Cidis/Alisei

European Commission

HEALTH FOR ALL, ALL IN HEALTH

European Experiences on Health Care for Migrants

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IMMIGRANTS IN EUROPE AND HEALTH SERVICE STRATEGIES: AN INTRODUCTORY OUTLINE

Tullio Seppilli

1. In order to deal with the issue of European health services' ability to meet the health needs of immigrants coming from other areas of the world, we should start from two basic assumptions.

The *first*: nowadays, great migratory flows from many poorly industrialized (or characterized by harder or more insecure life conditions) areas of the world towards Europe have become a "structural" phenomenon. This could be further regulated but not stopped, since it stems from a widening gap between life conditions in the North and South of the planet and, at the same time, from the concurrent globalization of markets - including labor market - boosted by development logic and the resulting opening and leveling processes the industrialized West has imposed on the whole planet, though with many contradictions. As a result, the tendency of almost every European country to become, up to a certain degree, a multiethnic and multicultural society, which has been under way for some decades, will inevitably persist, at least in the medium term.

The *second* assumption is that those migratory flows come from more than one hundred countries located in all areas of the world, thus establishing in Europe the presence of new citizens, largely heterogeneous in their ethnic features, historical roots, cultural set-ups, personal vicissitudes and experiences, theories and practices concerning health/illness states. It must be stressed that this heterogeneity is inadequately reflected by homogenizing, bureaucratic and all-inclusive labels such as "non-European immigrants" and the like. Apart from their juridical and administrative value, such labels can be misleading and bring about misunderstandings, fostering among European natives a globalizing attitude towards immigrants, wherein the

concreteness of people and cultures is lost, their real specificity is erased, while the distance from "those from abroad" is increased and they are seen as different and alien people altogether. They are considered as threatening in various ways and, all in all, "inferior", coming from poor and "underdeveloped" areas of the world, so much so that people coming from "rich countries", such as Canada and the United States, are never labeled like that in the public imagination. Furthermore, such globalizing labels do not account for the immigrants' point of view. They, at least for the time being, only occasionally consider their common condition as newcomers - and the various and often serious problems this brings about for all of them, although to different extents - as the ground for an actual common characterization and conscience of their own rights. On the contrary, they go on referring almost exclusively to their own ethnic group, i.e. they feel Peruvian, Nigerian, Filipino or Chinese, as different among them as they are from Europeans.

2. Moreover, we must take into account the nature of those processes involving immigrants' cultural set-ups within this reference framework.

To this purpose, it is advisable to reassert, first of all, what might seem obvious: each culture - being a more or less organic system of "patterns" oriented towards knowledge and interpretation of reality, evaluation of events and effective interventions on that reality - is the result of a social construction, gradually elaborated within a *specific* historic-territorial context, characterized by a *specific* productive set-up and *specific* social relationships of supremacy and power, as well as by the weight of its former *specific* material and cultural history. Therefore, a culture may find its basis and "reason" only by referring to its own context, consistently taking the shape of a repertoire of trends, through which people who have introjected it may effectively respond to the tangible problems each of them has to face every day, according to his own position within that context. Consequently, for communities and single individuals alike, each change in life prospects - be it the product of a variation in the social scene or, more interestingly for us, the result of a migration process towards a different territory - inevitably determines an objective *infunctionality* of behaviors supported by old cultural patterns. Ultimately, in the face of new situations and issues, the patterns elaborated in the former context may no longer provide an appropriate response. In such a condition, the frustrating experience of the impracticability or ineffi-

cacy of one's own usual behaviors produces experiences of unsuitability and cultural crisis, and the ensuing need to get out of that state, painfully relinquishing old models and elaborating new ones (or borrowing them from the local population, as is the case with immigrants), consistently with the logic of the hosting society and, thus, sufficiently functional and effective.

Therefore, a certain degree of detachment from the culture of origin and an actual opening towards the new context seem inevitably linked with every migratory process: not just because of the physical removal of migrants from the society where their culture had its roots, its internal logic and its effective operation, but especially because of the very reasons of their migratory project - that is, to settle and work in an *elsewhere* that they consider, rightly or wrongly, "better" than their homeland, more "advanced" and heralding more opportunities, at least in some respects and temporarily. Such reasons, as a matter of fact, may spontaneously (aside from the possible effects of specific and deliberate "conversion" policies) bring them to adopt local cultural instruments, representing the necessary condition for all settling and integration processes.

Essentially, their culture of origin appears inevitably weakened, made fragile and open. This is both an effect of the uprootedness of its "carriers" from the old context and of the mechanisms of their integration in a new and different context. The result is the formation, among immigrants, of a mixed and syncretic cultural heritage, characterized by a dynamic balance between the two cultures: their respective weights and thematic areas of competence, as well as the pace at which that syncretism develops, depend on the quality and progress of objective and subjective conditions through which the integration process gradually comes to fruition. But we must reassert that this is a process that - even because of its impact on health issues - necessarily brings about painful and conflictual situations, wherein expectations and opening towards "the new" are fatally intertwined with experiences of disorientation and homesickness about a customary and now lost world, of extraneousness and frustration, conflicting rules and values, recurring anti-acculturating constraints.

3. It seems that only by taking into account the relevant factors involved in recent mass migrations towards Europe and the West at large, as well as the nature of processes affecting the migrants' cultural set-ups, it is pos-

sible to build around the resulting issues some realistic and positive response strategies. These, consistently with what we have pointed out, must needs set up a reference framework for the formulation, on this basis, of an effective health care policy.

Accordingly, we have to highlight at once the impracticality, for different and negative reasons, of the three basic trends frequently emerging from the debates on immigration policies.

A. The *first* trend is based on *rejection*, that is the refusal of immigration or a tendency to contain it as much as possible, while demonizing immigrants. This is a highly unrealistic trend, if we consider the extent of the factors determining the displacement of great masses from the South to the North of the planet. Furthermore, it collides - in the rural and industrial areas of many European countries - with the lack or unavailability of local manpower, so that immigration becomes an inalienable condition for the survival of plenty industries and their linked activities. The drive towards such a rejection, on the other hand, must necessarily be rooted - or express itself - in ideological tendencies that are essentially xenophobic and racist, exploited and augmented by the most conservative social and political groups, in order to pursue goals of hegemony and control over large population strata, creating an intolerant climate; conveying real conflicts and tensions towards an "alien" scapegoat, and thus building a mass basis to urge for an indiscriminate reinforcement of repressive institutions and the militarization of the entrances to the country: in short, to "armor" society and redirect the country towards adventurist solutions of the ultra-conservative and authoritarian kind. This would lead not only to the rejection of both new and old "misfits", but to the challenging of "democracy for all" as well.

B. The *second* trend is based on the mere *assimilation*, that is a policy whose target is to induce citizens coming from other areas of the world to acquire, as rapidly as possible, the models in operation in their host country, turning their backs to cultures of origin to identify with the culture and lifestyle of the residents. Such a trend, based on a superficial opening towards newcomers ("there are no barriers or inferiority preventing others to become just like us and thus to live with us"), actually reflects a strong ethnocentrism ("our goal is to make them become like us"). But, most of all, the theory of a possible quick cultural absorption of newcomers appears largely unrealistic as well: the experience of Western countries wherein this

phenomenon is old-established shows that descendants of the first immigrants keep or take up anew, even in the third or fourth generation, significant elements of their original cultures, characterized by an intense symbolic value of identity (ethnicisms). On the other hand, such a trend would needs require the implementation of strategies and institutions that may produce, in immigrants and their children, a strong and lasting compulsion, aimed at the nullification of their former identities and at their complete assimilation within the host country's culture (for instance, educational rules revolving around Eurocentric programs and learning mechanisms exclusively based on local language and culture, an absolute monolingualism in transport facilities and workplaces, cautionary procedures against the development of media, cultural and religious centers independently managed by immigrants and so on). This substantial constraint implies a double corollary: (*a*) on the one hand, the loss for the host country of an opportunity to get, from a partial coexistence with other cultures, greater knowledge tools in the face of other realities that are by this time integrated in an interactive world network, in order to play a more effective and realistic role of mediation, and especially (*b*) for immigrants, an inevitable defensive reaction, resulting in phenomena of concealment and resistance, of actual fundamentalism and anti-acculturating revivalism, heralding more unrest. Without considering that every process of fast deculturation and the following fall of old values and social control mechanisms implies, in the course of a socio-cultural repositioning, experiences of frustration, isolation and anomy which - along with the objective difficulties involved in the "normal" integration process within the new context - facilitate "deviant" behaviors and lifestyles, and a likely fall into local organized crime networks.

C. The *third* trend is based on an uncritical *multiculturalism*, i. e. a policy assuming as a possible permanent and desirable set-up the mere coexistence, in the host society, of the local culture with the cultures of the immigrants' countries of origin. We have already examined the reasons making this theory largely unrealistic. Firstly, because the immigrants' cultures of origin are depleted and weak when they reach host countries, due to the uprootedness of their carriers from their original contexts and from the conditions where such cultures represent an actual subsistence and social integration instrument. Secondly, because, for migrants, the very decision to leave their own country is the result of a breaking-off, at least partial, of the identifica-

tion with their traditional context and the outcome of an option wherein a far-off *elsewhere* becomes a positive and feasible life alternative, implying some kind of *anticipated acculturation*. Secondly - and this is the main factor into play - because the very impracticality or inefficacy of many aspects of the culture of origin, in the new context, inevitably induce newcomers striving to reach integration to borrow some basic elements from the local culture, consistently with the operating logic of the host society. Ultimately, since every culture is built with reference to a well-defined historical-territorial context - wherein it "works", manifesting itself in effective behaviors, whereas it may not hold on indiscriminately in every time and place - it cannot be integrally transposed in a radically different context. Its "carriers" must subject it, sooner or later, to a profound alteration, re-signification and contamination. That is why we cannot even imagine an organic social set-up integrating individuals of different origin, effectively operating and interacting, while each of them remains locked up within his own culture. That would lead to a scenario where behavioral styles created by the most widely varying social systems of reference are implemented. Actually, if such a social set-up could exist, as an aggregation of individuals "carrying" different cultural prospects without a common and consistent unifying matrix, it would eventually disintegrate itself. A strategy aimed at the integration of migratory flows through such an uncritical and impractical multiculturalism would not only be unrealistic, but ultimately negative. In some emblematic areas of Western societies, such as industrial production, most activities imply an adjustment to the underlying "cultural logic", namely the Western logic. Furthermore, in some aspects of social life, there is a meeting of incoherent rules - those belonging to the immigrants' culture, originating in other contexts, and local rules, rooted in the very "logic" and basic structure of the host society. This explains why such a theory, other than impractical, may lead to conflicts and troubles. We can only imagine the results of the coexistence of different behavioral rules among parties in the same commercial transaction, or what would happen if residents should be compelled to conform, under penalty of heavy sanctions, to tax measures or state regulations, whereas the same obligation would not be imposed to those immigrants in whose society of origin those regulations are absent, in the name of the "equal dignity of all cultures". Such an inequality of treatment would bring about quite a lot of tensions and it would then be hard to prevent protests

and xenophobic rejection on the part of the residents. Surely, the idea of "pure multiculturalism" appears as a stupendous and reassuring utopia, a fine metaphor of brotherhood among the peoples and of the value of all cultures (or is it an emblematic tower of Babel?) but, at the end of the day, if we try to put it into effect in social life, it turns out to be precisely that, an utopia.

In this perspective, we must look for a strategy that is both realistic and able to reduce to a minimum those risks and contradictions inevitably implicit in such a complex and wide-ranging phenomenology. We must also consider that, beyond and even before any possible state intervention policy, there are other social subjects participating in this phenomenon with their own strategies, who are interested in its implications and its prospective uses in economic, social and political fields.

Apparently, there are no established and homogeneously feasible formulas for every situation. But the factors we have pointed out and the experiences accumulated in the countries where the immigration phenomenon has begun earlier allow us, at least, to delineate a strategic prospect that appears as the most suitable these days. Such a prospect should be based on the immigrants' sharing, although slow and difficult to implement, of a *common public area of culture*, essentially revolving around the basic cultural cores of host societies, regulating and ensuring their cohesion and functioning. A number of significant elements of the immigrants' cultures may spontaneously progress around that area and interact, in different forms, with the context, while maintaining a more dramatic autonomy and even bringing forth possible re-functionalizations and expansions.

It is actually difficult to establish once and for all which are the "basic cores" in the culture of a country hosting immigrants that substantiate a *common public area of culture*, valuable both for old residents and people coming from the most different regions of the world, in order to define and guarantee, somehow, a common integration ground and their common *citizenship*. Nonetheless, there can be no doubt that these must be a part of the "package" of notions and rules regulating behavioral scopes connected with collective life and relationships among citizens, in compliance with the baselines of the legislative framework, with the interrelation modalities used in dealing with work structures, state institutions and services. Essentially, as we have already pointed out, this is a common area of rights and obligations,

competence and basic cultural trends that would enable a more regular and balanced functioning in communication and integration processes among old and new citizens. Thus, xenophobic intolerance factors against immigrants would be reduced, and immigrants themselves would feel less attracted to gravely devious life solutions. Most importantly, this would positively increase their ability to "move" knowingly and rapidly within their new context, heading towards those goals of "improvement" that were the very reason of their migratory project.

To this purpose, we must stress that a part of what we call a *common public area of culture* actually includes a combination of notions and rules that can be rather rapidly acquired by immigrants, at least in some measure and *even spontaneously*, that is aside from every specific state intervention policy, since they represent prerequisite instruments for a daily and close interindividual relationship and for an effective access to work structures and services satisfying the most immediate needs. But a general orientation following this direction, and thus a *state intervention policy* aiming at an organic and programmed promotion of the whole *common public area of culture*, though interweaving with and strengthening spontaneous cultural dynamics moving in the same direction, is something much wider and complex and it has to involve not only the immigrant population, but the residents as well, affecting their cognitive set-ups, their ideological perspectives, their vision, attitudes and behaviors towards those who are "different".

It must be stressed that a *common public area of culture* - being a systematic and planned *state intervention policy* - can only be implemented, as every other *social control* policy, by starting up and interweaving among them a number of processes aimed at the introduction of behavioral transformations through forcible education mechanisms (*primary control, hegemony*) and projects meant to manipulate behaviors, threatening or putting into effect repressive mechanisms (*secondary control*). This is a strategy that revolves around a double plan but, in the complex and contradictory framework brought about by the migratory phenomenology, it should nonetheless emphasize forcible education processes, without renouncing altogether to repressive mechanisms, provided that: (*a*) the regulatory framework is dutifully made explicit, transparent, definite and the same for all, enforced with equal strictness on all citizens, residents and immigrants alike, and (*b*) great respect for the personal dignity of new residents and citizenship rights

solidly and constantly assured for them, especially the right to freely carry on every aspect of their culture and tradition that is not in patent contrast with precise and explicit prescriptive measures enforced on all citizens in the host society. This implies, on the one hand, that the traditional practices of some immigrant groups may be characterized as offenses within the new context, when they contradict clear-cut codified principles in the legislation of the host country. This holds true for the controversial issue of women's sexual mutilations, although these are sometimes requested and consented to by the very "victims" of the ritual, and authorized health care services are often required to perform it. However, on the other hand, this also means that the promotion of a *common public area of culture* must pursue a greater mutual knowledge of the groups involved and their cultures, the ensuing diminution of stereotypes and prejudices and, more generally, a considerable increase in "tolerance" towards opinions and traditions that may, at a first glance, seem "absurd", "threatening" or "devious" to one of the subjects into play.

It appears that there is one more suitable and fundamental statement to be made in this regard. We have seen that the promotion of a *common public area of culture* - i. e. the strategy expounded here as both feasible and able to reduce risks and contradictions unavoidably inherent in such a complex phenomenology - implies the acquisition, for immigrants as well, of a considerable "package" of notions and regulations, attitudes and operational rules, culturally elaborated by the host society and deemed essential for its functioning. It must be clear, however, that the option in favor of this strategy does not necessarily entail concurrence or consent to the current set-up of the target societies of migratory flows, nor to the galaxy of values molding their culture and lifestyle. To share this option does not in the least mean to integrally approve of and, much less so, to expand and solidify all current regulations of the host society, their overall logic and the objective conditions supporting them, in a sort of "apologia of the existing". On the contrary, it means that any change made to those regulations must start from the operation mechanisms of the social context wherein immigrants live today and from the contradictions they give rise to. Ultimately, this implies that those contradictions cannot find their appropriate answers in lifestyles issuing from dramatically different contexts, and that every realistic action bent on change may only come from the common commitment of residents and immigrants alike, notwithstanding their different traditions, in order to

jointly elaborate and support functional patterns of response for their *common* emerging problems *here* and *now*.

4. What does it take to transpose the trends so far expounded as a strategic reference framework into the actual ground of the response of European health care services to the immigrants' health needs?

Certainly, the issue seems to be a rather complex one, even because, when we talk about *health needs*, the term *health* refers to at least five "conditions", each one ranking on a different plan and underlying different procedures of identification and response: (*a*) an "objective" disease, as defined by Western scientific medicine (*disease*), which may not be subjectively perceived or not perceived as a "disorder", or even be considered as just a "risk" in the face of which some prevention procedures must be put into effect; (*b*) the subjective perception of an illness under way (*illness 1*); (*c*) the patient's interpretation, based on his cultural universe and the relevant emotional experiences (*illness 2*); (*d*) the social reactions determined by the disease and the consequences for the patient's status and social role (*sickness*); (*e*) the diagnostic-therapeutic procedure culturally envisaged in response to a specific case and the networks of expectations, roles and behavioral procedures wherein it occurs (*therapeutic path*).

But, in this regard, we must examine, first of all, some empirical evidence, showing that most diseases found among immigrants appear to be contracted *after* they leave their countries of origin: sometimes during never-ending and dangerous journeys made under conditions of harsh exploitation and semi-clandestinely but, mostly, following their entrance in Western Europe. Thus, only to a very limited extent can immigrants be considered as vectors of exotic diseases, or as carriers of infirmities already begun before they left their homeland. Furthermore, this is a common factor in almost every migration of workers: immigrants are usually younger and healthier adults, more willing to try the risky adventure of a new life and a sudden reconversion of their skills.

Thus, an intervention strategy about the diseases most frequently presented by immigrants has to be pursued by operating *here in Europe*, on *local* pathogenic factors, established long ago, namely appalling housing, dietary and working conditions that immigrants have to face, especially at first. Such hardships are often exacerbated by the subjective and objective effects of

their lack of a regular residence permit and by psychic states of stress and depression caused by their uprootedness from their context of origin, by the difficulties found in integrating themselves in a new and different society and by the heavy pressure of more or less explicit forms of exclusion and racist violence. This is a radically precautionary basic strategy, in that it is meant to affect the very framework of pathogenic factors.

Strictly "professional" answers to specific disorders, full-blown or latent, must in like manner be built in this same reference perspective, as well as the response to treatment demands expressed by immigrant citizens. These demands put the activity of health care services directly on the line and are more dramatically related to the therapeutic ground. Thus, precisely for the reasons expounded above, to adjust health care services to a growing multiethnic reality, or rather, to *calibrate* them to that reality, should not only imply the training of social health workers to enable them to treat diseases that are unknown or long absent in Europe; but also, and much more so, an increasing demand in the services themselves to gradually acquire socio-cultural interrelation skills in order to deal with new and very heterogeneous beneficiaries.

That is to say, essentially, in the field of communication networks and codes, of the different interpretive perspectives for diseases, of expectancy and behavioral patterns with reference to the relationship between physicians and patients and, finally, of the highest consideration for people, their subjectivity and their real life conditions.

The major problem, therapeutically speaking (with reference to so-called "secondary prevention"), is the calibration of health care services to suit the complex and multi-faceted socio-cultural reality of new users, coming from a number of different countries.

Obviously, the problem takes on different shapes according to the character of health care systems in operation in the different countries. Nevertheless, there is no doubt that the whole burden of its solution cannot be carried by public services networks and those more systematically related to them ("social privacy", voluntary work, etc.) within the framework of a modern welfare state.

Other contributions in this volume will analyze and compare response strategies adopted in some European countries. Accordingly, here I will confine myself to highlighting some general issues that, in the perspective we are formulating, stand out with a rather problematic relevance.

The *first* and crucial issue concerns the subjects and methods of the cultural calibration of services. How should we relate - while making our relationship with patients open and meaningful- to the differing interpretive perspectives for diseases and to the resulting expectancies and behavioral modalities of users coming from a variety of countries? Which notions and general attention and interrelation skills are essential requirements for personnel working in health care services? How can they develop those skills? What changes must be made to this end in educational curricula for health care professionals? What is the role played in this perspective by cultural intermediaries or anthropologists? How to overcome mutual linguistic barriers, within a work schedule enhancing the informative and symbolic-emotional importance of the relationship between physicians and patients? And how to build a communication network around services that may actually contribute to promote its use by new citizens?

The *second* issue (partially connected with the first), reintroduces in "updated" terms the core of 1970's debates on social and health-care services: how to solve the specificity problem of the health care needs of some segments of the population, without formulating "ghettoizing" institutional responses? In other words, and as far as we are concerned today: how to equip health care services destined to all citizens, enabling them to calibrate their answers to their users' different cultural matrixes, including new immigrants', without using separate health care structures, which would inevitably lead to segregating and low-quality services?

The *third* issue results from the fact that most new immigrants come to Europe from countries where Western medicine has already - more or less widely and deeply - penetrated. They are almost always more acquainted with Western medicine than they are with local traditional medicine, especially so if they come from urban areas.

Therefore, as a result of the cultural dynamics we have tried to delineate above, they often choose "Western" health care services to treat all or most diseases. This option must not be ignored in the name of a misinterpreted "multiculturalism", which would "drive them back" towards an interpretation of the disorder that is no longer theirs. In fact, in this case as well, the cultural calibration of services must translate into respect for the outcome of events in the life of users and, if need be, the analysis of their decision criteria (for instance, the typology of disorders) when they choose to

turn to "Western" health services or, possibly, to other therapeutic response modalities.

Indeed, there arises a *fourth* issue closely connected with the former. The question is: what should be the attitude of European health care services when new citizens turn to "alternative" therapeutic response practices, performed by other immigrants from their own country of origin or falling into the vast and multi-faceted phenomenon, spreading wide and large in all Western countries under different generic labels ("alternative medicine", "unconventional medicine", "other medicine"). This is actually a composite reality, giving rise to an "updated" revivalism of ancient European medicine, degraded fragments of African and Afro-American protection rituals, formulae expunged by the great oriental medical systems, practices that, while waiting for a better definition, we are used to call "paranormal", all-engaging participation to neo-religious cults of different matrixes, heterodox lines of development of Western medicine, just to name a few of its main components. Some of which, by the way, are slowly gaining a space of their own even in some authorized health care services. This is an issue that must be tackled taking into account the fact that most users of unconventional medicine are, at the same time, users - although usually for different diseases - of authorized services *as well*, thus bringing about a "commuting" consultation style involving residents themselves, perhaps even to a greater extent.

This last issue brings us to an inescapable conclusion, especially for societies like those of many European countries, already traditionally characterized by a strong cultural heterogeneity. A true socio-cultural calibration of health care services to the heterogeneous features of their users will represent, other than a good answer to immigrants health needs, a definitely positive step forward for all their beneficiaries.

HEALTH POLICIES AND PRACTICES OF THE ITALIAN SERVICES TOWARD IMMIGRANT BENEFICIARIES: RESPONSE TYPOLOGIES

Maya Pellicciari

Overview of non European Union immigration in Italy

The last decades have witnessed periods of deep transformation in Italy, with changes that have affected the root of the socio-economic and political structure, as well as the cultural order. It is now widely recognised that the beginning of the 1970s sanctioned the start of a turning-point that would slowly redefine the country's configuration, from a departure place of large levers of emigrants in search of work opportunities, to a place of arrival for hundreds of thousand of immigrants fleeing from their countries of origin, animated by a spirit similar to that of Italian emigrants of some time ago: the escape from poverty (and not only) in search of better living conditions.

In the first half the 1980s, this phenomenon nevertheless begins to take on a certain relevance: the central (and therefore strategic) position that Italy occupies in the basin of the Mediterranean, together with the vague and almost absent laws in force at the time concerning the matter of entries into the country, contributed to rendering this phenomenon the object of new migratory strategies and projects. However, while in principle the country's location clearly emerged as "a place of passage", a transit-point through which to reach the desired destinations (countries regulated by perhaps more restrictive and severer entry procedures), it recently seems to have taken on the physiognomy of a "permanent type" of immigration place.

In fact, it is only in 1986 that the need for a legislative regulation on the matter of immigration begins to be seriously taken into consideration[1].

[1] Cf. Law n. 943 of December 30th 1986, containing: "*Norme in materia di collocamento e di trattamento dei lavoratori extracomunitari immigrati contro le immigrazioni clandestine*".

From this moment on, the frame-work of Italian migratory policies is outlined through a series of interventions, the first objectives of which are the regularisation of the numerous clandestine immigrants already present in the country and the predisposition of more restrictive measures on the subject of entries[2]. Yet, it is wide-spread opinion that this has had the function of, perhaps unexpectedly, being the catalyst of the actual migratory flows towards our country and has constituted, "due to the rather distorted expectations of an extension of stay or a certain flexibility of indemnity mechanisms, an attraction factor for an immigration that in the preceding circumstances would not have been mobilised"[3]. Employment formalisation and therefore the possibility to become legally landed have moreover favoured the rejoining of families, thus contributing, as already mentioned, to the progressive consolidation of long-term permanence in the country. Periodic and progressive re-apertures of the terms of regularisation occur to date, allowing for large strata of clandestine immigrants to emerge in the official estimates even though their number still seems rather elevated as well as difficult to appraise (this however refers to at least one-fifth of the total of foreigners actually present).

According to the estimates elaborated by Caritas of Rome, based on data furnished by the Ministry of Interiors[4], foreigners currently present in

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["Norms on the matter of employment and treatment of non-European Union immigrant workers against clandestine immigration"].

2 Cf. in particular, the Legge Martelli [Law] of 1990 and the Decreto Dini [Decree] of 1995, pioneers in such sense. Currently, the Legislative Decree n. 286 of July 25th 1998 *("Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero") ["Unified Code of regulations concerning the discipline of immigration and norms on the condition of the foreigner"]* and the relative rule of implementation (n. 113 of April 13th 1999), which affront the matter in a more organic and global manner, completing a path that for several years has attempted to compare, under different aspects and to all effects, the position of the foreign citizen to that of the Italian citizen.

3 Marini Rolando, Montesperelli Paolo, *Gli immigrati extracomunitari in Umbria [Non-European Union Immigrants in Umbria]*, IRRES - Regional Institute of Economic & Social Research of Umbria, Perugia, March 1991 (first progress), cf. p. 10.

4 Estimates up-dated on 31.12.1999 and laid-out in the form of forecasts in the "Immigration Statistics Dossier 2000" on the Internet web-site: www3.chiesacattolica.it/caritasroma/home/settori/studi/ant1_00htm.

Italy number approximately a million and a half with an increase of around 20% in comparison to the preceding year[5], with an incidence in comparison to the resident population that does not exceed 2.5% (while the average incidence in the European Union is already 5.1%). The largest majority originate from the so-called Developing Countries (over 80%) and are stationed mainly in the North; the most represented groups are those coming from Africa (particularly Morocco and Senegal) and from Eastern Europe (mostly Albania and Rumania) and in particular, subsequent to the continuous political crises in the Balkans, from ex-Yugoslavia. Numerous also are the continuous arrivals from the Far East, the Indian Subcontinent (Philippines, Sri Lanka, China) and Latin America (Peru, Brazil)[6]. Such a composite population, represented by peoples originating from completely different geographical areas and therefore extremely heterogeneous under numerous aspects[7], brings to light how the presence of different ethnic groups and cultures contributes to generating a series of as many heterogeneous problems at various levels.

Overview of health rights

At the beginning of the 1980s, the first response to the problems caused by the substantial lack of preparation of institutions for receiving an ever more consistent migratory flow arrives from the private social, secular and religious sectors. These autonomously organised themselves in order to

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5 The quota is on the increase compared to 1998 also because, besides the new permits issued, those people that signed-up within 15.12.1998 in order to benefit from the regularisation offered them as they were in Italy before 27.03.1998, have also appeared in statistics.

6 Data on the distribution of immigrants, according to origin, are up-dated to 31.12.1998 [Caritas Roma (administrative institution), *Dossier Immigrazione 1999*, Rome, 1999] and therefore not available in the forecasts for 2000. Notwithstanding, for a more detailed analysis of the data, see the commentary of Aldo Morrone included in this volume.

7 Cf. the critical analysis submitted by Tullio Seppilli, in the present volume, the term (extracomunitario) "non-European Union": deals in fact with a negative definition, that establishes that which an individual is not, and therefore reifies a complex and much more articulated reality of persons that do not feel united among themselves by anything else other than their extraneousness to the European Community.

offer immigrants with a series of services, ranging from first reception to assistance and counselling regarding integration in the country of reception. However, the dual role carried out by such centres soon becomes evident. On one hand they act as an indispensable reference-point for the needs of the immigrant population, while on the other, they stimulate (programmatically and sometimes unconsciously) the institutional organs. This action fosters the acknowledgement of the need to reconsider the more important aspects and therefore the recalibration of various juridical-administrative procedures in relation to the changed conditions of the population and the new problems emerging. Among them, those relative to health rights assume the prominent position. Since 1978, through the establishment of the National Health Service, that is guaranteed by the State to all Italian citizens according to the welfare regulations, but which the Italian Constitution as well as the Human Rights Declaration guarantee on principle to all individuals despite their legal status.

Moreover, the necessity to equalise the position of foreign citizens to that of the local population in such regard, assumes even more importance in the measure in which it becomes evident that the health conditions of immigrants do not depend on "exotic" pathogenic factors, but from the material and relational conditions in which they live during and after their arrival in the country of adoption. Furthermore, the strong unbalances that tend to arise in the initial phase of entry in which the bonds with the culture of origin and the cultural push toward the new model of reference are inter-woven, provoking major identity conflicts and consequent states of disorientation[8].

Initially, the right to use the country's public health structures was guaranteed free of charge and concerning immigrants, only to those registered on the National Health Service; therefore to regularly recorded foreigners in possession of a job. Whereas, for non-registered immigrants the only possibility to accessing health care services was through First Aid (emergencies, accidents and maternity), the use of which nonetheless involved a signalling to the Prefecture by the hospital in order to be able to recover the effected expenses from the State and, de facto, a real and proper denunciation of irre-

[8] In this regard, consult section f) of the Italian bibliography published at the end of the volume entitled: *Fattori patogeni e configurazioni epidemiologiche concernenti gli immigrati extracomunitari [Pathogenic factors and epidemic configurations concerning non-EU immigrants].*

gular immigrants. Consequently, they became strongly penalised in regard to public assistance as all clandestine and the like, who live in conditions of great emargination and poverty, would be far more needier of such services.

It is in this direction that the private volunteer associations moved after Elio Guzzanti was nominated Minister of Health (December 1994), with whom they began - together with his delegates with the institutions in general - a series of meetings which discussed the necessity to fill the void of such a selective health legislation incapable of assuming the realistic datum of the submerged irregular presence. The absolutely revolutionary result of this collaboration was the Legislative Decree n. 489 of 18/11/1995[9], commonly known as the "Dini Decree", Article 13 of which extends to all foreigners present in the country the right to ordinary and continuous care and preventive medicine programmes, without this involving any type of signalling (except for cases in which a report is compulsory, but nevertheless at conditions of parity with the Italian citizen)[10]. After a series of reiterations and complex vicissitudes, the decree was transformed into Law n.40 of March 6th 1998[11].

Despite the iter of the bureaucratic-administrative intricacies and the nebulosity of some legislative procedures, that to date have allowed for loopholes and non-fulfilment, it is necessary to remember that the Italian nor-

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9 Containing: "*Disposizioni urgenti in materia di politica dell'immigrazione e per la regolamentazione, ingresso e soggiorno nel territorio nazionale dei cittadini dei Paesi non appartenenti all'Unione Europea*" ["*Urgent dispositions on the subject of immigration policies and for the regularisation, entry and stay on national territory of citizens of Countries not belonging to the European Union*"].

10 The route thus far traced regarding the national normative on the subject of immigrant health recalls, along greater lines and in synthetic manner, those elaborated by the authors of the text edited by Salvatore Geraci and the Caritas Diocesan of Rome: *Immigrazione e salute: un diritto di carta? Viaggio nella normativa internazionale, italiana e regionale [Immigration and Health: Just a law on paper? A journey through international, Italian and regional normatives]*, Anterem, Rome, 1996, XVIII+283 ps.

11 Containing: *"Disciplina dell'immigrazione e norme sulla condizione dello straniero" ["Immigration discipline and the norms on the condition of the foreigner"]*. Currently enforced: *"Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero" ["Unified code of regulations concerning the discipline of immigration and norms on the condition of the foreigner"]* - and the relative implementation rule of 1999 (cf. note 2) - in which Article 13 has become Article 35.

mative in reference to the delivery of public type health services to clandestine immigrants is one of the most advanced in Europe, and perhaps in the world, and has become a reference model for countries that intend to face the matter and which already count a far higher number of foreigners, with an incidence on the local population decidedly greater in comparison to Italy.

The research

That which has been stated thus far, brings to light a clearer picture of the fervour with which the issue of the health of immigrants has for a long time been faced in Italy. However, such ferment is not expressed exclusively on the political and welfare level, but above all, on the plane of research where a broad debate has evolved that now involves scholars of social sciences (first of all anthropologists), psychologists, psychiatrists, physicians and health operators of various kind. The routes of investigation are in such sense innumerable, but among the most significant it is possible to identify three highly interconnected research directives: *a*) that relative to the type of health resources to be utilised. For instance, if need be, to organise specialised centres for managing the "ghetto" immigrants, or if not the case, to better calibrate public services in a manner suitable for multiethnic beneficiaries; *b*) that which focuses on the operator-beneficiary relationship: if and how to act for modifying the standard approach, currently based on an outdated medical-centric vision, in view of better therapeutic results, also and especially towards immigrant patients; *c*) that which deepens the study of other medical systems in comparison to bio-medicine, which in turn proceeds in a two-fold direction. On one hand, if and how to use knowledge of medical concepts and practices, of which non-EU immigrants are carriers, for the purpose of promoting improved management of services and offering suitable performances for the needs of foreign beneficiaries. On the other hand, measures in which the scientific method can be used for verifying the effectiveness of "non conventional" medical treatment - to a large extent deriving from non-western medical traditions - so as to contribute to the realisation of an integrated medicine able to satisfactorily respond to the crisis that the orthodox medical system is undergoing[12].

[12] Seppilli Tullio, "Antropologia medica: fondamenti per una strategia" [Medical Anthropology: basis for a strategy] (editorial), *AM. Italian magazine of the Italian Society of Medical Anthropology*, n.1-2, October 1996, p.7-22.

The more heterogeneous and composite aspects of this debate have clearly emerged through each of the three phases in which the present research has been articulated: the first, bibliographical reconnaissance; the second, preliminary investigation through questionnaires; the third, in depth interviews at those centres that could be considered of "excellence".

The work of bibliographical survey[13] was conducted using a selection criterion concerning only the scientific work edit in Italy, in autonomous form or within collective or periodic publications focused entirely, or in wide measure, on the health/illness thematic concerning non-European Community citizens recently immigrated into Italy[14]. Among volumes, essays, readings, minutes of conferences and others, almost eight hundred titles have been gathered (reduced at this writing to less than sixty for motives of space) and re-ordered for coherence and consultation convenience into six separate thematic categories: *a) Generality; b) Health Policies concerning non-EU immigrants; c) Normative Policies concerning the health of non-EU immigrants; d) Centres of public or private response to the health problems of non-EU immigrants; e) Relationship between health operators and non-EU beneficiaries; f) Pathogenic factors and epidemiological configurations concerning non-EU immigrants [f.a. Psychic disturbance; f.b. Pathologies and situations of maternal-child risk; f.c. Other pathologies]; g) Others.*

Contemporarily, partly using the selected bibliographical material, a general census of public and private centres that offer health care to non-EU immigrants in Italy was carried out. This census allowed for the activation of the second phase of the research: all 103 structures, spread across the entire national territory (with prevalence in the area of Lazio), were in fact surveyed through a questionnaire directed at investigating the institutional nature and activities carried out by these. Each centre was therefore contacted and forewarned of the imminent arrival of the questionnaire in order to sensitise and stimulate a much more complete and deeper response possible. In fact, 33 forms were filled-out and returned (or rather approx. 32% of those

[13] Here presented due to its consequence as an autonomous result of the research, even though having obviously been utilised also as an important instrument of the research as such..

[14] For further information concerning the formal and thematic structure of the bibliography, refer directly to the preliminary foreword in the introduction of the Italian bibliographical section.

sent), but considering the type of target (therefore the lack of time and other logistic difficulties), as well as the average response generally received via postal questionnaires, it can be considered quite a satisfactory result.

The third and last phase foresaw the identification of the most interesting and significant examples which were subsequently re-contacted in view of a further in-depth interview.

Distribution and characteristics of the centres

The questionnaire sent was entitled "European experiences and strategies against social exclusion of immigrant people by health care services"[15], and divided into eight sections, each of which referred to information of various nature (institutional, historical, relative to performance and use, plus opinions) devised for the purpose of outlining a synthetic but sufficiently clear profile of each centre.

The first block of institutional information requested (frame A) brought to light an equal distribution between public and private activity, significant information which shows the increased interest of institutional organs towards the problem in question and signs of a positive reaction to the challenge launched by the normatives of 1995 onwards (most of these public services were in fact established after to the Dini Decree, while almost all the voluntary associations precede to this date).

Concerning the section relative to the functions of the centre (frame B), the indicators were two: the typology of performances offered and the beneficiaries of the service. Regarding the first point, it clearly emerged that there are no specific performances that differentiate the public from the private in a radical way. Nevertheless, the former seem to be characterised by a prevalence of health type performances, further articulated and sustained by more sophisticated diagnostic-therapeutic instrumentation and technologies; instead the latter have shaped into delivering a broader range of services, able to respond not only to health needs but an assistance of welfare type - through internal structures (lodgings, cafeterias, dormitories, etc.) and through real and proper services (legal counselling, employment opportunities, support to prisoners, general primary assistance) - or nevertheless concerning the integration of non-EU immigrants in the social context of

15 Cf. Annex A

reception to all effects (language courses, professional preparation, accompaniment to social health structures, etc.). Regarding the second point, it must be underlined that there is a certain difference regarding the type of use which the service offers. While the public sector generally defines its target groups by ethnic connotation (or selects patients according to their origin, at times delivered exclusively to foreigners, at others to Italians and foreigners indifferently), the beneficiaries of private social services is characterised rather by their position within society (the poor and needy, those without fixed abode, prostitutes, addicts and the emarginated in general), regardless of the fact if they are Italians or foreigners. This could be interpreted as a distinguishing mark of the specifics that have always denoted the role of the volunteer, or the capacity to fill those gaps that the public sector (for various reasons) does not manage to cover: tracing a route that advances in concentric circles towards the emarginated sectors of society, acting also as a guard-rail for a progressive amplification of the basin of public service beneficiaries.

Further information emerges from frame C regarding the real health service beneficiaries: the areas of origin of non-EU immigrants are the most disparate and further differentiate according to the territorial distribution that the various groups assume in the zones where each of the centres are located. The annual average index ranges from a minimum of a few hundred beneficiaries to a maximum of various thousands: the variables seem obviously to be; the extent of the range of performances offered; the more or less recent date of centre's establishment; in reference also to the above mentioned institutional nature of the service (the private surpasses the public with beneficiaries that in some cases - Caritas Health Area of Rome and Naga in Milan - reaches 20.000 units, against the maximum of 5.000 reached by the Italian Red Cross). In general, it is not possible to speak of a specific pathological profile concerning foreigners, even if data collected indicates the most frequent complaints to which suitable therapeutic responses are targeted through the appropriate organisation of health personnel and necessary equipment. To confirm that which is initially mentioned, regarding the risks which the person is subject to when emigrating, for the most part risks of "external" nature and often subsequent to arrival in the country of reception, the most frequent symptoms are of gastrointestinal, respiratory, dermatological nature, degenerative joint disease, psychiatric character or linked to sexually transmitted pathologies. It must also be said that the public

service is particularly active in the sector of maternal-child care, which private social services therefore now treat in a rather marginal manner, devoted instead, in a more specific manner, to pathologies of infectious nature and the innumerable discomforts that result from living in poverty.

Frame D foresaw a brief history of the centres[16], while frame F has allowed to isolate a second block of institutional information, fundamental for a complete and extensive knowledge of activities carried out and resources employed. In fact, from the data collected, it has emerged that other than clinical and assistance activities, most centres carry-out substantial research activity[17] as well as internal and external training-information, often aimed at the immigrant population. The presence of supervisors is very scarce[18] while very frequently one or more linguistic-cultural mediators show up (especially in the public service and in the larger volunteer centres), whose activity generally consists in translation and interpreting interventions, although in some cases (especially structures that deal with mental health, where the approach to the patient involves the person as a "whole", or wherever a certain level of anthropological sensibility has developed) they carry-out a broader function, acting as an interface in the difficult encounter between two completely different cultural codes often reciprocally overlooked by patient and therapeutic operator. Moreover, almost all the centres put didactic-training infrastructures of various kind (documentation centres, libraries, video-libraries, press and on-line archives, etc.) at public disposal and produce periodic publications and multilingual information material, the consultation of which is often available through the Internet.

Finally, a section relative to opinions and critical evaluations on activities carried-out was included in the questionnaire (frames E, G, H). The results expressed are substantially positive in almost all cases, notwithstan-

[16] For matters of space, details that emerged from the historical analysis of activities carried out by each centre are presently omitted; referred to, for further investigation, in the following paragraph concerning the typology of centres of excellence.

[17] Evidence of this appears in the numerous publications produced, partly quoted in the bibliography.

[18] A sign, perhaps, that a paternalistic vision of the operator-patient relationship is still very rooted which does not foresee, or nevertheless underestimates, the possible difficulties that arise among the said operators; i.e. states of uneasiness and feelings of incapability, refusal or other (cf. the so called "*burn-out syndrome*").

ding the great awareness of difficulties to be faced and the problems still unresolved. In some cases, a reason for great satisfaction is the verification of the good level of resonance that the service has reached within local immigrant communities as an important reference point for an increasingly greater number of foreign beneficiaries. In other cases, emphasis poises upon: *a*) the centre's ability to elaborate innovative project-interventions coherent with those needs that are becoming progressively evident on the territory; *b*) the level of professionalism reached by the operators thanks to a continuous updating in training-formation and above all calibrated for delivering suitable response to immigrant beneficiaries; *c*) the level of internal organisation achieved, that allows for optimum co-ordination between personnel members, an easy connection between the composition of the administrative institution's sub-structures, as well as a continuous and constant relationship with the territorial reality and the resources available. The problems reported mark instead the opposite direction and focus through a more realistic view, perhaps, on the weak points of interaction (that with non-EU patients) which continuous to create a series of difficulties, ranging from the more strictly normative-administrative to the purely anthropological of human relations. For many, the greatest problem remains the lack of co-ordination and collaboration between the various centres: the warning of a certain hiatus mainly between the private and the public sector, as well as between the private and the institutions in general (police headquarters, Town administrations etc.). Moreover, the volunteer associations complain of the major difficulties in accessing the necessary medicines and a lack of resources in general (above all financial, adequate premises and suitable personnel), also in regard to the elevated number of flows. The public service particularly complains of the shortage of "first reception" centres, other than the low number of permanent medical and nursing personnel, reporting also the semi-volunteer condition in which a large part of these operates. A prominent issue concerns the awareness expressed by many regarding their inability to relate to beneficiaries from "other" cultures; an inadequacy that the simple presence of linguistic mediators does not contribute to fully attenuating[19]. The communication difficulties perceived are in fact hinged at

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[19] All those persons that have signalled such problems constantly dispose of the auxiliary aid of one or more linguistic- cultural mediators.

a deeper level than mere oral comprehension. The demand for a deeper knowledge of the cultural origin of the beneficiaries is rather strongly felt, particularly regarding specialised personnel in this sense. The inability of fully comprehending the real necessities of immigrant beneficiaries was admitted; or however the non-success in involving them through the standard systems of external communication, such as health education campaigns concerning contraception and sexually transmitted disease, which do not appear to have enough resonance. It would seem almost futile to remember how the lack of adequate anthropological formation in many cases contributes to aggravating relational difficulties with foreign patients, even though the brief and irregular collaboration that some centres have in fact established with anthropologist researchers has produced more than positive results in such sense.

Typology of some centres of excellence

On the basis of the data collected through the questionnaires, it is thought to be able to identify some "ideal types" somehow representative of the whole range of experiences surveyed. As often occurs when attempting to simplify and put in order what has been observed, forcing the result of such an operation into generalised categories, can give rise to accentuating the borders and confinements between classes that in fact often overlap each other. The typologies presented are therefore not to be considered as a rigid rule but rather as an attempt to give an over-view of the tendencies that designate the basic orientation with which the various services approach the matter of the health of immigrants. In this perspective, the "ideal types" identified are four: the most representative cases for each have been selected and elaborated in a brief informative outline.

A. Public institutions endowed with specific competencies for immigrants
   The Polyclinic of the Hospital of Modena and the Scientific Institute of Recovery and Care of the Dermatological Hospital of Santa Maria and San Gallicano in Rome have been selected to represent this group. Despite the elements that unite the two centres, there are some important differences to hold in account: while the polyclinic, by definition, offers a complete range of health services which therefore renders it indiscriminately beneficial to any type of user, San Gallicano was established as a structure specia-

lised in dermatology,[20]under the personal direction of Dr. Aldo Morrone, physician in charge of the Institute, to intervene in favour of individuals pertaining to emarginated categories. A strong relationship with immigrant beneficiaries was immediately established, so much so, that extension of the areas of medical intervention to other sectors such as paediatrics, infective illness, internal medicine and psychiatry, subsequently occurred due to the influx of immigrants that began to address to the Institute, thus introducing very different pathologies (from 1985, the year it was established, to 1998, the date of the last census, almost 40.000 regular and clandestine non-EU patients were received for first consultations). Moreover, such a centre is distinguished by two fundamental characteristics: decennial experience in the field of research (in collaboration with the Department of Cultural Anthropology chaired by Prof. Gioia Longo, of the Rome University "La Sapienza"), the results of which have had important relevance in regard to both clinical activities and the ability to organise training-formation courses, seminars and conferences at international level[21]. Also, the key role, in a certain sense provocative, carried out by linguistic-cultural mediators (15 in all), who besides receiving immigrants, settle various matters, preside over medical examinations when requested to, giving council to physicians on the cultural reference systems of patients, working also with the public relations office, supplying information to all beneficiaries of the structure, Italians included. The Polyclinic of Modena, during the last years, has also been equipped for responding more effectively to the demands which have subsequently arisen due to the great increase of immigrants present in the city. In fact, in 1997, an Office of Cultural Mediation was founded that comprises 24 mediators of different nationalities. It is important to underline that the office was established in response to the request put forward by the

[20] Currently called "Servizio di Medicina Preventiva delle Migrazioni, del Turismo e di Dermatologia Tropicale" ["Preventive Medicine Service of Migrations, Tourism and Tropical Dermatology"].

[21] The Service has been recognised, through deliberation n.1358 of 15.04.1998, as a "Centro di riferimento e consulenza per la Regione e le aziende sanitarie in merito ad iniziative di formazione degli operatori sui temi della Tutela della salute degli immigrati" ["Centre of reference and consultation for the Region and Sanitary Institutions in merit to formation-training initiatives of the operators on the themes of Safeguarding the health of immigrants"].

Town Council's Immigration Department to create a service capable of interacting with foreign beneficiaries, due to the consequent difficulties in suitably responding to their expectations, reported by the said operators of the polyclinic. The initiative[22] has been the latest of a series of interventions aimed at establishing a rational hospital in favour the humanisation of its services. According to Dr. Maha Beydoun, co-ordinator of the said office, the most significant experience in this regard, has been the realisation of the Safe Maternity Surgery, wherein an interesting research has begun on the traditional phyto-therapy of the four areas (Sub-Saharan Africa, Maghreb, India & China) from where the major part of the foreign women addressing the surgery originate. Due to their requests for specific therapies they have somehow been the true promoters of the project.

B. Structures specifically addressed to immigrants within a public institutions

The most significant examples on the subject are certainly the Frantz Fanon Centre of the Mental Health Department of (ASL n.1 of the Piedmont Region (Turin) and the Trans-cultural and Community Psychiatric Modules of the Mental Health Department of ASL n.7 of the Calabrian Region (Catanzaro). Whereas the configuration of the former is expressly directed only to immigrants (regular & clandestine, refugees & torture victims), the latter theoretically offers performances to the benefit of all citizens in conditions of social emargination, even though it de facto offers services calibrated for the foreign user. Both have adopted an anthropological type of approach and affront psychic disturbance in a trans-cultural key, although through different strategies. The Fanon Centre (founded in 1996) is a broadly structured centre, which comprises two psychiatrists, eight psychologists (between scholarship-holders, volunteers, trainees and psychotherapists) and eight linguistic-cultural mediators. Patient care procedures are of particular relevance as they foresee the intervention of an interdisciplinary and intercultural team comprising Italian and foreign operators of various formation (defined by the physician in charge, Dr. Roberto Beneduce, as

22 Entitled: "Le scelte di oggi per un ospedale di domani: le iniziative per coinvolgere le etnie minoritarie e valorizzare le differenze" ["Today's choices for the hospital of tomorrow: the initiatives for involving ethnic minorities and valorising differences"]. (ASL = Local Health Assistance).

"ethnic-clinical mediators") for the most part psychologists, psychiatrists, psycho-pedagogues, psychotherapists and sociologists whose principal purpose is that of reducing the risk of diagnostic error to the minimum, which is particularly elevated in the psychiatric field and above all with foreign beneficiaries. This trend in some measure recalls the experience of psychological aid to immigrant families conducted by Tobie Nathan at the George Devereux Centre of Paris VIII University, with which the Fanon has been engaged for a long time. Also, the formula activated by Dr. Salvatore Inglese in 1997 which, theoretically, is not distant from the formulations of Beneduce and Nathan. Although in fact autonomously constituted by Dr. Inglese, without a team of internal experts, has established a reference network composed of "informal mediators", often non-EU students of medicine belonging to immigrant communities present on the territory, who carry out indispensable functions of "cultural negotiation" which have allowed for entering into contact with, and gaining the trust of, various foreign groups[23]. Moreover, these activities are characterised by either a certain "mobility" of intervention (home visits and in loco), or above all by the function of support to persons[24]. More than just a classical type of psychiatric performance, it has aimed rather at the establishment of a "broad social secretariat" network often active in the form of indirect consultations, without the psychiatrist personally seeing the patient who does not wish to become visible and who therefore addresses those reference figures within the community who collaborate with Dr. Inglese as informal mediators. In addition, thanks to the substantial activity in the field of ethnic-anthropological research (and relative publications), both centres have assumed an outstanding position in the international scientific panorama. In conclusion, it is not by chance that this second category is represented in both cases by services of psychiatric nature. In fact, psychological discomfort by nature lends itself to many difficulties - often with scarce results - to a purely mechanistic or bio-reductionisic approach. It is precisely because of this that psychiatry, in its more advanced aspects, has been one of the first medical disciplines to recognise the indi-

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[23] 1999, has seen it additionally engaged in the management a refugee camp.

[24] The most frequent troubles, by and large, are substantially connected to situations of maladjustment and confusion consequent to the adoption of different life styles and connected to matters such as inter-ethnic marriages and children born in Italy.

spensability of the holistic approach to the patient as a person. Yet the question that arises is still controversial[25]: should the existence of mental health centres specifically targeted to addressing immigrants be considered an answer, subsequently refined to the request of a qualitative and personalised reformulation of the operator-beneficiary relationship (which becomes even more evident, as mentioned above, when the disorder is of mental nature and particularly where the cultural distance between the two becomes greater)? Or, could it not be but the confirmation that the cultural matrix, which is at the basis of the bio-medical system (founded upon the mind/body dichotomy and consequently on the presupposition that cultural variables are relevant within the sphere of psychological disturbance and not necessarily referable to organic pathologies), still currently reflects on the institutions?

C. Volunteer associations that offer health services to immigrants and other emarginated groups

The private social sector offering this kind of service is represented by two pioneer centres which standout, on the entire national territory, due to their relevance and basin of beneficiaries[26]: the Health Area of the Caritas Diocesan of Rome (established in 1983) and the Naga of Milan (established in 1987). Other than the cliuical activities performed in favour of emarginated categories, clandestine immigrants in particular, both associations have chiefly distinguished themselves by the commitments on the level of political proposal and planning/programming. In fact, Naga and the Caritas of Rome were the principal promoters of the aforementioned stimulus action towards the institutions, which had the outcome of broadening the health rights of irregular inmigrants. The ultimate objective of both centres has always been that of facilitating access and use of health services to those who in fact resulted excluded from them (first and foremost non-EU immigrants). It is for this reason that the new normatives enforced had led to expectations of a progressive decrease of beneficiaries to volunteer structures. IIowever, such expectations have had to deal with the non-preparation

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25 Although this is not the seat for penetrating the intricate debate that has developed around this theme in the field of ethnic-psychiatry and that of universal medical anthropology.

26 The annual average for each one, is approximately 20.000 performances.

of institutions and therefore with the delays in the effective application of the law: in Milan the number of patients has never dropped, except in the paediatrics and obstetrics sections of the maternal-child care sector, which became superfluous and were finally eliminated thanks to the efficiency activated by the consulting-rooms which absorbed a large part of non-EU beneficiaries. Whereas in Rome, although the flux initially showed a slight decrease it has recently started to re-increase due to a certain percentage of patients, re-routed to public structures, who tend to return to the Caritas consulting-rooms. This is usually because the structure they have been sent to does not apply (or only partially enforces) the norm, or because the patients, already disorientated by the substantially foreign reality, declare themselves incapable of orienting the scattered lay-out of the public services, which frequently operate in entirely separate compartments from one another. While the Italian beneficiary often complains about this inconvenience, this becomes a insurmountable obstacle for the foreigner and indicates the necessity to establish prefixed and well encoded routes for the purpose of facilitating access to the services. It is precisely in this direction that the collaboration between the Caritas Health Area of Rome and the public sector is presently directed, in coherence with the reception policies that have always characterised the health approach of Caritas. While the services offered, initially revolved around basic medicine, a series of specialisations (e.g. psychiatry, gynaecology, paediatrics, dermatology, pulmonary medicine, etc.) have gradually been introduced, modulated and diversified in relationship to the demands and the most recurrent pathologies, in order to follow the patient's therapeutic term, from the beginning to the end, within their structures. It is this very model that the Caritas association intends to export to the public structures. Another distinctive element of great interest is the theoretical formulation which they refer to and on the basis of which they form their volunteers[27], each of which must follow a six month internal course before being inserted within the staff system. Although they believe in a kind of "mediation system", they do not have proper linguistic-cultural mediators to delegate assignments to, which instead are shared by everybody.

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[27] They currently number approximately three hundred, plus five persons (among which Dr. Salvatore Geraci, physician-in-charge), that deal with the direction and organisation of the centre and the co-ordination and supervision of the operators.

For this reason, through a general training apprenticeship, then subsequent specialisation according to the sector to be covered, everyone needs to be capable of receiving and attending to any person addressing the centre, although for language purposes foreign volunteers tend to take charge of some patients. Concerning the activity of Naga, the internal configuration is constituted by operational sub-groups, each of which covers a sector of intervention. Around 250 volunteers operate within the association, including physicians, psychologists, psychiatrists and nurses. Besides guaranteeing internal medical performances (basic medicine, cardiology, general surgery, dermatology, gynaecology, infective illness, neurology, orthopaedics, psychiatry, psychology, urology) a mobile group of "street medicine" exists. The group offers assistance to foreign prisoners in the jails, a team of female agents that organise internal counselling and external formation-training meetings on the themes of prevention and contraception, while an ethnic-psychiatric team (formed by a psychiatrist, a psychologist, a general or specialised medical practitioner, an educator and a cultural mediatress) work along the lines of the therapeutic procedures of the aforementioned Tobie Nathan. Formation-training and research activity is quite developed in both the associations, even if the Caritas Health Area of Rome covers a particularly important role as an emission centre of initiatives of national and international calibre. For years, it has in fact activated a residential course and more recently, a masters in migration medicine, other than having an agreement with the Veneto Region for the formation-training of health operators in the zone, relative to the themes in question. Moreover, the long collaboration with the anthropologist Nicoletta Diasio must also be remembered, who for years has carried out the function of consultant and supervisor to the Caritas[28]. The publications are numerous for both but we signal the importance of the convention stipulated between Naga and the publishing house Harmattan Italia, which starting from 2000, has put at its disposal a series of two volumes per year that shall,

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[28] Some important operational choices have been calibrated and activated in relationship to the observations elaborated by Nicoletta Diasio during her "field work" within the centre: for instance, subsequent to the recent restructuring of the spaces, when facing the doubt whether or not to increase the number of the surgeries or to enlarge and render the waiting-room more comfortable, on suggestion of the anthropologist, the second possibility was opted for.

from various points of view, intensify the thematic relative to the health of the emarginated and non-EU immigrants in particular.

D. Public services that deliver non-conventional medicine performances to the entire population

Public structures that deliver performances of non-conventional medicine are now numerous in Italy. Among these, acupuncture (which unlike homeopathy belongs to non-western medical tradition) is considered medical action to all effects and the national tariff nomenclature includes it with those recognised by the National Health Service[29]. At this writing, The "Fior di Prugna" (Plum Flower) Centre of traditional Chinese medicine of ASL n.10 of the Tuscan Region (Florence) has been selected to represent this group for various reasons. Unlike many others, it does not offer one or more single techniques, but makes available an integrated service, or rather all the techniques (acupuncture, moxi-bustion, Tui Na massage, plum flower technique, glass-cupping, Chinese dietetics and phyto-therapy, energetic gymnastics) that compose the entire traditional Chinese medical spectrum. Furthermore, although it addresses the entire population (Italian patients number almost 90% of total beneficiaries and only a few are neither Italian nor Chinese), it has been expressly thought-out to respond to the demands of the large number of Chinese immigrants in the "extensive beneficiary basin" comprising Florence, Prato, Empoli and Pistoia[30]. After a period of experimental activities (1995-1998), the centre is currently recognised as a stable scheme of the Health Institution. The staff team is constituted by an acupuncturist physician, two massage-physiotherapists, a rehabilitation therapist, a professional nurse, two linguistic-cultural mediators, some volunteers alongside the physicians and some that deal with the administration. The fact that acupuncturist in charge of the centre is Dr. Sonia Baccetti, or

[29] Cf. the [Ministry of Health Decree] Decreto del Ministero della Sanità, 22.07.1996, in particular the items quoted in the chapter: *"Prestazioni di assistenza specialistica ambulatoriale erogabili nell'ambito del SSN e relative tariffe". ["Specialised Medical Ambulatory Assistance delivered in the sphere of the National Health Service and relative tariffs"].*

[30] Considering that in the municipalities in which the presence of Chinese immigrants is higher, the incidence in comparison to the local population is around 3%, therefore the percentage of Chinese that refer to the (Fior di Prugna) "Plum Flower Centre" should be considered rather elevated.

rather an Italian of biomedical formation, does not seem to be a problem for the Chinese patients, who consider it sufficient that the doctor learned the traditional techniques from Chinese teachers. Paradoxically, Italian beneficiaries often give up the idea of this therapy when they learn that it is not administered by a Chinese expert. Nevertheless, Dr. Bacccttti claims that it is precisely because of her formation and credibility as an "orthodox" physician which has facilitated her relationship with the medical institution, guaranteeing a certain degree of respectability to the project when initially presented to the Regional Administration. For quite some time now, the number of patients exceeds the annual average of 2.000 (two thousand) persons. The Chinese in particular are sharply increasing, thanks above all to the credit gained during these years through her Chinese cultural mediatress in community, (which Dr. Baccetti considers herself to be part of), alongside the linguistic mediatress with relational type of interventions, maintaining contacts with the patients outside visiting-hours, accompanying them when necessary to other health structures and above all establishing an information office (technical-bureaucratic and for health education) within the centre. Most interesting is the project, that Dr. Baccetti intends to soon make operational, relative to the set-up of a network of immigrant Chinese physicians which, in accord with and following the health-hygiene protocols of the public service, shall deliver the possibility to practise both "official" as well as Chinese medicine[31].

Conclusions

The division by typology adopted as a reading instrument of the data collected through the base-line survey, has made it possible to put a clearer picture into focus concerning that which appears to be a complex and polyhedric reality, which could be defined as a "leopard's skin". In fact, although the recent legislative regulation would have rendered uniform the Italian response regarding the advantages of the health services for non-EU immigrants, the bureaucratic-administrative obstacles and the political-ideological

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31 So-called Chinese "clandestine physicians" are in fact numerous and although in possession of a regular Chinese degree, their title of study is not recognised in Italy. They therefore continue to assist Chinese patients in covert conditions, often scarcely hygienic and totally inadequate structures and instruments.

resistance of the institutional structures have allowed, in some cases, for a kind of laxity in the real application of the law. This has contributed to reinforcing a heterogeneity of response already present at local level and strongly connected to the entity of public or private services, as well as to the philosophy of intervention (religious or secular, conservative or progressive) of the promoters. In this still rather confused and diversified panorama, private social intervention plays an unquestionably important role in guaranteeing a means of delivery that was for a long time postponed, but having since received the correct attention from the competent organs seems finally to be on the road to realisation. The public institutional bodies, or at least those more sensitised to the problem and somehow already active in this field prior to the Dini Decree[32], seem to have reacted promptly to the new apertures, guaranteeing non-EU immigrants with services and performances more comparable to those enjoyed by Italian citizens. All this results evident not only regarding each separate centre, as verified, but above all at the larger level of programming (Institutional Health Bodies, Regions, etc.) where ever planning and intervention strategies become more substantial and diversified (either at structural level, personnel formation-training or the degree of wide-range information to foreign beneficiaries) in order to improve accessibility to the health services by non-EU beneficiaries[33].

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32 Two of the centres that, together with the Naga of Milan and the Caritas of Rome, signed the Legislative proposal for the health rights of non-EU citizens formally presented to Minister Guzzanti (see above), were two public structures: the *Istituto di Ricovero e Cura del San Gallicano di Roma* [San Gallicano Institute of Recovery and Care of Rome] and the doctors of the Local Health Unit USSL n.18 of the Region of Lombardy (Brescia) - Infectious Illnesses. e i Medici.

33 Quoted as examples: the Region of Tuscany, the Region of Veneto, the ASL n.10 of the Region of Tuscany (Florence), and the ASL n.18 of the Region of Lombardy (Brescia).

ITALY: A SELECTED BIBLIOGRAPHY

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Introduction

Within the research connected to the Project "Experiences and strategies for reducing the exclusion to health services of the immigrant population in Europe" a bibliographical investigation was conducted finalised at giving an account of the Italian publications, of scientific nature, relative to health and disease problems concerning non-European Union citizens recently immigrated to Italian territory.

As far as concerns the main themes, the investigation was centred on the works that examine or discuss the situations and factors of somatic and psychic pathologies, the state and policies of the health services and how these have been calibrated to meet the demands of the new beneficiaries and the cultural dynamics that arise in the relations of immigrants with health personnel and the relative institutions.

As far as concerns the formal typology of the research, all pertinent works of scientific nature were reviewed, whether published in the form of volumes, collection of readings, minutes of meetings, etc., autonomous books or specific essays inserted in a volume or a periodical or as an "item" in an encyclopaedia or in an encyclopaedic dictionary.

Finally, as far as concerns the territorial and linguistic characteristics, the works originally published in Italy, or translated from preceding editions which originally appeared in other countries, were reviewed and examined.

As a result of such investigation, approximately eight-hundred-and-fifty publications were catalogued, articulated in seven thematic areas, one of which was subsequently divided into three sub-areas: A. Generalities / B. Health policies concerning non-EU immigrants / C. Normative policies

concerning the health of non-EU immigrants / D. Centres of public or private response to the health problems of non-EU immigrants / E. Relationship between health operators and non-EU beneficiaries / F. Pathogenic factors and epidemiological configurations concerning non-EU immigrants [F.a. Psychic Disorders; F.b. Pathologies and situations of maternal-child risk; F.c. Other pathologies] / G. Others.

This book presents a selection of fifty-three significant publications of the different thematic aspects examined, taking into particular account the most recent research.

1. Generalities

Beneduce R., Costa G., Favretto A. R., Frigessi D., Gogliani F., Lemma P., Pastore M., Rossignoli F., *La salute struniera. Epidemiologia Culture Diritti*, premessa di P. Maggiorotti, Edizioni Scientifiche Italiane, Napoli, 1994, pp. 191.

Caritas Diocesana di Roma, Università degli Studi di Roma "La Sapienza", Cattedra di Igiene Mentale, Associazione "Fernando Rielo", Assistenza e Ricerca Sanitaria, Harvard University Department of Health Policy and Management (Boston) (enti curatori), Geraci S. (curatore), *Medicina e migrazioni. Traumi e problemi di salute fisica e mentale in immigrati e rifugiati. Atti del II Congresso internazionale. Roma 11-13 luglio 1990*, Presidenza del Consiglio dei Ministri. Dipartimento per l'Informazione e l'Editoria, Roma, 1992, pp.693.

CIDIS, Centro di Informazione Documentazione e Iniziativa per lo Sviluppo (curatore), *La tutela della salute in una società multietnica*, Atti del Seminario tenuto a Perugia il 14-16 dicembre 1995 da CIDIS e Regione dell'Umbria, CIDIS, Perugia, 1996, pp.139.

Colasanti R., Geraci S., Pittau F. (curatori), *Immigrati e salute: paure, miti e verità*, Edizioni Lavoro - ISCOS, Roma, 1991, XVI+ pp. 260.

CUAMM, Collegio Universitario Aspiranti Medici e Missionari (curatore), *Il paziente immigrato. Quaderno di aggiornamento per il medico di medicina generale e il pediatra di base*, CUAMM, Padova, 1991, pp. 99 (suppl. a "CUAMM Notizie. Salute e Sviluppo", n. 2, maggio-agosto 1991).

Geraci S. (curatore), *Argomenti di medicina delle migrazioni*, Edizioni Peri Tecnes, Busseto (provincia di Parma), 1995, XII+ pp. 243.

Geraci S., Marceca M., Del Vecchio R. (curatori), "Immigrazione e salute: problematiche sanitarie in una società multiculturale", *Annali di Igiene, Medicina Preventiva e di Comunità*, vol. 7, n. 3, maggio-giugno 1995 (numero monografico), pp. 139-231.

Lampronti V., Maciocco G. (curatori), "Il paziente immigrato", *Salute e Territorio. Rivista bimestrale di politica socio-sanitaria*, anno XIX, n. 106, gennaio-febbraio 1998 (numero monografico [contributi al Convegno "Immigrazione e salute", promosso dalla Provincia di Firenze in collaborazione con il Comune e l'Azienda sanitaria di Firenze, 24 ottobre 1997]), pp. 12-64.

Morrone A., *L'altra faccia di Gaia. Salute, migrazione e ambiente tra Nord e Sud del Pianeta*, introduzione di G. Gabriele, F. Bonadonna, Armando Editore, Roma, 1999, pp. 334.

2. Health policies concerning on-EU immigrants

IRES, Istituto Ricerche Economico-Sociali Del Piemonte (curatore), *Atteggiamenti e comportamenti verso gli immigrati in alcuni ambienti istituzionali*, Rosenberg & Sellier, Torino, 1995, X+205 pp. / in particolare: cap. IV. Allasino E., Etica professionale, conflitti e cambiamenti organizzativi nei servizi sociosanitari di fronte all'immigrazione, pp. 91-121.

Loiudice M., Baglio G., Geraci S., "Confronto tra le politiche sanitarie verso le popolazioni immigrate in diversi Paesi sviluppati", p. 137, in Società Italiana Di Igiene Medicina Preventiva E Sanità Pubblica (curatore), 37° Congresso nazionale *L'igiene e la sanità pubblica alle soglie del 2000*. Napoli, 25-28 settembre 1996, vol. Abstracts (Relazioni - Comunicazioni - Posters), pp. 618 [volume fuori commercio].

Marceca M., Berlinguer G., Geraci S., La politica sanitaria sull'immigrazione in Italia, *Annali di Igiene, Medicina Preventiva e di Comunità*, vol. 7, n. 3, maggio-giugno 1995 (dedicato a Immigrazione e salute: problematiche sanitarie in una società multiculturale, a cura di S. Geraci, M. Marceca, R. Del Vecchio, pp.139-231), pp. 225-231.

Tognetti Bordogna M., "La cultura della salute: gli immigrati di fronte ai servizi socio-sanitari", pp. 17-27, in Fondazione Cariplo I.S.MU., ICEI. Istituto

per la Cooperazione Economica Internazionale (enti curatori), Lanzanova L., Lombardi M. (curatori), *Sanità e immigrazione. Atti del Corso per dirigenti di servizi sanitari,* Milano, ottobre 1992, prefazione di L. Lanzanova e M. Lombardi, Fondazione Cariplo per le Iniziative e lo Studio sulla Multietnicità, Milano, 1993 ("Quaderni I.S.MU.", n. 5, 1993, 45 pp.).

3. Normative policies concerning the health of non-eu immigrants

Caritas Diocesana di Roma (ente curatore), Geraci S. (curatore), *Immigrazione e salute: un diritto di carta? Viaggio nella normativa internazionale italiana e regionale,* presentazione di R. Bindi, introduzione di L. di Liegro, Edizioni Anterem, Roma, 1996, XVIII+ pp. 301.

Gennari M., D'Andrea M.S., "Assistenza sanitaria agli extracomunitari irregolari e clandestini. Obblighi del medico", *FM. Federazione Medica*, suppl. a *Il Medico d'Italia*, n. 37, dicembre 1995, pp. 26-30.

Pastore M., "Il diritto alla salute", pp. 161-188, in Beneduce R., Costa G., Favretto A. R., Frigessi D., Gogliani F., Lemma P., Pastore M., Rossignoli F., *La salute straniera. Epidemiologia Culture Diritti*, premessa di P. Maggiorotti, Edizioni Scientifiche Italiane, Napoli, 1994, pp. 191.

Zincone G., "Introduzione e sintesi. Un modello di integrazione ragionevole", pp. 13-120, in Zincone G. (curatore), Commissione per le Politiche di Integrazione degli Immigrati (ente curatore), *Primo rapporto sull'integrazione degli immigrati in Italia*, Il Mulino, 2000, pp. 571 / in particolare: 3.6. L'area della salute, pp. 87-89.

4. Centres of public or private response to the health problems of non-EU immigrants.

Coppo G., "Il consultorio familiare pubblico e l'utenza straniera: l'esperienza della zona 1", pp. 50-59, in Fondazione Cariplo I.S.MU., U.S.S.L. 75/Prima di Milano (enti curatori), Zanfrini L. (curatore), *La salute degli immigrati: problemi e prospettive. Atti del Corso per operatori sanitari*, prefazione di L. Zanfrini, presentazione del Corso di A. Tropiano, Fondazione Cariplo per le Iniziative e lo Studio sulla Multietnicità, Milano, 1994 ("Quaderni I.S.MU.", n. 6, 1994, pp. 61).

Esposito T., L'immigrazione extracomunitaria in Campania e nell'U.S.L. 27:

dati e prospettive, pp. 25-39, in Dama A., Esposito T., Arcella T. (curatori), *Cultura malattia migrazioni. La salute degli immigrati extracomunitari in Italia ed in Campania: aspetti sociali, medici e psicologici. Atti del I Corso di formazione sul disagio psichico da transculturazione (1990-1991)*, Regione Campania. U.S.L. 27 (Pomigliano D'Arco). Dipartimento di Salute Mentale, s.l., 1992, pp 198.

Giacomarra M., Giordano F., "I centri di prima accoglienza a Palermo. Problemi d'impatto socio-culturale e qualità dei servizi", pp. 91-106, in Affronti M., Spinelli A. (curatori), *I Congresso nazionale della Società italiana di medicina delle migrazioni e III Consensus Conference sulla immigrazione "L'immigrato: una realtà del nostro tempo: dall'accoglienza alla integrazione"*, Palermo, 29 maggio - 1 giugno 1994. Atti, Società Italiana di Medicina delle Migrazioni - Università degli Studi di Palermo, Cattedra di Medicina Interna - Poliambulatorio Santa Chiara per Cittadini Extracomunitari di Palermo, Palermo, s.d., pp.118.

Guizzardi M., "L'ASL e gli immigrati a Bologna", pp. 15-18, in Affronti M., Racalbuto A., Messina M. R. (curatori), *VI Consensus Conference sulla immigrazione e IV Congresso nazionale della Società italiana di medicina delle migrazioni "Untori e unti: dall'esotismo alla realtà". Palermo, 25-28 maggio 2000*, Atti, Società Italiana di Medicina delle Migrazioni - Università degli Studi di Palermo. Cattedra di Medicina Interna - Poliambulatorio Santa Chiara per Cittadini Extracomunitari di Palermo, Palermo, 2000, pp. 248.

Hamad I.E.L., Chiodera A., Castelli F., Trinato A., Quaresimi G., Carosi G., "Esperienza bresciana nell'assistenza sanitaria agli immigrati extracomunitari", *La Medicina Tropicale nella Cooperazione allo Sviluppo. Rivista ufficiale della Società italiana di medicina tropicale*, vol. 8, n. 1, gennaio-marzo 1992 (dedicato a Atti del Convegno "Migranti e sanità". Colombella (comune di Perugia), 24 ottobre 1991, [IV]+93 pp.), p. 35.

Ligozzi M. M., "Immigrazione e identità migranti: il Consultorio medico-antropologico dell'Istituto San Gallicano", pp. 165-173, in Morrone A., Mazzali M., Pistolese A. (curatori), *Oltre il colore della pelle. Italia crocevia di migranti e culture*, Bagatto Libri, Roma, 1999, pp. 272.

Merini A., Santarini F., "L'esperienza dell'Unità di psichiatria multietnica G. Devereux", pp. 325-346, in Losi N., *Vite altrove. Migrazione e disagio psichico*, con contributi di G. Cardamone, M. Corrente, R. del Guerra, C. Edelstein,

S. Inglese, F. James, S. Mellina, A. Merini, F. Santarini, S. Von Overbeck Ottino, Feltrinelli, Milano, 2000, pp. 364.

NAGA, Associazione Volontaria di Asssistenza Socio-Sanitaria e per i Diritti di Stranieri e Nomadi - ONLUS (Milano), "Il NAGA a Milano", pp. 89-107, in Colasanti R., Geraci S., Pittau F. (curatori), *Immigrati e salute: paure, miti e verità*, Edizioni Lavoro - ISCOS, Roma, 1991, XVI+ pp. 260.

Tonini A., "Il progetto "Tutela della salute dei cittadini e delle cittadine migranti" dell'Azienda Unità Sanitaria Locale di Parma", pp. 82-89, in Affronti M., Racalbuto A., Messina M. R. (curatori), *VI Consensus Conference sulla immigrazione e IV Congresso nazionale della Società italiana di medicina delle migrazioni "Untori e unti: dall'esotismo alla realtà". Palermo, 25-28 maggio 2000.* Atti, Società Italiana di Medicina delle Migrazioni - Università degli Studi di Palermo. Cattedra di Medicina Interna - Poliambulatorio Santa Chiara per Cittadini Extracomunitari di Palermo, Palermo, 2000, pp. 248.

Zurlo A., "Attività svolta dal Poliambulatorio Caritas-ASFR in qualità di osservatorio epidemiologico per la popolazione migrante a Roma", pp. 528-529, in Caritas Diocesana di Roma, Università degli Studi di Roma "La Sapienza". Cattedra di Igiene Mentale, Associazione "Fernando Rielo", Assistenza e Ricerca Sanitaria, Harvard University Department of Health Policy and Management (Boston) (enti curatori), Geraci S. (curatore), *Medicina e migrazioni. Traumi e problemi di salute fisica e mentale in immigrati e rifugiati. Atti del II Congresso internazionale*, Roma 11-13 luglio 1990, Presidenza del Consiglio dei Ministri. Dipartimento per l'Informazione e l'Editoria, Roma, 1992, pp. 693.

5. Relationship between health operators and non-eu beneficiaries

Colasanti R., Geraci S., "I livelli d'incomprensione medico-paziente migrante", pp. 81-89, in Geraci S. (curatore), *Argomenti di medicina delle migrazioni*, Edizioni Peri Tecnes, Busseto (provincia di Parma), 1995, XII+ pp. 243.

Diasio N., "L'uomo di vetro e l'uomo velato: la relazione terapeutica con il paziente eteroculturale", *Annali di Igiene, Medicina Preventiva e di Comunità*, vol. 7, n. 3, maggio-giugno 1995 (dedicato a Immigrazione e salute: problematiche sanitarie in una società multiculturale, a cura di S. Geraci, M. Marceca, R. Del Vecchio, pp. 139-231), pp. 209-216.

Esposito T., "Curare l'altro: i rapporti tra paziente extracomunitario e medico generale", *S.I.M.G. Rivista di politica professionale della medicina generale - The journal of the Italian college of general practitioners*, n. 9, novembre 1995, pp. 17-21.

Falteri P., "Diversità culturale e marginalità sociale: il rapporto con l'utenza straniera", pp. 153-168, in Regione dell'Umbria. Area Operativa Servizi Socio-Sanitari (curatore), *Donne migranti in Umbria. I servizi materno-infantili nel confronto con culture diverse. "Un percorso formativo" verso servizi multietnici (settembre-dicembre 1994) [Atti del percorso]*, introduzione di G. Barro, Regione dell'Umbria, Perugia, s.d., pp. 189.

Giarelli Guido, "I problemi di comunicazione nella consultazione clinica in una prospettiva interculturale", pp. 9-21, in Collegio Universitario Aspiranti Medici e Missionari (CUAMM) (curatore), *Il paziente immigrato. Quaderno di aggiornamento per il medico di medicina generale e il pediatra di base*, CUAMM, Padova, 1991, pp. 99 (suppl. a "CUAMM Notizie. Salute e Sviluppo", n. 2, maggio-agosto 1991).

Terranova Cecchini R., Tognetti Bordogna M., *Migrare. Guida per gli operatori dei servizi sociali, sanitari, culturali e d'accoglienza*, Franco Angeli, Milano, 1992, pp. 126.

6. Pathogenic factors and epidemiological configurations concerning non-EU immigrants.

F.a. *Psychic Disorders*

Beneduce R., *Frontiere dell'identità e della memoria. Etnopsichiatria e migrazioni in un mondo creolo*, con un saggio di M. Boucebci (Tra due rive) in appendice, Franco Angeli, Milano, 1998, pp. 314.

Cardamone G., Inglese S. F., "Migrazione e malattia mentale nella realtà italiana (1978-1996)", pp. 391-405, in Lanternari V., Ciminelli M. L. (curatori), *Medicina, magia, religione, valori*, vol. II. Dall'antropologia all'etnopsichiatria, Liguori Editore, Napoli, 1998, X+ pp. 452.

Cuzzolaro Massimo, "Psichiatria e nuove migrazioni. La salute degli immigrati tra assistenza pubblica e volontariato", pp. 107-124, in De Micco V., Martelli P. (curatori), *Passaggi di confine. Etnopsichiatria e migrazioni*, Liguori Editore, Napoli, 1993, pp. 170.

Frighi L., Piazzi A., Mazzetti M., "Caratteristiche socio-demografiche, salute psichica e fattori di rischio psicopatologico dell'immigrazione extracomunitaria a Roma", *Difesa Sociale*, anno LXXII, n. 5, settembre-ottobre 1993, pp. 183-200.

Losi N., *Vite altrove. Migrazione e disagio psichico*, con contributi di G. Cardamone, M. Corrente, R. Del Guerra, C. Edelstein, S. Inglese, F. James, S. Mellina, A. Merini, F. Santarini, S. Von Overbeck Ottino, Feltrinelli, Milano, 2000, pp. 364 / in particolare: parte I, 3. Psicoterapie occidentali adattate ai migranti ed etnopsicoterapia, pp. 99-119 / [nota: i saggi degli altri autori che hanno contribuito al volume vengono indicati come lavori autonomi].

F.b. *Pathologies and situations of maternal-child risk*

Bertollini R., Di Lallo D., "Immigrazione e salute materno-infantile", *Prospettive in Pediatria*, n. 23, 1993, pp. 299-305.

Favaro G., "Immigrazione e maternità", pp. 77-97, in Regione dell'Umbria. Area Operativa Servizi Socio-Sanitari (curatore), *Donne migranti in Umbria. I servizi materno-infantili nel confronto con culture diverse. "Un percorso formativo" verso servizi multietnici (settembre-dicembre 1994) [Atti del percorso]*, introduzione di G. Barro, Regione dell'Umbria, Perugia, s.d., pp. 189.

Grechi M., Palma E. (curatori), *Donne immigrate bisogni e servizi. Atti del Seminario di aggiornamento per operatori consultoriali per la tutela della salute delle donne e bambini di etnie minoritarie*, Regione Toscana. Giunta Regionale, Firenze, 1994, pp. 115 ("Formazione & Informazione. Immigrati e cittadini di etnie minoritarie", vol. 1).

Regione dell'Umbria. Area Operativa Servizi Socio-Sanitari (curatore), *Donne migranti in Umbria. I servizi materno-infantili nel confronto con culture diverse. "Un percorso formativo" verso servizi multietnici (settembre-dicembre 1994) [Atti del percorso]*, introduzione di G. Barro, Regione dell'Umbria, Perugia, s.d., pp. 189.

F.c. *Other Pathologies*

Bugiani M., Piccioni P., Cavallero M., Carosso A., Arossa W., "Impatto sull'epidemiologia della tubercolosi dell'immigrazione da Paesi ad alta incidenza", *Epidemiologia & Prevenzione*, vol. 17, n. 57, dicembre 1993, pp. 267-271.

Ciampi G., Garofalo G., Gaspari R., Basetti-Sanì G., Ciraolo F., Converti F., Di Renzo L., Comodo N., "Tubercolosi in una comunità cinese: il ruolo della rete sanitaria nella sorveglianza e controllo", *Difesa Sociale*, anno LXXV, n. 6, novembre-dicembre 1996, pp. 181-188.

Diasio N., "AIDS e migrazione. Rappresentazioni culturali e comportamenti a rischio presso le popolazioni femminili peruviana e somala a Roma", *AM. Rivista della Società italiana di antropologia medica*, n. 3-4, ottobre 1997, pp. 357-360 [nella sezione Lavori in corso della rubrica Osservatorio].

Geraci S., Latini E., Nonis M., Piazzi A., "Le malattie degli immigrati", *Difesa Sociale*, anno LXX, n. 5, settembre-ottobre 1991, pp. 45-146.

Morrone A., Passi S., Fazio M., "Immigrati clandestini extracomunitari a Roma: osservazioni dermatologiche e venereologiche", pp. 585-597, in Caritas Diocesana di Roma, Università degli Studi di Roma " La Sapienza". Cattedra di Igiene Mentale, Associazione "Fernando Rielo", Assistenza e Ricerca Sanitaria, Harvard University Department of Health Policy and Management (Boston) (enti curatori), Geraci S. (curatore), *Medicina e migrazioni. Traumi e problemi di salute fisica e mentale in immigrati e rifugiati. Atti del II Congresso internazionale. Roma 11-13 luglio 1990*, Presidenza del Consiglio dei Ministri. Dipartimento per l'Informazione e l'Editoria, Roma, 1992, pp. 693.

Rossi P., Senis L., Contini A., Nardecchia B., Rogliani P., Bisogni V., Rossi S., "Osservazioni clinico-epidemiologiche sulla tubercolosi polmonare nei pazienti extracomunitari ricoverati", *Igiene e Sanità Pubblica*, vol. 52, n. 4, luglio-agosto 1996, pp. 271-280.

Salmaso L., Realdon P., Cattelan A. M., Scaggiante R., Sattin A., "Chi infetta chi? AIDS, italiani e immigrati", *Prospettive Sociali e Sanitarie*, anno XXIV, n. 2, 1 febbraio 1994, pp. 12-14.

Sanguigni S., Madeo M., Marangi M., Santercole C., Pancallo D., Perroni L., Tessitore S., Pellegrinotti A., Pica R., Dottorini S., Sebastiani A., "Ruolo della patologia parassitaria negli immigrati", *La Medicina Tropicale nella Cooperazione allo Sviluppo. Rivista ufficiale della Società italiana di medicina tropicale*, vol. 8, n. 1, gennaio-marzo 1992 (dedicato a Atti del Convegno "Migranti e sanità". Colombella (Comune di Perugia), 24 ottobre 1991, [IV]+93 pp.), pp. 21-31.

Diasio N., "Diventare bianco: crisi di passaggio e riformulazione dell'identità in un poliambulatorio per immigrati a Roma", pp. 170-181, in Geraci S. (curatore), *Argomenti di medicina delle migrazioni*, Edizioni Peri Tecnes, Busseto (provincia di Parma), 1995, XII+ pp. 243.

Favaro G., Tognetti Bordogna M., *La salute degli immigrati: una ricerca sui bisogni socio-sanitari degli Eritrei a Milano*, Edizioni Unicopli, Milano, 1988, pp. 219.

Pistolese A., "Il consultorio medico-antropologico. Metodologia e risultati della ricerca", pp. 141-149, in Morrone A., Mazzali M., Pistolese A. (curatori), *Oltre il colore della pelle. Italia crocevia di migranti e culture*, Bagatto Libri, Roma, 1999, pp. 272.