 6).

Social determinants of health should also be considered more deeply, in particular integration pathways and the healthcare access agreements between ASL and reception centres should be always guaranteed, corresponding to the national legislation and based on best practice cases' extension nationally.

Lastly, the civil society must be more involved in assistance and integration activities, to overcome the eventuality of racist, xenophobic or islamophobic incidents and political movements, which could affect negatively the asylum policy formulations in the future, including healthcare entitlements.

List of References

Abbondanti, A. (2013). *Il diritto alla salute dei richiedenti asilo tra emarginazione, isolamento e programmazione locale dei servizi - Uno studio di caso Ferrara: i percorsi sanitari per i richiedenti asilo e titolari di protezione internazionale*. Master dissertation, faculty of work, social citizenship and interculturality, University Ca' Foscari, Venice, Italy.

Alfred, C. (2015). *What History Can Teach Us About The Worst Refugee Crisis Since WWII*. The World Post, 09.12.2015 Retrieved from http://www.huffingtonpost.com/entry/alexander-betts-refugees-wwii_us_55f30f7ce4b077ca094edaec (26.02.2016)

Ammirati, A., Bove, C., Brambilla, A., Garbin, N., Leo, L., Marengoni, V., Morandi, N., Reccardini, G., Schiavone, G. (2015*). Il diritto d'asilo tra accoglienza e esclusione*. @uxilia Onlus, Faraway, so close project. Edizioni dell'Asino. E-book format.

Amnest International. (2011). *Europe must reaffirm its commitment to the rights of refugees and migrants.* Online article, 21.06.2016, by Sherif Elsayed-Ali, Head of Refugee and Migrants' Rights at Amnesty International. Retrieved from https://www.amnesty.org/en/latest/campaigns/2011/06/europe-must-reaffirm-its-commitment-to-the-rights-of-refugees-and-migrants/ (22.05.2016)

Amnesty International. (2015). *Europe's sinking shame: The failure to save refugees and migrants at sea*. London, United Kingdom. Retrieved from http://bit.ly/1ErynqE (02.03.2016)

Associazione Frantz Fanon. (n.d). *Il centro Frantz Fanon.* Official website. Retrieved from http://associazionefanon.it/index.php?option=com_content&view=article&id=13&Itemid=17&lang=it (01.05.2016)

Associazione Mosaico – Azioni per I rifugiati. (n.d). *L'associazione.* Official website. Retrieved from http://www.mosaicorefugees.org/site/?page_id=119 (01.05.2016)

Associazione Nazionale Comuni Italiani (ANCI), Caritas italiana, Cittalia, Fondazione Migrantes, Sistema di Protezione Richiedenti Asilo e Rifugiati (SPRAR), United Nations High Commissioner for Refugees (UNHCR). (2014). *Rapporto sulla protezione internazionale in Italia*. Annual Report. Retrieved from http://www.meltingpot.org/IMG/pdf/sintesi_rapporto_protezione_internazionale.pdf (06.04.2016)

Associazione per gli studi giuridici sull'immigrazione (ASGI). (2012). *La protezione sussidiaria. Scheda pratica*. Retrieved from http://www.asgi.it/wp-content/uploads/2014/04/protezione.sussidiaria.morandi.bonetti.11.marzo_.2012.pdf (06.04.2016)

Associazione per gli studi giuridici sull'immigrazione (ASGI). (2013). *L'Italia dei rifugiati: un'emergenza infinita*. Interview with Gianfranco Schiavone. Retrieved from http://www.asgi.it/asilo-e-protezione-internazionale/litalia-dei-rifugiati-unemergenza-infinita/ (09.04.2016)

Associazione per gli studi giuridici sull'immigrazione (ASGI). (2014). *Sbarchi, per chi chiede asilo tanta burocrazia e tempi di attesa biblici.* 29.04.2014. Retrieved from http://www.asgi.it/asilo-e-protezione-internazionale/sbarchi-per-chi-chiede-asilo-tanta-burocrazia-e-tempi-di-attesa-biblici/ (16.05.2016)

Associazione per gli studi giuridici sull'immigrazione (ASGI). (2016). *Asilo e assistenza sanitaria : lettera delle associazioni al Ministero di Salute.* 07.01.2016. Retrieved from http://www.asgi.it/notizia/asilo-diritto-salute-lettera-associazioni-ministero-salute/ (19.05.2016)

Associazione per gli Studi Giudirici sull'Immigrazione (ASGI), Sistema di protezione per Richiedenti Asilo e Rifugiati (SPRAR), United Nations High Commissioner for Refugees (UNHCR). (2013). *La tutela dei richiedenti asilo, manuale giuridico per l'operatore*. Retrieved from http://asgi.it/wp-content/uploads/2014/04/2012_manuale_asilo_FER.pdf (11.04.2016)

Asylum Information Database (AIDA). (2013a). *National country Report – Italy*. AIDA project and European Programme on the Integration and Migration (EPIM)

Asylum Information Database (AIDA). (2013b). *Not there yet: an NGO Perspective on Challenges to a Fair and Effective Common European Asylum System.* Annual report 2012/2013. Retrieved from http://www.asylumineurope.org/sites/default/files/shadow-reports/not_there_yet_02102013.pdf (19.05.2016)

Asylum Information Database (AIDA). (2015a). *Common asylum system at a turning point: Refugees caught in Europe's solidarity crisis*. Annual Report 2014/2015. Retrieved from http://www.asylumineurope.org/sites/default/files/shadow-reports/aida_annualreport_2014-2015_0.pdf (25.02.2016)

Asylum Information Database (AIDA). (2015b). *National country Report – Italy*. AIDA project and European Programme on the Integration and Migration (EPIM)

Asylum Seeker Resource Centre (ASRC). (2013). *World Statistics*. Retrieved from http://www.asrc.org.au/resources/statistics/world-statistics/ (25.02.2016)

Baggio, F. (n.d). *Descriptive classifications of migration.* Retrieved from Centre for Migration Research, at http://www.cserpe.org/wp-content/uploads/2015/09/Classification-Baggio-EN.pdf (19.02.2016)

Barros, L., Lahlou, M., Escoffier, C., Pumares, P., Ruspini, P. (2002). *Sub-Saharan irregular immigration to Morocco*. ILO. Geneva, Switzerland

Bell, M., Ward, G. (2010). Comparing Temporary Mobility with Permanent Migration. *Tourism Geographies 2(1*), pp.97-107. DOI: 10.1080/146166800363466. Retrieved from https://espace.library.uq.edu.au/view/UQ:7964/mb_gw_tg.pdf (15.03.2016)

Biella Cronaca. (2016). *Viaggio a Zimone, il paese dei migranti.* Video-report, 25.03.2016. Retrieved from https://www.facebook.com/biellacronaca/videos/1524062114566265/?__mref=message (20.05.2016)

Biella, D. (2016). *La Carta della buona accoglienza è ora nazionale: firmano anche Anci e Viminale.* Vita. Newspaper article, 18.05.2016. Retrieved from http://www.vita.it/it/article/2016/05/18/la-carta-della-buona-accoglienza-e-ora-nazionale-firmano-anche-anci-e-/139446/ (20.05.2016)

Bischoff, A., Schneider, M., Denhaerynck, K., Battegay, E. (2009). *Health and ill health of asylum seekers in Switzerland: an epidemiological study*. European Journal of Public Health, Vol. 19, No. 1, 59-64.

British Medical Association (BMA). (2004). *Meeting the healthcare needs of refugees and asylum seekers - a survey of general practitioners.* London, United Kingdom. Retrieved from http://www.refugeetoolkit.org.uk/sites/refugeetoolkit/files/imce_user_files/meeting-the-needs-of-asylum-seekers-bma-report.pdf (06.03.2016)

Centro Astalli. (n.d.). *Ambulatorio*. Official website. Retrieved from http://centroastalli.it/servizi/ambulatorio/ (30.04.2016)

Chiodo, S. (2016). *Una delegazione è entrata a Ponte Galeria, ecco cosa ha visto.* Newspaper article, 24.03.2016. Official website "Left". Retrieved from http://www.left.it/2016/03/24/una-delegazione-e-entrata-a-ponte-galeria-ecco-cosa-ha-visto/ (30.04.2016)

Chiswick, B.R., Lee Y.L., Miller P.W. (2008). *Immigration selection systems and immigrants health*. Contemporary Economic Policy, 26(4): 555-78

Comunità, Impegno, Servizio, Volontariato (CISV). (2015). *Accoglienza Rifugiati*. Official website. Retrieved from http://www.cisvto.org/cisv/accoglienza-rifugiati (01.05.2016)

Consiglio Italiano per i Rifugiati Onlus (CIR). (n.d). *Quali sono i diritti dei richiedenti asilo?* Official website. Retrieved from http://www.cir-onlus.org/it/per-i-rifugiati/come-posso-richiedere-asilo/798-quali-sono-i-diritti-dei-richiedenti-asilo (28.04.2016)

Consiglio Italiano per i Rifugati Onlus (CIR). (2012). *Maieutics - Elaborazione di una comune metodologia di lavoro interdisciplinare (legale-psicologica) per garantire ai sopravvissuti alla tortura e alla violenza il riconoscimento dello status di protezione internazionale appropriato.* Retrieved from http://www.cir-onlus.org/images/pdf/MAIUTICS%20ITALIANO%20per%20sito.pdf (16.05.2016)

Consiglio Italiano per i Rifugiati Onlus (CIR). (2014). *Oltre i confini: tre anni "together with VI.TO".* Cooperation with Association Jeunesse pour la Paix et la Non Violence, AJPNV, Ciad Trauma Centre Cameroun, TCC, Camerun and the Embassy of Netherlands. Retrieved from http://www.cir-onlus.org/images/pdf/Oltre_i_confini.pdf (28.04.2016)

Constitution of the Italian Republic. (1948).

Cooperativa Sociale Perusia. (2013). *Rifugiati in Umbria, secondo rapporto sul Sistema di protezione per richiedenti asilo e rifugiati in Umbria e focus sull'Emergenza Nord Africa 2011-2012*. Retrieved from http://www.integrazionemigranti.gov.it/Documenti-e-ricerche/ANCIUmbria-rapporto%20regionale%202012.pdf (11.04.2016)

Croce Rossa Italiana (IRC). (n.d). *Progetto Praesidium, strumento di supporto alle vulnerabilità dei migranti*. Official website. Retrieved from https://www.cri.it/praesidium (13.04.2016)

Council of Europe. (n.d). *The European Social Charter*. Council of Europe official website. Retrieved from http://www.coe.int/en/web/turin-european-social-charter (27.03.2016)

Council of Europe. (1996). *European Social Charter (Revised).* Strasbourg, European Treaty Series - No. 163

Council of Europe, Comité Européen sur les Migrations. (2006). *Current trends in International Migration in Europe*. (CDMG (2006) 22e). Retrieved from http://www.coe.int/t/dg3/migration/archives/Documentation/Migration%20management/2005_Salt_report_en.pdf (21.02.2016)

Council of Europe, Parliamentary Assembly (2012). *Lives lost in the Mediterranean Sea: who is responsible?.* 5 April 2012, Doc. 12895. Retrieved from http://www.refworld.org/docid/4f7be86b2.html (19.05.2016)

Council of the European Union. (2012). *EU Strategic Framework on Human Rights and Democracy*. Brussels, 25 June 2012, Document 11855/12. Retrieved from http://data.consilium.europa.eu/doc/document/ST-11855-2012-INIT/en/pdf (01.04.2016)

Council of Ministers. (2012). *Pact between the State, Regions and autonomous Provinces on the indications for the proper application of the healthcare assistance legislation to the immigrant population, by the Regions and Autonomous Provinces*. Original name: Patto tra il Governo, le Regioni e le province autonome di Trento e Bolzano sul documento recante – indicazioni per la corretta applicazione della normativa per l'assistenza sanitaria alla popolazione straniera da parte delle Regioni e Province autonome. Act. 255/CSR, 20.12.2012

De Bruycker, P., Di Bartolomeo, A., Fargues, P. (2013). *Migrants smuggled by sea to the EU: facts, laws and policy options*. MPC RR2013/09, Robert Schuman Centre for Advanced Studies, San Domenico di Fiesole (FI): European University Institute.

Del Grande, G. (2016). *La strage*. Fortress Europe Blog. Retrieved from http://fortresseurope.blogspot.cz/p/la-strage.html (19.05.2016)

Demos & Pi. (2015). *Immigrazione e cittadinanza.* Stastical website. Retrieved from http://www.demos.it/a01157.php (20.05.2016)

Domnich, A., Panatto, D., Gasparini, R., Amicizia, D. (2012). *The "healthy immigrant" effect: does it exist in Europe today?*. Italian Journal of Public Health, 9(3), DOI: 10.2427/7532

Epicentro, il portale dell'epidemiologia per la sanità pubblica. (2015). *Migranti e Salute – informazioni generali.* Retrieved from http://www.epicentro.iss.it/argomenti/migranti/migranti.asp (19.05.2016)

European Commission. (2008). *Policy Plan on Asylum*. Brussels, 17.06.2008. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0360:FIN:EN:PDF (21.03.2016)

European Commission. (2014). *Frontex Joint Operation 'Triton' – Concerted efforts to manage migration in the Central Mediterranean*. Memo, 07.10.2014. Retrieved from http://europa.eu/rapid/press-release_MEMO-14-566_en.htm (22.03.2016)

European Commission. (2015a). Migration and home affairs. *External Aspects.* Retrieved from http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/external-aspects/index_en.htm (21.03.2016)

European Commission. (2015b). *A European Border and Coast Guard to protect Europe's External Borders*. Press Release, 15.12.2015. Retrieved from http://europa.eu/rapid/press-release_IP-15-6327_en.htm (22.03.2016)

European Commission. (2015c). *European Agenda on Migration*. Retrieved from http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/index_en.htm (01.04.2016)

European Commission. (2015d). *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions – A European Agenda on Migration*. Brussels, 13.5.2015 COM(2015) 240 final. Retrieved from http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/background-information/docs/communication_on_the_european_agenda_on_migration_en.pdf (01.04.2016)

European Council. (2001). *Directive on Temporary Protection (2001/55/EC)*. Official Journal of the European Union L 212, 07.08.2011. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32001L0055&from=en (21.03.2016)

European Council. (2004a). *Regulation Establishing Frontex (Council Regulation (EC) No. 2007/2004).* Official Journal of the European Union L 349, 25.11.2004. Retrieved from http://ec.europa.eu/dgs/home-affairs/pdf/fr_reg_consolidated_en.pdf (22.03.2016)

European Council. (2004b). *First Qualification Directive* (2001/55/EC). Official Journal of the European Union L 304/12, 30.09.2004. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32004L0083&from=EN (09.04.2016)

European Council on refugees and exiles (ECRE) and Refugee Council. (2007). *Refugee Council and the European Council on Refugees and Exiles (ECRE) joint response to Select Committee on the European Union Sub-Committee F (Home Affairs): Frontex Inquiry.* PP3/09/2007/extPC. Retrieved from http://www.ecre.org/component/content/article/57-policy-papers/96-ecre-a-brc-joint-response-to-house-of-lords-inquiry-on-frontex.html (19.05.2016)

European Court of Human Rights (ECHR). (2012). *Case of Hirsi Jamaa and others v. Italy*. Application no. 27765/09, final judgement. Strasbourg, 23.02.2012. Retrieved from http://www.asylumlawdatabase.eu/sites/www.asylumlawdatabase.eu/files/aldfiles/Original%20judgment%20-%20HIRSI%20JAMAA%20AND%20OTHERS%20v.%20ITALY.pdf (19.05.2016)

European Parliament and Council. (2011). *Qualification Directive (2011/95/EU*). Official Journal of the European Union L 337/9, 20.12.2011. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32011L0095&from=EN (21.03.2016)

European Parliament and Council. (2013a). *Asylum Procedures Directive (2013/32/EU)*.Official Journal of the European Union L 180/60, 29.6.2013. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32013L0032&from=en (21.03.2016)

European Parliament and Council. (2013b). *Dublin Regulation (Regulation (EU) No. 604/2013).* Official Journal of the European Union L 180/31, 29.06.2013. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32013R0604&from=EN (21.03.2016)

European Parliament and Council. (2013c). *EURODAC Regulation (Regulation (EU) No. 603/2013)*. Official Journal of the European Union L 180/1, 29.06.2013. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32013R0603&from=EN (21.03.2016)

European Parliament and Council. (2013d). *Reception Conditions Directive (2013/33/EU).* Official Journal of the European Union L 180/96, 29.06.2013. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32013L0033&from=EN (21.03.2016)

European Policy Centre. (2014). *Frontex and the respect of fundamental rights: from better protection to full responsibility.* Policy brief, Pascouau, P. and Schumacher, P. 03.06.2014. Retrieved from http://www.epc.eu/documents/uploads/pub_4512_frontext_and_the_respect_of_fundamental_rights.pdf (19.05.2016)

European Union (EU). (2000). Charter of Fundamental Rights of the European Union. Official Journal of the European Communities C 364/1.

European Union. (2002). *Treaty establishing the European Community (Nice consolidated version)*. Official Journal of the European Union C 325, 24.12.2002 P. 0033 – 0184 and C 340, 10/11/1997 P. 0173 - Consolidated version. Retrieved from http://eur-

lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12002E/TXT&from=EN (21.03.2016)

European Union (2012). *Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union.* Official Journal of the European Union C 326, 26.10.2012. Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12012E/TXT&from=EN (21.03.2016)

European Union Agency for fundamental rights. (FRA). (2013). *Inequalities and multiple discrimination in access to and quality of healthcare*. European Union, Luxemburg. ISBN 978-92-9239-022-8 doi:10.2811/17523

Eurostat. (2015a). *Migration and Migrant Population Statistics.* Retrieved from http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics (20.02.2016)

Eurostat. (2015b). *Asylum in the EU in the first quarter 2015 185 000 first time asylum seekers in the EU in the first quarter of 2015 Half are Kosovars, Syrians or Afghans*. Eurostat News Release, 112/2015. Retrieved from http://ec.europa.eu/eurostat/documents/2995521/6887997/3-18062015-CP-EN.pdf/4457b050-26f9-4cf1-bf27-9ffb73ff8c7b (26.02.2016)

Eurostat. (2015c). Asylum Statistics. Retrieved from http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics (26.02.2016)

Fondo Europeo per i Rifugiati (FER). (2011). *Il Diritto alla Protezione, La protezione internazionale in Italia, quale futuro? – Studio sullo stato del sistema d'asilo in Italia e proposte per una sua evoluzione*. Progetto co-finanziato dall'Unione Europea e dal Ministero dell'Interno. Retrieved from http://www.meltingpot.org/IMG/pdf/ASGI_finale.pdf (18.04.2016)

Fondo Europeo per i Rifugiati (FER). (2012). *Le strade dell'integrazione, ricerca sperimentale quali-quantitativa sul livello di integrazione dei titolari di protezione internazionale presenti in Italia da almeno tre anni.* Retrieved from http://www.cir-onlus.org/images/pdf/RICERCA%20PER%20%20presentazione_LE%20STRADE%20DELL'INTEGRAZIONE.pdf (30.04.2016)

Frontex. (n.d.). *Archive of Operations*. Official website. Retrieved from http://frontex.europa.eu/operations/archive-of-operations/ (22.03.2016)

Frontex. (n.d.). *General, how joint operations work*. Official website. Retrieved from http://frontex.europa.eu/operations/types-of-operations/general/ (22.03.2016)

Ghezzi, A. (2016). *Laurea a Pavia, l'università adotta 15 studenti-profughi.* La Provincia Pavese. Newspaper article, 26.03.2016. Retrieved from http://laprovinciapavese.gelocal.it/pavia/cronaca/2016/03/25/news/laurea-a-pavia-l-universita-adotta-15-studenti-profughi-1.13190052 (20.05.2016)

Health for Undocumented Migrants and Asylum Seekers (HUMA Network). (2009). *Access to health care for undocumented migrants and asylum seekers in 10 EU countries, law and practice*. Retrieved from http://www.epim.info/wp-content/uploads/2011/02/Legislative-Rapport-HUMA-Network.pdf (30.03.2016)

Health for Undocumented Migrants and Asylum Seekers (HUMA Network). (2010). *Are undocumented migrants and asylum seekers entitled to access health care in the EU? A comparative overview in 16 countries*. Retrieved from http://www.epim.info/wp-content/uploads/2011/02/HUMA-Publication-Comparative-Overview-16-Countries-2010.pdf (29.03.2016)

History of Migration. (n.d). Retrieved from History World, at http://www.historyworld.net/wrldhis/PlainTextHistories.asp?groupid=1278&HistoryID=ab18& gtrack=pthc (19.02.2016)

International Catholic Migration Commission (ICMC). (2011). *Mayday! Strengthening responses of assistance and protection to boat people and other migrants arriving in Southern Europe*. Retrieved from http://www.refworld.org/docid/4f02ebd92.html (27.02.2016)

International Organization for Migration (IOM). (2015). *World Migration Report 2015, Migrants and Cities: New Partnerships to Manage Mobility*. Geneva, Switzerland. Retrieved from https://www.iom.int/world-migration-report-2015 (19.02.2016)

International Organization for Migration (IOM), World Health Organization (WHO), United Nations High Commissioner for Human Rights (UNHCR). (2013). *International migration, health and human rights.* Geneva, Switzerland. Retrieved from http://www.ohchr.org/Documents/Issues/Migration/WHO_IOM_UNOHCHRPublication.pdf (22.02.2016)

Kalt, A., Hossain, M., Kiss L., Zimmerman, C. (2013). Asylum Seekers, *Violence and Health: A Systematic Review of Research in High-Income Host Countries*. American Journal of Public Health*,* 2013 March; 103(3): e30–e42.

Karamanidou, L., Schuster, L. (n.d). *Deportation in International and Regional Law.* Retrieved from the Refugee Law Project, at http://www.refugeelawproject.org/files/briefing_papers/Deportation_in_International_and_Regional_Law.pdf (24.02.2016)

Kuschminder, K., de Bresser, J., Siegel, M. (2015). *Irregular Migration Routes to Europe and Factors Influencing Migrants' Destination Choices.* Maastricht Graduate School of Governance, Maastricht, the Netherlands.

La denuncia di un infermiere: troppi Tso ai migranti dei centri di accoglienza. (2016). Newspaper article, 17.02.2016. Unknown author. Wereporter. Retrieved from http://www.wereporter.it/la-denuncia-di-un-infermiere-troppi-tso-ai-migranti-dei-centri-di-accoglienza/ (06.03.2016)

Law 722/1954 ratifying and giving execution to the 1951 Geneva Convention. Original name: Legge 24 luglio 1954, n. 722 "Ratifica ed esecuzione della Convenzione relativa allo status dei rifugiati firmata a Ginevra il 28 luglio 1951". Retrieved from http://www.asgi.it/wp-content/uploads/public/legge.24.luglio.1954.n.722.pdf (09.04.2016)

Law 225/1992, establishment of the National Service of Civil Protection agency. Original name: Legge n. 225 del 24 febbraio 1992 "Istituzione del Servizio nazionale della protezione civile". Retrieved from http://www.protezionecivile.gov.it/resources/cms/documents/Legge_225_24febbraio1992.pdf (09.04.2016)

Law 94/2009, dispositions regarding public security. Original name: Legge n. 94 del 15 luglio 2009 "Disposizioni in materia di sicurezza pubblica". Retrieved from http://www.parlamento.it/parlam/leggi/09094l.htm (19.05.2016)

Law Decree no. 89/2011 "Urgent provisions for the full application of the Directive 2004/38/CE on the free movement of EU citizens and for the transposition of the Directive 2008/115/CE on returning illegally staying third-country nationals, converted into Law 129 of 2 Augusts 2011. Original name: Decreto-Legge 23 giugno 2011, n. 89 "Disposizioni urgenti per il completamento dell'attuazione della direttiva 2004/38/CE

sulla libera circolazione dei cittadini comunitari e per il recepimento della direttiva 2008/115/CE sul rimpatrio dei cittadini di Paesi terzi irregolari". Retrieved from http://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:decreto-legge:2011;89 (09.04.2016)

Law Decree no. 119/2014 for assuring the functionality of the Ministry of interior (Article 5 to 7) implemented by Law no. 146/2014. Original name: Decreto Legge 22 agosto 2014, n. 119 "Disposizioni urgenti in materia di contrasto a fenomeni di illegalità e violenza in occasione di manifestazioni sportive, di riconoscimento della protezione internazionale, nonché per assicurare la funzionalità del Ministero dell'Interno". Retrieved from http://www.serviziocentrale.it/file/server/file/Decreto%20legge%2022%20agosto%202014,%20n_%20119.pdf (09.04.2016)

Legislative Decree no. 286/1998 Consolidated Act on provision concerning the Immigration regulations and foreign national conditions norms" (modified by the Law 189/2002). Original name: Decreto Legislativo 25 luglio 1998, n. 286 "Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero". Retrieved from http://www.camera.it/parlam/leggi/deleghe/98286dl.htm (09.04.2016)

Legislative Decree no. 251/2007 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted. Original name: Decreto legislativo 19 novembre 2007, n. 251 "Attuazione della direttiva 2004/83/CE recante norme minime sull'attribuzione, a cittadini di Paesi terzi o apolidi, della qualifica del rifugiato o di persona altrimenti bisognosa di protezione internazionale, nonche' norme minime sul contenuto della protezione riconosciuta." Retrieved from http://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:decreto.legislativo:2007;251 (09.04.2016)

Legislative Decree no. 25/2008 on minimum standards on procedures in Member States for granting and withdrawing refugee status. Original name: Decreto Legislativo 28 gennaio 2008, n.25 "Attuazione della direttiva 2005/85/CE recante norme minime per le procedure". Retrieved from http://www.camera.it/parlam/leggi/deleghe/08025dl.htm (09.04.2016)

Legislative Decree 9/2013. Original Name: Decreto 30 luglio 2013 (G.U. n. 207 del 4 settembre 2013), Modalità di presentazione delle domande di contributo da parte degli enti locali che prestano servizi finalizzati all'accoglienza dei richiedenti e dei titolari di protezione internazionale ed umanitaria, triennio 2014-2016. Linee guida e modelli di domanda. (13A07254). Retrieved from http://www.lexitalia.it/leggi/dm_2013-07-30.htm (09.04.2016)

Legislative Decree no. 18/2014 on "Implementation of Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast)". Original Name: Decreto Legislativo 21 febbraio 2014, n. 18 "Attuazione della direttiva 2011/95/UE recante norme sull'attribuzione, a cittadini di paesi terzi o apolidi, della qualifica di beneficiario di protezione internazionale, su uno status uniforme per i rifugiati o per le persone aventi titolo a beneficiare della protezione sussidiaria, nonche' sul contenuto della protezione riconosciuta". Retrieved from http://www.gazzettaufficiale.it/atto/serie_generale/caricaDettaglioAtto/originario?atto.dataPubblicazioneGazzetta=2014-03-07&atto.codiceRedazionale=14G00028&elenco30giorni=true (09.04.2016)

Legislative decree no.24/2014 "Prevention and repression of trafficking in persons and protection of the victims", implementing Directive 2011/36/EU. Original name: Decreto Legislativo 4 marzo 2014, n. 24 "Prevenzione e repressione della tratta di esseri umani

e protezione delle vittime", in attuazione alla direttiva 2011/36/UE, relativa alla prevenzione e alla repressione della tratta di esseri umani e alla protezione delle vittime. Retrieved from http://www.altalex.com/index.php?idnot=66824 (09.04.2016)

Legislative Decree 142/2015, provisions related to the reception of beneficiaries of international protection. Original name: Decreto Legislativo 18 agosto 2015, n. 142 "Attuazione della direttiva 2013/33/UE recante norme relative all'accoglienza dei richiedenti protezione internazionale, nonche' della direttiva 2013/32/UE, recante procedure comuni ai fini del riconoscimento e della revoca dello status di protezione internazionale." http://www.gazzettaufficiale.it/eli/id/2015/09/15/15G00158/sg (09.04.2016)

Lo Escludo. (2014). *Sbarchi a Reggio Calabria, umanizzare l'accoglienza.* Youtube video. Retrieved from https://www.youtube.com/watch?v=PGFxEumsLsk (28.04.2016)

Loutan, L., Bollini, P., Pampallona, S., Bierens de Haan, D., Gariazzo, F. (1999*). Impact of trauma and torture on asylum seekers*. European Journal of Public Health, Vol. 9, No. 2, 93-96.

Médecins Sans Frontières (MSF). (2016). *Fuori campo - Richiedenti asilo e rifugiati in Italia: insediamenti informali e marginalità sociale.* Retrieved from http://www.integrazionemigranti.gov.it/Documenti-e-ricerche/Fuoricampo.pdf#search=sanitaria (28.04.2016)

Medici per I Diritti Umani (MEDU). (2006). *Rapporto centro di permanenza temporanea ed assistenza "Brunelleschi" di Torino.* Retrieved from http://www.mediciperidirittiumani.org/rapporto-centro-permanenza-temporanea/ (01.05.2016)

Medici per i Diritti Umani (MEDU). (2012a). *La sbarre più alte – rapporto sul centro di identificazione ed espulsione di Porta Galeria a Roma.* Rapporto Maggio 2012.

Medici per i Diritti Umani (MEDU). (2012b). *Rifugiati a Firenze, Rapporto di Medici per i Diritti Umani – un anno di attività del progetto Un camper per i diritti con i titolari di protezione internazionale*. Ottobre 2011/Ottobre 2012.

Medici per I Diritti Umani (MEDU). (2013a). *Porti insicuri, le riammissioni dai porti italiani alla Grecia e le violazioni dei diritti fondamentali dei migranti*. Rapporto Novembre 2013.

Medici per I Diritti Umani (MEDU). (2013b). *The CIE archipelago - Inquiry into the Italian Centres for Identification and Expulsion*. Summary, May 2013. Open Society Foundations. Retrieved from http://www.mediciperidirittiumani.org/pdf/CIE_Archipelago_eng.pdf (28.04.2016)

Medici per I Diritti Umani (MEDU). (2014a). *I sommersi ed i salvati.* Report. Retrieved from http://www.mediciperidirittiumani.org/i-sommersi-i-salvati/ (02.03.2016)

Medici per I Diritti Umani (MEDU). (2014b). *Roma capitale dei rifugiati. Urgente dare assistenza ai migranti forzati più vulnerabili*. Retrieved from http://www.mediciperidirittiumani.org/roma-capitale-dei-rifugiati/?upm_export=pdf&lang=it (30.04.2016)

Medici per I Diritti Umani (MEDU). (2015a). *Fuggire o Morire - Rotte migratorie dai paesi sub-sahariani verso l' Europa.* Synthesis. Retrieved from http://www.mediciperidirittiumani.org/rapporto-fuggire-o-morire/ (29.02.2016)

Medici per I Diritti Umani (MEDU). (2015b). *Rapporto sulle condizioni di accoglienza, Cara di Mineo.* Progetto ON.TO. Retrieved from

http://www.mediciperidirittiumani.org/pdf/REPORT_ACCOGLIENZA_MINEO_Giugno_2015.pdf (27.04.2016)

Migranti, ancora naufragi: muoiono 20 bambini. "A Bruxelles si discute, nel Mediterraneo si muore". (2016). Redattore Sociale. Newspaper article, 22.01.2016. Retrieved from http://www.redattoresociale.it/Notiziario/Articolo/498629/Migranti-ancora-naufragi-muoiono-20-bambini-A-Bruxelles-si-discute-nel-Mediterraneo-si-muore (19.05.2016)

Migranti, Oim: "Nel 2015 superata quota un milione di arrivi in Europa". (2015). La Repubblica. Newspaper article, 22.12.2015. Retrieved from http://www.repubblica.it/esteri/2015/12/22/news/migranti_oim_piu_di_un_milione_arrivato_in_europa_nel_2015_-129976756/ (20.05.2016)

Ministero dell'Interno. (2014). *Varato il Piano Nazionale per fronteggiare il flusso straordinario di migranti.* Retrieved from official webpage, department of civic rights and immigration,http://www.libertaciviliimmigrazione.interno.it/dipim/site/it/documentazione/documenti/politiche_immigrazione_asilo/2014/Varato_il_Piano_Nazionale_per_fronteggiare_il_flusso_straordinario_di_migranti (09.04.2016)

Ministero dell'Interno. (2015a). *Trend dell'arrivo dei migranti sulle coste italiane*. Retrieved from http://www.interno.gov.it/sites/default/files/dati_statistici_marzo_2015.pdf (06.04.2016)

Ministero dell'Interno. (2015b). Centri per l'immigrazione. Official website. Retrieved from http://www.interno.gov.it/it/temi/immigrazione-e-asilo/sistema-accoglienza-sul-territorio/centri-limmigrazione (11.04.2016)

Mollica, A. (2012). *Avvenire: lo scandalo dei Cie, i centri per i migranti*. Newspaper article, 03.10.2012. Gad Lender. Retrieved from http://www.gadlerner.it/2012/10/03/avvenire-lo-scandalo-dei-cie-i-centri-per-i-migranti (26.05.2016)

NAGA. (n.d). *Area Socio Sanitaria*. Official website. Retrieved from http://www.naga.it/index.php/socio-sanitaria.html (30.04.2016)

Norredam M., Mygind A., Krasnik A. (2005). Ethnic Disparities in Health - Access to health care for asylum seekers in the European Union—a comparative study of country policies. *European Journal of Public Health*, Vol. 16, No. 3, 285-289.

Nufer, S., Trummer M. (2013). *Reception conditions in Italy, Report on the current situation of asylum seekers and beneficiaries of protection, in particular Dublin returnees*. Swiss Refugee Council, SFH-OSAR editors. Bern, Switzerland.

Office of the United Nations High Commissioner for Human Rights (OHCHR). (n.d). *What are human rights?.* Official website. Retrieved from http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx (27.03.2016)

Piazza Pulita. (2016). *Pettinengo, integrazione pacifica e solidale.* Video-report, 04.03.2016. Retrieved from https://www.facebook.com/noallodiorazziale/videos/10153847674142856/ (20.05.2016)

Presidenza del Consiglio dei Ministri, dipartimento della Protezione Civile. (2011). *National Reception Plan for the North African Emergency*. Original name: Piano per l'accoglienza dei migranti in attuazione dell'accordo Stato Regioni Enti Locali del 6 aprile 2011. Retrieved from http://www.protezionecivile.molise.it/piano_migranti.pdf (10.04.2016)

Presidio nella terra di nessuno'. Il video che racconta il lavoro della Caritas contro lo sfruttamento. (15.12.2015). Newspaper article. Unknown author. Ragusah24.

Retrieved from http://www.ragusah24.it/2015/12/15/presidio-nella-terra-di-nessuno-il-video-che-racconta-il-lavoro-della-caritas-contro-lo-sfruttamento/ (28.04.2016)

Protezione Civile, official website. (n.d*). Dossier - Emergenza umanitaria Nord Africa: l'accoglienza dei migranti*. Retrieved from http://www.protezionecivile.gov.it/jcms/it/view_dossier.wp?facetNode_1=f1_1&prevPage=dossier&facetNode_2=emergenza_nord_africa&contentId=DOS24090 (10.04.2016)

Protezione Civile, official website. (2011). *News - Emergenza umanitaria: indicazioni operative per l'accoglienza dei migranti*. 10th May 2011. Retrieved from http://www.protezionecivile.gov.it/jcms/it/view_new.wp?contentId=NEW24538 (10.04.2016)

Provincia di Parma. (2011). *Per un'accoglienza e una relazione d'aiuto transculturali – linee guida per un'accoglienza integrata e attenta alle situazioni vulnerabili dei richiedenti e titolari di protezione internazionale.* Produced and printed in May 2011.

Roskilde University and Working Lives Research Institute. (2008). *Undocumented Migration Glossary.* Retrieved from the Undocumented Worker Transition (UWT) project, EU Sixth Framework Programme http://www.undocumentedmigrants.eu/library/h11625_3.pdf (25.02.2016)

Sabbati, G., Poptcheva E. (2015). *Irregular Immigration In The EU: Facts And Figures*. European Parliamentary Research Service Blog. Retrieved from http://epthinktank.eu/2015/04/27/irregular-immigration-in-the-eu-facts-and-figures/ (26.02.2016)

Sala, D. (2015). *Storie di rifugiati accolti in famiglia a Torino*. FaiNotizia. Newspaper article, 01.10.2015. Retrieved from http://www.fainotizia.it/inchiesta/01-10-2015/welchome-storie-di-rifugiati-accolti-famiglia (20.05.2016)

Schultz, C. (2014). Migration, *Health and Cities - Migration, health and urbanization: Interrelated challenges*. Background Paper to World Migration Report, IOM. Retrieved from https://www.iom.int/sites/default/files/our_work/ICP/MPR/WMR-2015-Background-Paper-CSchultz.pdf (21.02.2016)

Singer, A. (2013). Contemporary Immigrant Gateways in Historical Perspective. *Daedalus, Journal of the American Academy of Arts and Sciences*, Vol. 142, No. 3, 76–91.

Sistema di Protezione per Richiedenti Asilo e Rifugiati (SPRAR). (2010). *Le dimensioni del disagio mentale nei richiedenti asilo e rifugiati – problemi aperti e strategie di intervento.* Retrieved from http://www.sprar.it/images/Documenti/Quaderni_servizio_centrale/Le_dimensioni_del_disagio_mentale_-_Cittalia_2010.pdf (06.03.2016)

Sistema di Protezione per Richiedenti Asilo e Rifugiati (SPRAR). (2011). *La salute mentale dei rifugiati: un nuovo disegno per l'accoglienza.* Retrieved from http://www.sprar.it/images/Documenti/Quaderni_servizio_centrale/La_salute_mentale_dei_rifugiati.pdf (16.05.2016)

Sistema di Protezione per Richiedenti Asilo e Rifugiati (SPRAR). (2012). *Rapporto annuale del Sistema di protezione per richiedenti asilo e rifugiati - Anno 2011/2012*. Rome, Italy. Retrieved from http://www.sprar.it/images/Documenti/Quaderni_servizio_centrale/SPRAR-rapporto_2012defmg.pdf (18.04.2016)

Skeldon, R. (2013). *Global Migration: Demographic Aspects and Its Relevance for Development* (Technical Paper No 2013/6). New York, NY: United Nations Depart of Economic and Social Affairs.

The UK Faculty of Public Health. (2008). *The health needs of asylum seekers*. Briefing Statement. Editor Lindsey Stewart, London, United Kingdom. ISBN: 1-900273-31-4. Retrieved from http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf (06.03.2016)

Tondo, L. (2016). *How One Sicilian Village Learned to Love Migrants*. Time. Newspaper article, 27.01.2016. Retrieved from http://time.com/4186819/sutera-sicily-migrants/ (20.05.2016)

United Nations Committee on Economic, Social and Cultural Rights (CESCR). (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant).* Document E/C.12/2000/4. Retrieved from http://www.refworld.org/docid/4538838d0.html (27.03.2016)

United Nations Department of Economic and Social Affairs (UN DESA). (2013). *International Migration 2013 Wallchart*. New York, NY. Retrieved from www.un.org/en/development/desa/population/migration/publications/wallchart/docs/wallchart2013.pdf (21.02.2016)

United Nations Development Program (UNDP). (2010). *Mobility and Migration*. Human Development Report Office A Guidance Note for Human Development Report Teams. New York, NY. Retrieved from http://hdr.undp.org/sites/default/files/nhdr_migration_gn.pdf (15.03.2016)

United Nations General Assembly. (1948). *Universal Declaration of Human Rights*. United Nations, resolution 217 A (III). Retrieved from http://www.un.org/en/universal-declaration-human-rights/ (25.02.2016)

United Nations General Assembly. (1951). *Convention Relating to the Status of Refugees*. United Nations, Treaty Series, vol. 189, p. 137. Retrieved from http://www.unhcr.org/3b66c2aa10.html (23.02.2016)

United Nations General Assembly. (1965). *International Convention on the Elimination of All Forms of Racial Discrimination*. United Nations, Treaty Series, vol. 660, p. 195

United Nations General Assembly. (1966a). *International Covenant on Civil and Political Rights*. United Nations, Treaty Series, Vol. 999, p. 171

United Nations General Assembly. (1966b). *International Covenant on Economic, Social and Cultural Rights*. United Nations, Treaty Series, Vol. 993,1-14531

United Nations General Assembly. (1979). *Convention on the Elimination of All Forms of Discrimination Against Women*. United Nations, Treaty Series, vol. 1249, p. 13

United Nations General Assembly. (1989). *Convention on the Rights of the Child*. United Nations, Treaty Series, vol. 1577, p. 3

United Nations General Assembly. (2007). *Convention on the Rights of Persons with Disabilities*. Resolution 81/106, A/RES/61/106

United Nations High Commissioner for Refugees. (UNHCR). (n.d). *Key Facts and Figures.* Retrieved from http://www.unhcr.org/pages/4a1d406060.html (27.02.2016)

United Nations High Commissioner for Refugees. (UNCHR). (2012a). *Global report 2012*. Geneva, Switzerland. Retrieved from http://www.unhcr.org/gr12/index.xml (26.02.2016)

United Nations High Commissioner for Refugees (UNHCR). (2012b). *Refugee Protection and International Migration: Achievements, Challenges and Lessons Learned from UNHCR's 10-Point Plan Project*. Retrieved from http://www.refworld.org/docid/4f2654362.html (01.04.2016)

United Nations High Commissioner for Refugees. (UNCHR). (2012c). *UNHCR recommendations on important aspects of refugee protection in Italy*. July 2012. Retrieved from http://www.refworld.org/docid/5003da882.html (19.05.2016)

United Nations High Commissioner for Refugees. (UNCHR). (2012d). *UNHCR concerned at detention of asylum-seekers, releases new guidelines.* Official website. 21 September 2012. Retrieved from http://www.unhcr.org/505c33199.html (19.05.2016)

United Nations High Commissioner for Refugees. (UNCHR). (2013). *Global report 2013*. Geneva, Switzerland. Retrieved from http://www.unhcr.org/gr13/index.xml (23.02.2016)

United Nations High Commissioner for Refugees (UNHCR). (2015a). *World at War, UNHCR Global Trends – forced displacement in 2014*. UNHCR, Geneva, Switzerland. Retrieved from http://unhcr.org/556725e69.html (25.02.2016)

United Nations High Commissioner for Refugees. (UNHCR). (2015b). *Refugees and migrants crossing the Mediterranean to Europe - Overview of arrival trends as of 28 September 2015*. Geneva, Switzerland. Retrieved from http://www.refworld.org/docid/561377284.html (26.02.2016)

World Health Organization (WHO). (n.d). *Environmental Health in Emergencies*. Retrieved from http://www.who.int/environmental_health_emergencies/displaced_people/en/ (23.02.2016)

World Health Organization (WHO). (1946). *Constitution of the World Health Organization*. WHO, New York, NY. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf (21.02.2016)

World Health Organization (WHO). (2008). The Tallinn Charter: Health Systems for Health and Wealth. Tallinn, Estonia. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf (06.03.2016)

World Health Organization (WHO). (2010). *How health systems can address health inequities linked to migration and ethnicity*. Regional Office for Europe, Copenhagen, Denmark. ISBN 978 92 890 0204 2

World Health Organization (WHO), Regional Office for Europe. (n.d). *Migration and health: key issues*. Retrieved from http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292931 (28.03.2016)