

Unplanned migration flow: the acceptance system response, Perugia

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Summary. *Background and aim of the work:* Since several years, Italy is facing an important flow of immigration. Umbria is not a region of disembarkation of refugees, nevertheless is one of the Italian regions with the highest rate of foreign population compared to the total resident population. Aim of this paper is to collect data on migrants and refugees' health care services access, focusing on migrants' characteristics arrived and living in Umbria. *Methods:* We conducted a retrospective cohort study at the Local Health Unit Umbria of Perugia, Italy. Descriptive analysis was performed in order to identify the characteristics of the migrants living in Perugia area. Data analysis was performed using Excel[®] software. All frequencies are expressed as percentage. *Results:* Between 2015-2017, 2,688 migrants came to Umbria Region. The mean age is 23.6 years, almost all are male, and however the majority of female comes from Nigeria. Only 25.5% of migrants durably sojourned in Umbria Region, and only half of them are residents and received the assignment of general practitioner. *Conclusions:* Unplanned migration may cause an abrupt rupture of the social-cultural supports that sustain both psychological and physical well-being. Regional Health Service should collect data on migrants and refugees' health and their health care services access, in order to offer an efficient and appropriate regional health system. (www.actabiomedica.it)

Key words: unplanned migration, Italy, migrant health, refugees, Regional health service

1. Introduction

Due to the presence of wars, high social inequalities and low grade of physical and mental health in several areas of the world, more and more people are forced to leave their own country. World Health Organization (WHO) estimates an amount of 1 billion of migrants all over the world, with important public health impacts for both people and health services (1). Actually, the right to health was established in the WHO Constitution and confirmed, without racial differences, in the Sixty-first World Health Assembly in 2008, through the approval of Health of migrants resolution (2). Even though, the Universal Declaration of Humans rights imagines all health rights equally dis-

tributed to all people, including migrants, refugees and vulnerable people, there are still differences in health services access and health care (3).

Since several years, Italy is facing an important flow of immigration. Actually, only in 2016, arrived 181,436 migrants (4). Data similar also in 2014 and 2015 (4). Umbria is not a region of disembarkation of refugees, nevertheless is one of the Italian regions with the highest rate of foreign population compared to the total resident population (10.87% vs 11.99% of Emilia-Romagna, first in the ranking). Actually, according to the State-Regions Conference, due to the large amount of new migrants arrival during the 2014-2015, Italy had to reorganize the immigration policies and acceptance system (5). Migrants had to be reas-

signed among the Italian regions taking into account the population, gross domestic product (GDP) and the number of migrants already hosted by each region. This important issue had challenged Regions in order to rearrange the health services. Actually, Umbria Region has been fit out, since 2000, important rules on migrants' access to health services, promotion and protection of immigrants' health (6).

In fact, it is one of the Italian region that have promoted the use of all health territorial services such as General Practitioners and Paediatricians. In particular, the Regional Resolution 106/2015, followed by operating protocol, figures out the operating procedure for migrants' health care. According to this protocol, the first medical examination provided to the migrants should take in account migrants' health status in relation to potential risks for migrants themselves and for the community. During the first medical examination, doctors should actively notify, to the surveillance system, potential notifiable infectious diseases. Moreover, if there are some critical conditions, such as risk of health, the hospital transfer is urgently provided. Nevertheless, first medical examination is also important to guarantee the communication of migrants' name list to the health districts and successively registration in Regional Health Service. The aim of this paper is in line with the conclusions of sixty-first WHO assembly, which emphasized the importance to recognize migrants' health risks and needs, and to collect additional data on migrants and refugees' health and their health care services access. In particular, we want to focus on migrants' characteristics arrived and living in Umbria.

2. Methods

We conducted a retrospective cohort study during the period February 2015–November 2017 at the department of Prevention at the Local Health Unit Umbria of Perugia, Italy. Data on migrants arrived were electronically recorded in an *ad hoc* registry. Later, we cross-checked data from this electronic database with data from health-service registry. We survey the health-service registry in order to identify information related to migrants staying in Perugia area.

According to legal classification, migrants' status was defined as follow: Foreigner Temporary Present on the Italian territory (STP, Straniero Temporaneamente Presente) and migrant with residence permit. STP are illegal immigrants who can access the Italian National Health System in case of emergency care, without risk of being charged by police (7).

Migrants waiting for residence permit are foreign non-EU citizens with valid passport and/or entry visa. Resident permit should be apply as soon as possible at the entry time and if the stay exceed 3 months (8).

Descriptive analysis was performed in order to describe the characteristics of the migrants living in Perugia area. Data analysis was performed using Excel® software. All frequencies are expressed as percentage.

3. Results

During the period February 2015–November 2017, 2,688 migrants came in Umbria Region. In the majority of the case people come from Nigeria (n=595), Eritrea (n=245), Guinea (n=230), Gambia (n=223) and Senegal (n=202) (Figure 1). The mean age is 23.6 years, between 19.6 years among Syrians and 28.1 years among Pakistanis. Almost all are male, with 2,240 man vs 357 women (in 91 of the cases gender is not known). Figure 2 shows the distribution of genders according to country of origins. Even though, the majority of female comes from Nigeria (n=185) the highest proportion of Male/Female is among Palestinians (50%), followed by Nigeria (31.1%), Morocco (31.1%) and Cameroon (29.5%). Among the 2,688 individuals arrived in our Region, only 685 subjects (25.5%) are tracked for long time (more than 6 months) in our health-service registry and plausibly they durably sojourn in Umbria Region. Actually, only 7/685 left Umbria before than 6 months. Whilst, 194/685 persisted for a mean of 387.4 days, and they are no-more active in health-service registry. However, 484/685 migrants are still living in the area. Actually, 251 people are residents and received the assignment of general practitioner, 13/484 individuals had STP code, 45/484 migrants waiting for residence permit renewal and lastly 145/484 non-European migrants with residence permit is close to its expiry date. Figure 3 presents the

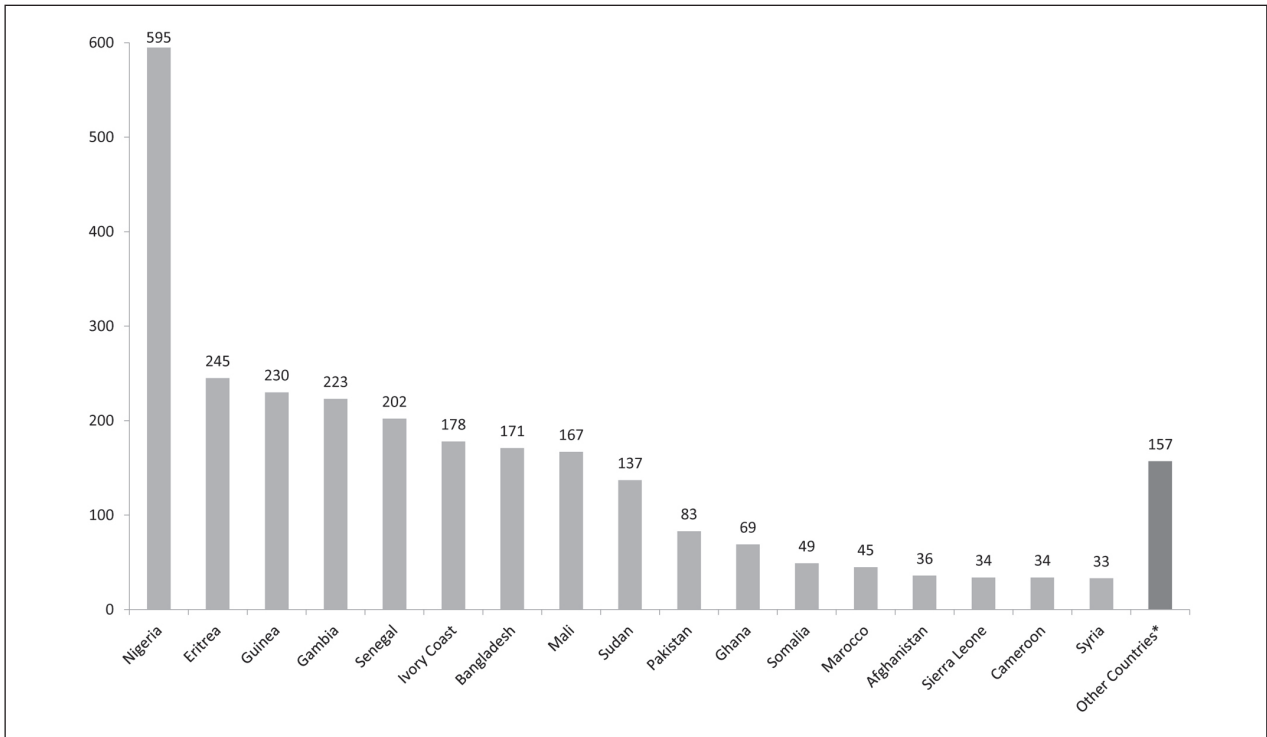


Figure 1. Total amount of migrants arrived in Umbria Region in February 2015- November 2017, according to country of origin.
 * Ethiopia, Liberia, Niger, Togo, Palestine, Iraq, Burkina Faso, Ciad, Guinea Bissau, Iran, Benin, Libya, Egypt, Congo, Nepal, Sri Lanka, Zimbabwe, South Africa, Angola, Comoros Islands, India

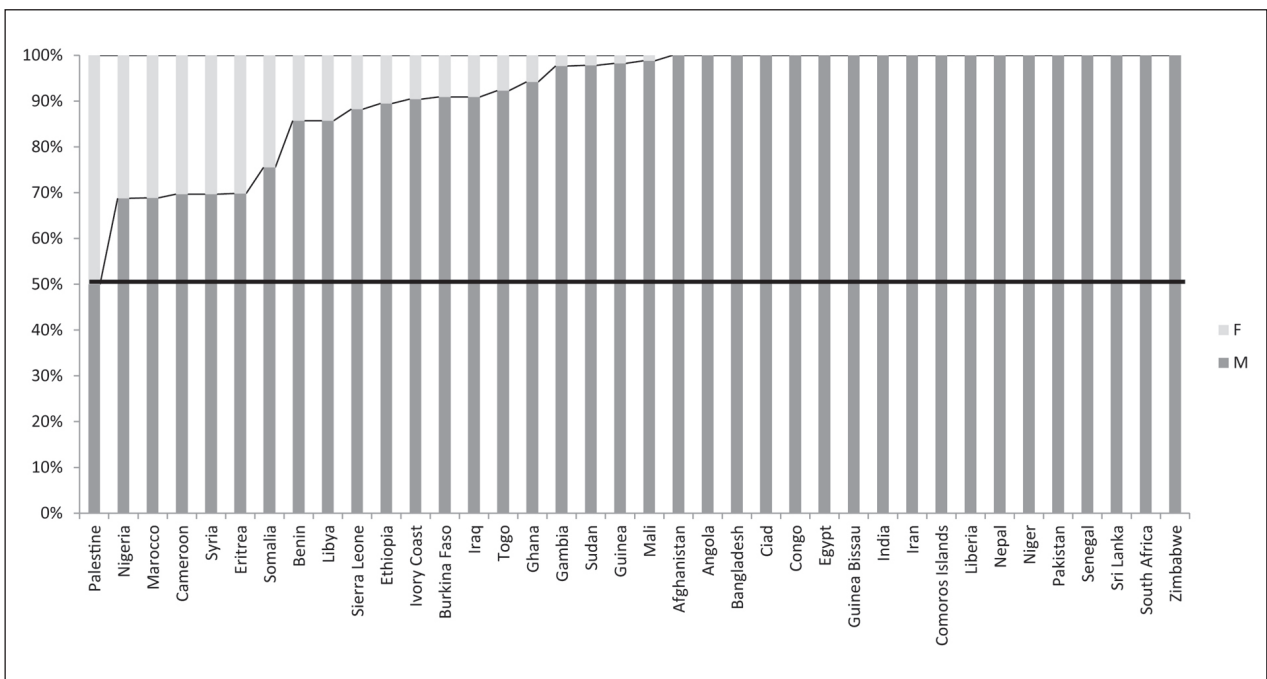


Figure 2. Distribution of genders according to country of origins

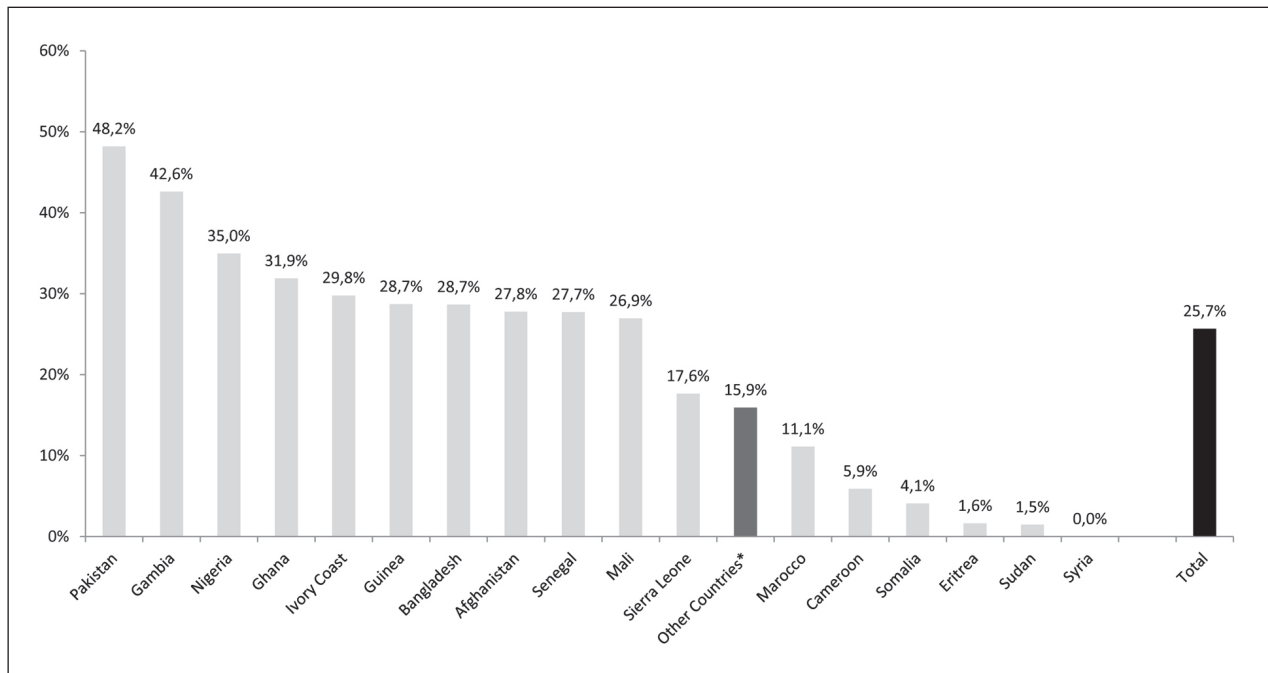


Figure 3. Percentage of migrants arrived and durably sojourning in Umbria Region, according to country of origin.

* Ethiopia, Liberia, Niger, Togo, Palestine, Iraq, Burkina Faso, Ciad, Guinea Bissau, Iran, Benin, Libya, Egypt, Congo, Nepal, Sri Lanka, Zimbabwe, South Africa, Angola, Comoros Islands, India

distribution of this subpopulation, in percentage on the total arrivals, according to the country of origin.

4. Discussion

According to Italian National data, citizenship of non-EU citizens are still increasing year by year, +16% compared to previous period (9). In particular, the number of asylum seekers is growing much more compared to other reasons such as work or family reunification. Asylum seekers are hosted with a higher hostile sentiment in many European Countries, however immigration is necessary for many European Countries economies. Actually, even though, growing evidences suggest that health systems are perceived inaccessible for the majority of migrants (10). Moreover, migrants are the cornerstones of health sector through the domestic care provided to sick and elderly people. Our study, according to literature evidence, found a young migrant population with a mean age of 23.6 years (11). This aspect generates several important considerations:

first, migrants who were able to survive to the trip and after the self-selection in their own countries, constitutes a pool of young and healthy people (12). This phenomenon is known as “healthy immigrant effect”, that means a no overuse of health care system. Moreover, young people are much more prone to work, in particular in low-skilled and hard jobs. Young migrants are also important to increase the birth rates, that is very low in the majority of developed countries, such as migration is able to contrast the aging of the western societies (13).

Moreover, migrant population faced different health needs, principally infectious diseases, dehydration, malnutrition and post-traumatic stress disorder. Regarding infectious diseases, in the majority of the cases they are infection acquired in the host countries, mainly due to poor living conditions, low educational level on preventive measures, or absence of information on health service access (14, 15). Dehydration and malnutrition are typical of both poor travel conditions and poverty faced also in the host countries; while post-traumatic stress disorder is the most frequent mental

health problem identified in particular among asylum seekers and refugees (16). Even though these symptoms could be common across different cultural background, growing evidence also supports the hypothesis that some symptoms might be culture specific (17). Cultural integration actions, such as migrant-specific information materials and screening programmes, are fundamental to reduce burden of diseases among migrants and to improve health management (17).

These considerations need to be taken into account in order to re-organize the health service systems, especially in a “health for all” prospective, where health service had to promote health, quality of life and human dignity (18).

In Italy there is an intense political debate, with some anti-immigrant parties focalizing on unsafety both regards health and social security. Nevertheless, according to most studies migrants are, at least initially, healthier compared to non-migrants, and the diseases appear after a lag of time principally due to low socio-economic status and low access to preventive health system. An important limit of our study is the impossibility to evaluate health status of migrants, however these data provide important information regarding migrants characteristics and are able to estimate the volume of migrants really presents in our area.

5. Conclusion

Unplanned migration may cause an abrupt rupture of the social-cultural supports that sustain both psychological and physical well-being (19, 20). Even though, Umbria is not a region of disembarkation of refugees, it has the highest rate of foreign population compared to the total resident population, among Italian regions. This is particularly true after the 2015, when the number of international migrants worldwide were the highest ever recorded. Actually, in order to face this new circumstance, Umbria region emitted the Regional Resolution 106/2015, followed by operating protocol, aimed to figure out migrants’ health risks and needs, and to collect additional data on migrants and refugees’ health and their health care services access, in order to improve and to offer an more and more efficient and appropriate regional health system.

Conflict of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

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