ASSESSMENT REPORT:
Health Situation at EU Southern borders -
Migrant Health, Occupational Health, and Public Health

ITALY

Field work 4–18 September 2013

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CONTENTS

ACRONYMS

ARCI	Italian Cultural and Recreational Association
ASGI	Association for Juridical Studies on Migration
ASP	Local Health Authority
CARA	Reception Centres for Asylum-Seekers
CAS	Extraordinary Reception Centre
CDA	Reception Centre
CIE	Identification and Expulsion Centres
CSO	Civil Society Organization
CSPA	First Aid and Reception Centres
EMN	European Migration Network
ENI	European Not Enrolled
HIV	Human Immunodeficiency Virus
HP	Health Personnel
ICT	Information and Communications Technology
IOM	International Organization for Migration
ISTAT	National Institute of Statistics
LEA	Essential Levels of Care
LEO	Law Enforcement Officials
MoH	Ministry of Health
MoI	Ministry of Internal Affairs
NCC	National Consultative Committee
NGO	Non-Governmental Organization
PPE	Personal Protective Equipment
SAR	Rescue at Sea
SPRAR	Protection System for Asylum-Seekers and Refugees
STP	Temporary Present Foreigner
SSN	National Health System
TB	Tuberculosis
UAM	Unaccompanied Minors
UNHCR	United Nations High Commissioner for Refugees
USMAF	Office of Maritime and Border Health
WHO	World Health Organization

EXECUTIVE SUMMARY

Data on irregular migrant flows from 2008 indicates that 28.4 per cent of irregular entries took place over land, 22.6 per cent over sea borders, and 48.9 per cent in the air (EMN, 2012). The number of arrivals by sea, however, varies from year to year, being dependent on both the presence of humanitarian crises and the existence of bilateral agreements. In 2013 and 2014, the Italian coastline has witnessed a massive influx of migrants from North Africa and the Near Middle East. The number of arrivals in Lampedusa, Sicily, increased from 3,624 in 2012 to 13,975 in 2013 (January-October). At the same time, other Sicilian provinces saw an upsurge as well: **landings in Ragusa increased from 606 in 2012 to 3,330 in 2013, and in Siracusa from 791 to 13,975 respectively (January to October).**[1] Among them, in 2013, 1,975 unaccompanied minors (UAM) landed in Sicily, 660 in Apulia, 572 in Calabria and 18 in Sardinia (Caritas Migrantes, 2014). In the first nine months of 2013, Italy had already received 18,780 asylum applications, more than the number of requests for all of 2012 (SPRAR, 2013).

It should be noted here that the term "landing" is often used improperly, since very often migrants have to be rescued at sea. Tragically, in 2013, more than 700 people died in an attempt to reach the Italian coast, most of them victims of two tragic shipwrecks on 3 and 11 October[2] respectively. As indicated by the Region Sicily representative, the increased number of the landing places alter completely the implications for assistance activities, with the **"Lampedusa model" difficult to apply in the rest of the Sicilian territory,** which covers a long stretch of the coastline with a high number of stakeholders involved.

Policy and legal framework

Italian law differentiates between "illegal immigration" and "irregular migration." "Illegal migrants" are defined as those who entered the country without any authorization for entry, whereas "irregular migrants" are foreigners who entered Italy legally but who subsequently ceased to satisfy the requisite conditions for legal stay.[3]

At the national level, the *first comprehensive legal framework on migration* was put in place in 1998 by the "Turco-Napolitano" Law 40/1998. The Legislative Decree n. 286 of 25 July 1998 contains *Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero.*[4] This Unified Text includes provisions against irregular migration (Art. 12) and establishes provisions for administrative expulsion both for overstayers and for migrants entering Italy illegally (Art. 13). The legislative framework provides that both illegal and irregular migrants are not authorized to stay in Italy and, according to the legislation currently in force,[5] must be refused entry at the border or expelled from within the country. The law does stipulate, however, that foreigners be provided "necessary assistance" at the border (Unified Text Art. 10.5) and that migrants, who cannot be immediately returned, be referred to detention facilities,

[1] Data provided by the Ministry of the Interior to the Praesidium project.

[2] See at: http://fortresseurope.blogspot.it/2006/02/nel-canale-di-sicilia.html (accessed 6 March 2014).

[3] See at: www.interno.gov.it/mininterno/export/sites/default/it/temi/immigrazione/sottotema002.html Throughout this report we use only the term "irregular migrants", including in it is both migrants who live and those who enter Italy without valid titles.

[4] The Unified Text of the Provisions Regarding Immigration Control and the Norms on the Condition of Foreign Nationals.

[5] See the already mentioned Unified Text at the articles 10–17 and the Directive 2008/115/EC.

as stated in Art. 14 of the Unified Text. The Unified Text, and its subsequent modifications, guarantees some basic rights for irregular migrants, **including health care and education.**

Italy recognizes the right of asylum in the Constitution (art. 10), **but does not have a comprehensive law on the subject, and refers mainly to European legislation**, especially the transposed[6] Directive 2003/9/EC, laying down minimum standards for the reception of applicants for asylum in Member States, and the Dublin Regulation, which significantly affects the lives of many asylum-seekers. During the field visit, it has been observed that many migrants, (especially of Syrian origin) on Italian soil since 2013, have declined to be identified in order to avoid the consequences of the Dublin system, and move onto other European countries where they have friends or relatives, and/or where they perceive better conditions for asylum-seekers than those in Italy. The Dublin Rule exacerbates vulnerabilities by creating a situation in which persons with valid asylum claims choose not to lodge their claims but rather continue their journey as undocumented migrants, and therefore at a high risk of exploitation (UN Special Rapporteur 2012).

The intake and processing system of irregular migrants arriving by sea in Italy is structured through an **articulated system of centres for reception and detention**. The system includes: first aid and reception centres *(Centri di Primo Soccorso ed Accoglienza* – CSPA), Reception centre *(Centri di Accoglienza* – CDA), Reception centres for asylum-seekers (*Centri di Accoglienza per Richiedenti Asilo* – CARA) and Identification and expulsion centres *(Centri di Identificazione ed espulsione* – CIE) (see Table 2). Particular concerns have arisen regarding a new type of centres (hereby called **ad hoc centres**)[7] which do not fall into the above mentioned categories, and which can be activated by local authorities (Prefettura) under the so-called "Apulia law"[8] as temporary structures aimed at responding to the primary needs of migrants. No clear-cut regulation as to how long people can be housed at these centres currently exists. The urgency that characterizes the nature of these facilities, together with the scarce economic resources allocated for migrant intake and medical and psycho-social assistance, adversely impact daily life of migrants and the coordination among different stakeholders/phases of the reception process.

Responsible for central coordination of all these facilities is the Ministry of Internal Affairs (MoI – *Ministero dell'Interno*), whereas MoI local bodies (*Prefetture*) are responsible for local reception. This process includes the appointment of the centre's manager (which usually are private entities and non-governmental organization (NGOs)) and the ongoing, monitoring of the centre's operations. The entity charged with the centre's *management* is responsible for its daily management, generic assistance (including linguistic-/-**cultural mediation**, information on migration law), **medical assistance, psycho-social assistance, hygiene and living conditions**, maintenance of the housing structure, administrative and financial reporting, and any arrangements with subcontractors for the needed services within the centre (Annex III). Selection procedure takes into consideration the lowest cost bid offered by the service providers. **Medical assistance is therefore described, yet not specified nor with specifically devoted budgetary line (left at the discretion of management).**

[6] Through the Legislative Decree n. 140 of 2005.

[7] After the field visit, their denomination is CAS – Centro Accoglienza Straordinario - Italian Ministry of Interior-Dipartimento per le Liberta' civili e l'Immigrazione "Circolare 19 Marzo 2014". However, this document indicates that any agreement with the structures should end by 30 June 2014.

[8] Law n. 563/1995.

In 2011, the maximum **length of stay** in the CIE has been extended from 180 days (l.94/2009) to 18 months following the amendment[9] to the Consolidated Immigration Act, which transposed the EU Return Directive (2008/115/CE). This change has worsened the situation of migrants within these detention-style centres.[10] **The assessment revealed that in fact the maximum stay clause is rather notional, as in reality people in the CSPA remain up to few months[11] and in the CARA up to 1.5–2 years, due, inter alia, to the bottlenecked process of asylum application.**

UAM, who due to the lack of places in targeted community and because of a national reception system that cannot identify available places, often remain in CPSA or in ad hoc centres for long periods of time without receiving adequate medical care. Further, they are exposed to health and social risks (in some cases they are victims of human trafficking). It's worth noting that **the Italian legislative framework applied to unaccompanied minors was designed for *Italian* nationality minors** who are in the territory without assistance and representation by the parents or other adults legally responsible for them. This clearly does not take into consideration additional difficulties with respect to migrant status, language and communication barriers, and asylum application claims, to mention a few.

Migrants' access to health care is regulated by the Art.34 and 35 of the Consolidated Text. In order to access health care services, **regular migrants** must register with the Italian National Health System in order to obtain their health card. **Asylum-seekers** can register in the health system as well, and receive health care on equal ground with Italian nationals and predicated on the same conditions.[12] **Irregular migrants**[13] are entitled to access preventive, urgent, and essential treatment of illness, as well as care considered necessary for public health reasons.[14] Regarding the reimbursement of benefits paid through the Temporary Present Foreigner (*Straniero Temporaneamente Presente*-STP), **the competent local health administration must apply with the Ministry of the Interior;** regular **migrants and asylum-seekers are instead signed up for the Italian National Health System, hence those costs fall under the Ministry of Health domain.**

[9] Law n. 129/2011.

[10] According to the association Medici per I Diritti Umani, the extension of the time of detention has not produced any tangible effects in terms of effectiveness of expulsions, but it has notably worsened living and health conditions of migrants. Medici per idirittiumani, *Arcipelago CIE,* May 2013.

[11] See Checklists Annex VI, question 5–6.

[12] See also Art.27 of Legislative Decree N.251/2007, which refers exclusively to recipient of international protection. The National Health System (SSN) provides to all citizens - for free or subject to co-payments – a basket of services and benefits called *Livelliessenziali di assistenza* (LEA -Essential levels of care), regardless of income and place of residence.

[13] Access to health care is facilitated through the assignation of a specific code, the STP (Straniero Temporaneamente Presente). The STP is valid for third country nationals. EU citizens staying in Italy for a period exceeding three months, with no health care coverage and requirements to be registered as resident have the right to receive urgent and essential care. Ministerial Circular of 19 February 2008. In some regions, such as, e.g., Lazio or Sicily, they can access the SSN through the ENI code ("Europei Non Iscritti" – European not enrolled).

[14] Turco Napolitano law, n.40/1998 and legislative decree 286/1998, article 35 (3). In particular, are guaranteed: the social protection of pregnancy and maternity with equal treatment with the Italian citizens; the protection of the health of the child; immunizations in accordance with the regulations and in interventions for prevention campaigns collective authorized by the Regions; actions of international prophylaxis; the prophylaxis, the diagnosis and treatment of infectious diseases and eventual reclamation of its focus. Irregular migrants are also guaranteed to the prevention, treatment and rehabilitation from drug addiction, from psychiatric illnesses and, in general, all interventions preventive, curative and rehabilitative.

Responsibility for providing health care assistance is **shared among authorities at the central, regional, and local level**. Because of its decentralized health care system, in Italy the implementation of the legislative framework and entitlement to health service provisions may differ at the regional **level**.

Partnerships, networks, and multi-country frameworks

A broad range of partners are involved with migration management in Italy. The **Ministry of Interior,** through its Department for Civil Liberties and Immigration, has the key responsibility of civil rights protection, including with respect to immigration, asylum, and citizenship procedures; the **Ministry of Foreign Affairs**, through the Office for Migration and Asylum Policies, is responsible for the development of bilateral agreements[15] in migration matters and for the incorporation of EU rules, laws, and procedures related to migration into Italian legislative framework; the **Ministry of Labour and Social Policies** – General Directorate of Immigration and Integration Policies works on the protection of unaccompanied minors and integration of third country nationals in the labour force.

The assessment covered all the phases of the reception process, identified as the following segments: rescue at sea, disembarkation, transfer, housing at a centre, and finally release/integration (see Figure 1). During the **first phase of search and rescue at sea**, a number of stakeholders from the MoI (*Guardia di Finanza*), to the Ministry of Transport (*Guardia Costiera*) and to the Ministry of Defense (*Marina Militare*) patrol the sea and intervene upon detecting a vessel with migrants. In case of rescue at sea (SAR event), which occurs whenever the vessel is deemed to be at risk (of sinking or other emergency), the inter-institutional operation is coordinated by *Capitaneria* di Porto.[16] The assessment showed that rescue operations are well regulated and tasks clearly defined for each agency involved. The main difficulty with respect to this first phase is the juggling of different priorities (vulnerable people, unity of the family, health conditions). At this stage, family members may be inadvertently separated, and later faced with the real possibility that, once ashore, they might be sent to different centres.

Together with *Prefettura* and Questura, other actors are involved in the **disembarkation phase**: the Local Health Authority (ASP) and, at the official enter/border point, the USMAF – *Uffici Sanità Marittima Aerea e di Frontiera* (Office of Maritime and Border Health) for the Ministry of Health (MoH), the *Forze di Polizia (*especially *Carabinieri, Polizia, Guardia di Finanza, Vigili del Fuoco),* the *Protezione Civile* and representatives of international organizations (IOM, UNHCR) or NGOs (such as Italian Red Cross, Save the Children or local NGOs). The Prefettura is responsible for the overall coordination. Procedures for health assistance at arrival differ if the vessel arrives at ports designated as official point of entry or not. In the former case, first medical aid and screening is performed by the *Uffici Sanità Marittima Aerea e di Frontiera (*USMAF), in collaboration with ASP

[15] In the interests of externalization of borders, bilateral agreements can contain both measures for readmission, and measures of cooperation between the police forces of the signing parties. Italy Has realized agreement with Algeria, Egypt, Tunisia and Libya. See at: www.integrazionemigranti.gov.it/archiviodocumenti/diritti-fondamentali/Documents/Rapporto%20Access%20to%20Protection_ITALIA_Epim.pdf, pp. 26–31 (accessed 6 March 2014).

[16] Since July 2004, a specific agreement specifies the key procedures and the different competences and responsibilities regarding irregular migration at sea. Subscribers of the agreement include *Polizia di Stato* (Police), *Marina militare* (Navy), *Guardia di finanza* (Tax and Customs Police) and *Comando delle capitanerie di porto* (Guardia Costiera, Port Authority) ("Accordo tecnico operativo per gli interventi connessi con il fenomeno dell'immigrazione clandestina via mare").

and NGOs. The emergency unit intervenes to provide first medical assistance in the latter case, although an immediate support is rather difficult to guarantee and the management of new arrivals is often carried out with ad hoc measures. **No inter-institutional Standard Operational Procedures are centrally drafted and adopted at the local level to run the landing operations.**

The assessment has highlighted the fact that, at the moment of the field visit, **there was not much national "burden sharing" of migrants** arriving by sea in Italy so that almost all of the arrivals are housed in structures on the same territory of arrival (the Sicily region in this case). The transfer from the disembarkation point to the detention centres usually occurs by bus provided by MoI and escorted by *Carabinieri* or Police. The assessment has found this stage in the process to be particularly problematic.

After initially being identified and processed, migrants are then transferred to a CPSA, a CDA or an ad hoc centres and, secondary, from there to different centres according to their particular needs and migratory experiences. However, in practice, due to the **scarce number of available places**, especially relevant for some of the most vulnerable migrants such as unaccompanied minors, people are sometimes housed in those centres that have available places without duly consideration of their specific needs.

Regarding the last phase of the reception process – outside the centres – greatly reduced funding for projects aimed at the subsequent integration of migrants not only has a direct negative effect on migrants, but creates a twofold effect on society: on one hand the interaction with the community is reduced and on the other the information about migrants in the community is mainly linked to negative events, thus stoking fear and animosity in a sort of a "social scaremonger" halo effect.

In terms of *public health in border communities*, findings from the field visit show that at the moment of disembarkation local authorities are immediately informed by USMAF in case of relevant risks for public health. In addition, since 2011, reception facilities are obliged to send a syndromic surveillance daily report to local health authorities and send them to the MoH. In CPSA, CDA, CARA and CIE the registered cases of outbreaks (mainly tuberculosis (TB), scabies and meningitis) have not been significant over time, and when occurring were promptly brought under control with prophylactic measures.

The assessment team reported various degrees of **integration of the public health system** along different phases of the reception process. The role of the ASP/hospitals is particularly crucial during disembarkation, with the noteworthy cooperation of NGOs, such as the Italian Red Cross, and once the migrant leaves the centre. At detention/reception facilities, the degree of integration can be defined on scale that goes from:

- Continuity – public health-care system covers the assistance in the centre ensuring continuity of care with assistance grounded in a public health approach (i.e. Pozzallo);
- Integration – health assistance in the centres is covered by a competent private entity, with the integration of some services provided by the public health system (i.e. Mineo);
- Detachment – no structured exchange/integration is in place, besides the referral to hospitals in case of need (i.e. Caltanissetta).

Fostering the effectiveness of the development of reception process could also mean to improve communication among different levels involved (between national and local level, between decision-makers and operational ones); among different institutions (between ministries at the

central level and between various institutional actors at local one, particularly between ASP, Prefetture, Municipalities and NGOs); among different structures (between hospitals and reception centres, detention and CIEs) and stakeholders.

Monitoring migrants' health

Upholding *migrant health* is particularly challenging as recent landings have included an ever increasing number of vulnerable groups-unaccompanied minors, pregnant women or women who have just given birth on the boat, infants, elderly and disabled people, have been registered. On arrival, migrants are generally exhausted, dehydrated, severely sunburnt and suffering from various skin abrasions. In addition, while at first they experience difficulties moving because of the cramped conditions during their sea voyage (migrants often reported that they had to stay in the same position for days or weeks on the boat), but in overall good health condition.

However, findings from the assessment confirm significant concerns about the **worsening physical and mental health of migrants during the reception process.** Extended duration of the asylum application and the subsequent uncertainty for migrants' future, coupled with limited opportunities for education, training, meaningful occupation, overcrowding conditions are considered as major additional factors affecting migrants' wellbeing. Those in the CIE present self-harm and as general issue in all the centres, disorientation in the immediate and anxiety for the future.

As indicated, the entity appointed as manager of a centre is responsible for *medical assistance, psycho-social assistance*, hygiene, and living conditions (Annex III).[17] If migrants need to access diagnostic tests and examinations, surgery, dentist or specialist care, they are referred to nearby hospitals. While urgent and basic medical assistance is usually provided during the reception process, migrant **mental health** is an area which continues to require attention and is insufficiently addressed from the very first.

Particularly relevant as **obstacles for providing adequate health and social assistance** are the insufficient health and supporting (mediators, interpreters, and legal advisors) staff, who recognize the problem and deplore not having enough time to dedicate to every migrant.

Shortcomings of health and psycho-social services generate four obstacles to health and well-being: 1) a perceived non-performance/ and long wait for health assistance, summarized by migrants in the slogan "*Come tomorrow, come tomorrow*"; 2) even when the assistance and the medical visit happens, migrants sometimes do not recognized it as such. Migrants declared that they did not have an initial "medical visit/check-up" upon entrance in the centre, but only a quick, cursory, once-over; 3) perception of a lack of interest in their personal/health situation, which generates high level of frustration and may engender aggressiveness against health professionals "*you feel annoyed, these people do not want to help me!*" (Migrant); 4) this contributes to the creation of a climate of antagonism between Health Personnel (HP) and migrants.

No standard criteria for *assessment, collection and ordering of the health-related data* for irregular migrants are available. At local level, the only activities of systematized collection of data are syndromic surveillance (guidelines drafted by the MoH) and, USMAF's report after every

[17] The specifications of the tender and the services required in each centres have been approved with a Ministerial Decree on 21 November 2008.

disembarkation event when a document that authorized the disembarkation with health-related data for migrants at the first screening is sent to the ASP and to the judiciary authority. Syndromic surveillance is not currently done in ad hoc reception centres, where on-site health care services are not available and where no medical screening is performed at migrants' admission.

The **lack of standardized health assessment of migrants and of availability of migrants' health related data** limit the assessment of migrant's health conditions and the responsiveness in provision of adequate level of services. **The collection of health-related data is left up to the reception facilities**, where once again standards and procedures differ greatly from one centre to another. Standardized system for health related data collection (and referral) is missing, and requested by the interviewees as an important improvement. **Referral mechanisms** have been also assessed as uneven and not always fluid. HPs respondents indicate the usefulness of an integrated data collection system not only within the reception system but with the National Health System (SSN) in order to guarantee continuity of care for migrants so as to be able to follow and support their conditions when they move within and outside the centres and the regions.

Migrant-sensitive health system

Infrastructure and physical conditions vary much between centres, and in relation to the type of centre and its function (Annex V).

Infrastructure and baseline conditions are quite varied and a number of other factors contribute to **critical overcrowding and excessive length of stay**, which eventually produce a sub-optimal standard of living and reduced health assistance. Some of these factors could be summarized as:

- steady arrivals of a complex flow of migrants;
- shortcoming in availability of places for reception;
- limited burden sharing at the national and international levels;
- long asylum procedures/and waiting period.

The long periods of time migrants spend in the centres appears to also dramatically **increase the demand for health services** due to both physical and psychological problems. Coordination and collaboration with the health-care system becomes even more crucial. Together with the overcrowding, a shift in the functions of the different centres has been observed: the CPSA and the *ad hoc* centres created to help the migrants in the first hours after the landing (and therefore designed with a bare minimum of services and infrastructure) have in fact become medium-term facilities, while the CARA, (where asylum-seekers are theoretically supposed to spend no more than 35 days but instead remain over a year and sometimes two) have taken on the role of second level reception centres (SPAR). This has forced the centres to adapt to tasks and functions for which they were neither designed nor equipped.

Overall, the biggest psychological distress factor for migrants in CARA centres remains the undetermined and protracted length of their stay, coupled with lack of **legal information and support**, especially related to their potential future integration in society. Other complaints are related to living conditions - such as variety and quality of food, hygiene, and lack of social activities. The assessment revealed the significant role played by civil society organizations (CSOs) in providing social assistance to the migrants.

At the Protection System for Asylum-Seekers and Refugees (SPRAR) centres, migrants' living conditions are generally better: this is especially due to the number of people hosted,[18] the assistance provided and the limited period of stay in the centres (maximum six months). Vocational training classes provided by the centres in coordination with other local entities are particularly important for the well-being of the migrants and their future integration in society.

The often very charged atmosphere in the centres, in view of prevalent frustration with length of stay and conditions, also impacts the *occupational health of staff*. While the health professionals did not indicate particular worries regarding safety in assisting a migrant – as "*sick persons are all the same, regardless of nationality*" – law enforcement officers (LEOs) expressed more concerns in relation to their own health and safety. The difficulty for LEOs in understanding the language of the migrants, even if English, can increase misunderstanding and tension between migrants and law enforcement officers and lower the quality of support provided by health professionals.

While *trainings* on first aid and on occupational health were organized time to time for LEOs, none are focused on topics specific to migration (for example in the field of migration law, intercultural interaction, or phenomena such as trafficking). The organization of this type of courses is regarded as useful by the interviewees. The need and interest in having more training on topics related to health protection or inter-cultural competences was evident in the various interviews conducted.

[18] Only few SPRAR project in Italy hosts more than 100 people (maximum 200). Most of them have a capacity of 0–20 or 20–100.

1. INTRODUCTION

This document has been developed within the framework of the EQUI-Health project EC/DG SANTE co-funded Southern EU Border component (MH SEUB) to present the findings of the IOM desk review[19] and field work held in Sicily - Italy (Caltanissetta, Catania/Mineo, Siracusa, Pozzallo) from 4th to 18th September 2013.[20]

The Equi-Health desk review and field work assessment aim to address: 1) migrants' health; 2) occupational health; and 3) public health under the overall lens of equity and well management of migration during the different stages of the **reception process of complex migration flows,**[21] from rescue at sea onward, including in detention and reception centres.

Health is an essential element of effective migration management. Moreover, the concept of health goes beyond physical diseases, and comprises the psychological and social wellbeing of mobile populations and communities affected by migration. Migration health addresses the needs of individual migrants as well as the public health needs of receiving communities through policies and practices corresponding to the emerging challenges facing mobile populations today.

Therefore, the approach used in the assessment attempts to be as comprehensive as possible, covering communicable and non-communicable diseases, emergency interventions, chronic diseases, mental health, the understanding of culture and health beliefs, human rights protection, migration health management and other factors that impact on the health of migrants and the communities along.

The desk review and field work findings are presented following the IOM/WHO/Spanish Presidency of the EU "Global Consultation on Migrant Health" conceptual framework (Madrid, 2010),[22] according to the following four pillars:

I. **Policy and Legal Framework;**
II. **Partnerships, Networks and Multi-country Frameworks;**
III. **Monitoring Migrant Health;**
IV. **Migrant-sensitive Health System.**

[19] The objective of the desk review was to collect all the relevant information on migrant health, occupational health of health professionals / law enforcement officers and public health in order to assess the gaps on the topics to be covered in the assessment phase. It reviewed available literature on national and regional level.

[20] This report presents the results of a snapshot assessment conducted at a given moment in time, so additional developments and policy actions may have taken place in the meanwhile.

[21] IOM identifies complex flows as comprising, in addition to asylum-seekers: victims of trafficking, smuggled and stranded migrants, unaccompanied (and separated) migrant children, those with specific health needs or subject to sexual, physical, and psychological violence (including gender-based) during the migration process and family members seeking to re-unite with their families. In addition, these flows may include migrant workers and migrants moving for environmental reasons (IOM, *Addressing complex migration flows and upholding the rights of migrants along the central Mediterranean route*, Discussion paper, 21 October 2013, Brussels).

[22] Please see Annex I.

2. BACKGROUND INFORMATION

According to the national statistics institute, **at the end of 2013 the number of regular foreign citizens in Italy was 4.9 million people, or 8.1 per cent of the Italian population.**[23] Over time, migration has mitigated Italy's negative population growth rates of Italy (-86,436 in 2013 due to decreasing birth rates over time.[24]

The biggest number of foreign residents is Romanian and other Eastern EU citizens - accounting for 1.18 million people. Considering non EU citizens, on 1 January 2014 there were 3,874 thousand people, of which the 49.1 per cent are women and the 24 per cent minors.[25] Among the most numerous were Albanians (502,000) and Moroccans (524,000). These two communities with Chinese (320,794), Ukrainian (233,726) and Philippine (165,783) account for more than 90 per cent of total number of non-EU foreign citizens in Italy (ISTAT, 2014). During the 2008–2013 economic downturn, regular international immigration decreased from over 350,000 to 307,000 (5.1 per thousand) (ISTAT, 2014).

At the end of 2013, the total number of unaccompanied minors (UAM)[26] in Italy was 6,537 units,[27] of which 93.5 per cent were male. According to the Ministry of Labour's data, the majority of children present is 17 year old (55.3%); 23.1 per cent are 16 year olds, 11.2 per cent are 15 year olds, and 10.4 per cent are 14 and younger. Among the major states of origin are Egypt, Bangladesh, Albania, Afghanistan and Somalia. In 2013, 1,975 UAM landed in Sicily, 660 in Apulia, 572 in Calabria and 18 in Sardinia (Caritas Migrantes, 2014).

As no official records on undocumented migrants exist, their numbers can at present be only estimated. According to the 4th European Migration Network Italy Report (EMN, 2012), if the number of irregular migrants during the first years of 2000s was estimated at nearly one million, today it is half of that. The ISMU Foundation – Initiatives and Studies on multi-ethnicity of Milan estimates at 560,000 the number of irregular migrants living in Italy in 2009, 544,000 in 2010, 443,000 in 2011, 326,000 in 2012 and 294,000 in 2013 (ISMU, 2013).

Considering the access channels of irregular migrant flows, data from 2008 indicates that the land border crossings were 28.4 per cent per cent of all irregular entries, while over water and across air borders 22.6 per cent and 48.9 per cent, respectively (EMN, 2012). The number of arrivals by sea, however, varies greatly from year to year, due to it being dependent on both the emergence of humanitarian crises and the existence of bilateral agreements. For example, the number of migrants entering Italy by sea in 2009 has declined a full 88 per cent (29,076 arrivals

[23] Data available on the ISTAT website www.istat.it/it/files/2014/08/CITTADINI-NON-COMUNITARI.pdf?title=Cittadini+non+comunitari+regolarmente+presenti+-+05%2Fago%2F2014+-+Testo+integrale.pdf (accessed 8 September 2014). See also at: ISTAT, Cittadini non comunitari regolarmente soggiornanti Anni 2013-2014, ISTAT, Rome. 5 August 2014.

[24] See the Italian Statistics Service for more details, available from http://demo.istat.it/bil2013/index_e.html At the beginning of 2014, 15 per cent of newborn were from foreign citizens.

[25] The proportion of women and minors is highly variable among different population groups by country of origin.

[26] According to the Wall Street Journal (In Italy, "Migrant Children Languish in Squalor", article from Giovanni Legorano, Wall Street Journal, 12 September 2014), the Ministry of Labour and Social Policy indicated that in 2014 the number of minor migrants disappeared is 1,213.

[27] This data are considered to be underestimated as do not include EU UAM, unaccompanied minors who have sought international protection.

from 1 August 2008 to 31 July 2009 and 3,499 arrivals from 1 August 2009 to 31 July 2010)[28] following the ratification of the Treaty of friendship, partnership, and cooperation with Libya by the Parliament. On the other hand, starting in the spring of 2011, the political and military turmoil in Libya have again caused the number of migrants undertaking the dangerous voyage across the Mediterranean to increase (60,656 in the first nine months of the year only).[29] According to the latest data available (Frontex, 2014), in the first quarter of 2014 detections reported from the Italian blue border[30] represented almost 50 per cent of all detections of illegal border-crossing.

During 2013 and 2014 in the Italian coast has seen a massive influx of migrants from North Africa and the Near Middle East. **It should be noted here that the term "landing" is often used improperly, since they are very often migrants rescued at sea**. Tragically, in 2013, more than 700 people lost their lives while trying to reach the Italian coast, most of them as a result of two separate boat sinking accidents – on 3 October and on 11 October. IOM estimates that **as of 2000, more than 22,000 migrants have died while crossing the Mediterranean Sea** (IOM, 2014).

The number of arrivals in Lampedusa, Sicily island increased from 3,624 in 2012 to 13,975 in 2013 (January-October). At the same time, other Sicilian provinces became more involved: **landings in Ragusa increased from 606 in 2012 to 3,330 in 2013 and in Siracusa from 791 to 13,975 (January to October).**[31] The main country of departure was Libya, followed by Egypt and Turkey. Most of the migrants are from Eritrea (29%) and the Syrian Arab Republic (18%), and often continue their journey from Italy towards other European countries.[32] As indicated by the Sicily Region representative,[33] the increase number of the landing places change completely the scenario of assistance, with the **"Lampedusa model" difficult to propose in the rest of the Sicilian territory,** which covers a large extension of the coastline with a high number of actors involved.

As confirmed by UNHCR (2009) migrants arriving by sea are especially people entitled to apply for protection. Consequently, as the number of disembarkments has risen, so too has the number of asylum requests (over 37,000) in 2011, compared to those submitted in 2009 and 2010 (19,090 and 12,121, respectively). It is possible to attribute this data especially to the already mentioned agreement between Italy and Libya that committed Libya to contrast irregular migrations starting from its coasts. The spike up in migrant flow starting in 2011 is clearly linked to the "North African Emergency" after the so called Arab Spring uprisings. In that year a high number of asylum requests were submitted by Nigerian citizens (7,030), followed by Tunisians (4,805) and Ghanaians (3,402). In 2011, the number of applications that has had a positive result in terms of international protection was 40.1 per cent, while the percentage of positive decisions in the EU in 2011 was 24 per cent. The first ten countries of origin of asylum-seekers which have been

[28] See at: www.libertaciviliimmigrazione.interno.it/dipim/site/it/documentazione/statistiche/politiche_immigrazione_asilo/Dati_su_sbarchi_immigrati_al_31_7_2010.html (accessed 6 March 2014).

[29] See at: www.interno.gov.it/mininterno/export/sites/default/it/sezioni/sala_stampa/notizie/immigrazione/0000070_2011_09_29_informativa_Viale_al_Senato.html (accessed 6 March 2014).

[30] Blue border is any external water border (maritime, river, or lake).

[31] Data provided by the Ministry of the Interior to the Praesidium project.

[32] See at: www.unhcr.it/news/100000-sea-arrivals-to-italy-in-2014-over-50-percent-of-them-are-fleeing-war-violence-and-persecution-it-is-necessary-to-provide-alternatives-to-the-perilous-sea-crossings (accessed 8 September 2014).

[33] At the IOM Equi-Health National Consultative Committee, Palermo 8 July 2014.

recognized as refugees in 2011 were African (Eritrea, Somalia, Sudan, Ethiopia, Ivory Coast) and Asian (Afghanistan, the Islamic Republic of Iran, Turkey, Pakistan and Iraq) (SPRAR, 2012). In 2012, applications for international protection were over 17,300, about 20,000 less than in 2011. **In the first nine months of 2013, Italy had 18,780 asylum applications, a figure already exceeding all applications of 2012** (SPRAR, 2013). According to UNHCR data, about 24,500 claims were registered during the first six months of the 2014, almost identical to the total number of applications lodged during the entire previous year (25,700) (UNHCR, 2014).

3. METHODOLOGY

The selection of sites and centres visited in Italy was driven by data and information collected in the desk review prior to field work and after consultation with national stakeholders, partners and IOM Rome based on the following criteria:

- *Migration flows*: to cover the route of different migration flows and nationalities in the country of destination. Sicily was the region most affected by landings in 2013. Prior to the field visit, the number of arrivals[34] had increased not only in Lampedusa (from 3,624 in 2012 to 13,975 in 2013), but in many other areas of the island as well. In Ragusa, for example, landings hade increased from 606 (2012) to 3,330 (2013); in Siracusa from 791 to 13,975;[35]
- *Management type*: to cover different types of management and types of facilities for migrants' reception.

The range of target groups involved during the assessment[36] was meant to gather information and perceptions from key informants involved during the whole reception process, being health professionals – HPs (both at senior and first line level); law enforcement officers – LEOs (both at senior and first line level); CSOs (including Church representatives, local authorities, NGOs, media); and migrants.[37] Active engagement of stakeholders from many sectors, civil society and local administration was therefore continuously sought and meetings held with local administration and authorities, including Local Ministry of Interior Authority (*Prefettura*), *Azienda Sanitaria Provinciale* (Local Health Authority), NGOs (Emergency, Italian Cultural and Recreational Association (ARCI), Association for Juridical Studies on Migration (ASGI), *Fondazione Integra/Azione*, Caritas, Red Cross, migrant associations), hospitals, migrants within and outside the centres, for a total of around 100 interviews (Table 1).

The field visit at each site started with a stakeholders meeting that gathered the four profiles covered in the analysis. After the stakeholders meeting, the assessment team continued with visits to various sites and data collection. A mixed research method was used during the assessment, including in depth-interviews, focus-group/stakeholder meetings and observational analysis.

Prior to each interview/focus group, information regarding the Equi-Health project was provided to the participants. Informed consents were secured and whenever allowed, the interviews were audio recorded if possible.

[34] This data cover the period January–October (2012 and 2013). According to UNHCR data, in 2013, Italy had 27,771 asylum applications, while in 2012 the figure was 17,352.

[35] However, it has to be noticed that irregular migrants entering Italy by sea are a minority if compared to those entering crossing green borders (around 5–15% in the period 2000–2006, CLANDESTINO, 2009).

[36] Ethical review clearance was obtained and the fieldwork activities complied with international, European and national standards regarding access to information, voluntary character of participation, informed consent process, confidentiality, anonymity and data protection.

[37] Some limitations have been encountered in the number of Law Enforcement Officers interviewed, especially at the operational level, although authorization at Ministerial level had been released to the research team. In Caltanissetta, it was not possible to interview the directorate of CARA/CIE centre, as well as most of the professionals working in the centre because the succession of another NGO in the management of the centre in the same days of the field visits.

National Consultative Committees (NCC) were held in Rome on 5 July 2013 before the field visit in order to adapt methodology to national context and Local Consultative Committees (Caltanissetta, Catania, Siracusa) as well as NCC in Palermo on 8 July 2014 after the assessment in order to validate findings and recommendations for finalizations of the SAR.

Table 1: List of interviews conducted and site visited

Profile	Total number of interviews	Sites Visited
Law Enforcement Officers	8	➢ CIE, Contrada Pian del Lago (CL) ➢ CDA/CARA women/family, Contrada Pian del Lago (CL) ➢ CDA/CARA men, Contrada Pian del Lago (CL) ➢ Caltanissetta ➢ CARA Mineo (CT) ➢ Catania ➢ Caltagirone Hospital (CT) ➢ Caltagirone ➢ Cannizzaro Hospital (CT) ➢ Garibaldi Hospital (CT) ➢ Ad hoc centre mix « Umberto I », Siracusa ➢ Ad hoc centre UAM "Papa Francesco", Priolo (SR) ➢ SPRAR Siracusa ➢ Umberto I Hospital (SR) ➢ CPSA, Pozzallo (RG)
Health-care Professionals	29	
Migrants	32	
Civil Society Organizations	33	

Source: IOM Equi-Health project.
Note: CL=Caltanissetta; CT=Catania; SR=Siracusa.

3.1. Limitations

- Due to a necessary selection for the assessment, the team was not able to visit Lampedusa, which remains one of the main landing places in Sicily. The three main reasons for this were that: 1) the reception centre was under refurbishment during the period of field visit; 2) the Lampedusa model has been already analysed in the past years, and it results to be a well-known type of management; 3) new routes have been identified in Eastern Sicily (Siracusa and Catania), which indeed become ones of the main landing places in the following months and during the 2014.
- There were some difficulties in interviewing a sufficient number of Law Enforcement Officers, especially at the operational level, although authorization at Ministerial level had been issued to the research team.

- In Caltanissetta, it was not possible to interview the manager of CARA/CIE centre, as well as most of the professionals working in the centre because another NGO was about to take over and substitute in the management of the centre during the days of our field visit.
- No minors were interviewed due to locally stated ethical consideration.
- We received checklists from three out of the five centres visited. It is worth noting that the documents were filled out and transmitted a full few months following our visit. In the case of the CIE/CARA "Contrada Pian del Lago" in Caltanissetta, the facility manager changed a few weeks after the field visit. Information submitted in the checklists was collected and reported by the facility's own manager and staff.

4. FIELD WORK

I. POLICY AND LEGAL FRAMEWORK

I.I EU and national/local legislative framework on interception/rescue at sea/green border

At European level, Italy became a full Schengen member on 1 April 1998 and for this reason applies Regulation (EC) n. 562/2006 of the European Parliament and of the Council of 15 March 2006 establishing a Community Code on the rules governing the movement of persons across borders (Schengen Borders Code). With the Decree Law n.89/2011, Italy has incorporated in its normative framework EU Directive 2008/115/EC which establishes common standards and procedures for Member States for returning illegally staying third-country nationals.

At national level, **the first comprehensive legal framework on migration was put in place in 1998 by the "Turco-Napolitano" Law 40/1998**. The Legislative Decree n. 286 of 25 July 1998 contains *Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero.*[38] The Unified Text includes provisions related to irregular immigration (Art. 12) and establishes the administrative expulsion both for over-stayers and for migrants entering Italy illegally (Art. 13). Art. 14 further provides for administrative detention for irregular migrants (as well as asylum-seekers) in specified facilities.

The Unified Text, and its subsequent modifications, **guaranteed some basic rights for irregular migrants, including health care and education.**

A major amendment to the Unified Text in 2002 (the so-called "*Bossi-Fini"* Law (Law 189/2002)) framed immigration principally as a problem of public order and led to the development of stronger measures to fight irregular migration, by placing more emphasis on removals, establishing longer periods of detention and increased penalties for migrants who failed to comply with the removal orders. The Bossi-Fini Law was fully implemented in 2005.

This approach was further consolidated by the so-called **"**Security Package**"** (Law 92/2008, and Law 94/2009), which aimed to fight "*widespread illegality linked to illegal migration and organized crime.*" Key highlights of the Security Package were that the criminalization of irregular immigration, of aiding and abetting irregular migration (covering such actions as providing housing or employment to irregular migrants), and of prohibited re-entry, as well as facilitated expulsion proceedings and the legalization of extended detention periods (up to six months). Furthermore, an irregular migrant status became an aggravating factor in the commission other crimes.

Italian law differentiates between "illegal" and "irregular" migrants; the former being defined as those who entered Italy without any authorization, whereas the latter as foreigners who entered Italy legally but who subsequently no longer satisfied the requirements for continued stay.[39] Neither group is authorized to stay in the country and, according to the legislation in

[38] The Unified Text of the Provisions Regarding Immigration Control and the Norms on the Condition of Foreign Nationals.

[39] Throughout this report it will be used only the term "irregular migrants" for both categories, see the leaflet on

force,[40] must be immediately turned back at the border or expelled unless it is necessary to rescue him/her, to further check his identity or nationality, or to acquire travel documents, or when carriers are not available.

Italy recognizes the right of asylum in the Constitution (Art. 10), but does not have a comprehensive law on the subject, and refers mainly to European legislation, especially the transposed[41] **"Reception Conditions" Directive** (Directive 2003/9/EC), laying down minimum standards for the reception of applicants for asylum in Member States. The transposed Directive 2003/9/EC provides for the prohibition of collective expulsions, including in this term any form of rejection at the frontier or forcible removal from the territory which does not permit the individual identification of the person and thus the proposition of an asylum application, or other form of international protection or recognition of a victim of torture or other inhuman or degrading treatment, or the detection of minors.

Italy has taken steps to complete the convergence of the internal with the European legislation mainly with the Legislative Decree n. 251 of 2007 and Legislative Decree n.25 of 2008, the first for the transposition of the Directive 2004/83/EC (**Directive "qualifications"**), the second of the Directive 2005/85/EC (**Directive "procedures"**).

Within European legislation, which as mentioned previously is the main point of reference for asylum procedures in Italy the **Dublin Regulation is the law provision most directly and significantly affecting** the living conditions of many asylum-seekers. Under the Schengen system, any irregular migrant who is registered in Italy will be returned to Italy even if he moves to another country within the EU. In the context of undocumented and irregular migrants, this can create a de facto situation where irregular migrants remain stuck in Italy. The field visit has made clear that many migrants, especially of Syrian origin, arriving on Italian shores in 2013, have refused to be voluntarily identified in order to avoid the consequences of the Dublin system. They hope instead to be able to continue onto other European countries where they hope to join friends or family, and/or where they believe there are better conditions and chances for asylum-seekers than in Italy. This has also been recently reported by the Italian press.[42]

I.II Legislative and financial framework of open/closed centres

In cases where migrants cannot be returned immediately, they will be referred to detention facilities, as stated by the Art. 14 of the Unified Text:

> *"When it is not possible to immediately run the expulsions trough the escort to the border or refoulement, because it is necessary to proceed to the relief of the stranger, further investigations regarding his identity or nationality, or the acquisition of travel documents, or for unavailability of the carrier or other*

terminology produced by the Platform for International Cooperation on Undocumented Migrants (PICUM). Available from http://picum.org/en/our-work/terminology/

[40] Leg. Decree N. 286/98 called "Consolidated Text on immigration" (TestoUnico sull'Immigrazione), articles 10–17 and Directive 2008/115/EC.

[41] Through the Legislative Decree n. 140 of 2005.

[42] See press article : Profughi siriani, Italia impreparata Unica salvezza fuggire di nuovo - Inchieste - la Repubblica http://inchieste.repubblica.it/it/repubblica/rep-it/2013/10/16/news/clandestini_i_profughi_siriani-68739999/ (accessed 26 May 2014).

suitable means of transport, the questore states that the foreigner is detained ***for the time strictly necessary at the nearest detention or assistance centre****, among those identified or established by decree of the Minister of the Interior, in consultation with Ministers for Social Solidarity and the Treasury, Budget and Economic Planning." (*Art. 14.1)

Under article 2.1 *"migrants present at the border or in the territory, enjoy the fundamental human rights provided by national law, international conventions and by principles of international law."* Article 14.2 states that conditions of administrative detention should ***"ensure the necessary assistance and the full respect for their dignity****."*[43]

The Consolidated Text (Art. 11.6) states the need to provide specific assistance to those who are newly arrived in the area, in particular with regard to potential asylum-seekers. It provides for the creation, at the border crossing points, of reception services which can provide information and assistance to foreign nationals who wish to apply for asylum or to enter Italy for a stay of longer than three months. These services operate only at border crossing points, and are not present in all the affected areas of landings.

The reception system of irregular migrants arriving by sea in Italy is therefore structured through an **articulated system of centres for reception and detention**, as reported in table 2.

New type of centres (hereby called **ad hoc centres**),[44] which do not fall into the above mentioned categories, can be by local authorities (**Prefettura**) under the so-called "Apulia law"[45] as temporary structures aimed at responding to the primary needs of migrants. No clear-cut regulation as to how long people can be housed at these centres currently exists. The urgency that characterizes the nature of these facilities, together with the scarce economic resources allocated for migrant intake and medical and psycho-social assistance, adversely impact daily life of migrants and the coordination among different stakeholders/phases of the reception process.

Minors cannot be expelled. In some cases, according to the best interests of minors, they can be included in projects of assisted repatriation. An unaccompanied minor (UAM) must be admitted to the territory and can legally reside on Italian soil receiving a residence permit "*per minore età"* (for underage persons) and once detected in the country needs to be placed in a safe place (*luogo sicuro*). At the same time, the minor has to be referred (as well as to the Directorate General) to the *Tribunale dei minorenni* (Tribunal for minors) and to the *Giudice tutelare* (judge for the guardianship) for guardianship assignment proceedings.[46] Migrant whose underage status has yet to positively be established are to be treated as minors until the conclusion of the tests necessary to ascertain their real age.

[43] Presidential Decree n. 394 of 1999, Art. 21.2, further states that detention centres should provide detainees essential health services, activities for their socialization and freedom of worship.

[44] After the field visit, their denomination is CAS – Centro Accoglienza Straordinario - Italian Ministry of Interior-Dipartimento per le Libertà Civili e l'Immigrazione "Circolare 19 Marzo 2014". However, this document indicates that any agreement with the structures should end by 30 June 2014.

[45] Law n. 563/1995.

[46] Art. 9.1 Law 184/1983.

Table 2: Detention and Reception Centres, Italy

Acronym	Type of Centre	Legislative Framework	Main features
CSPA	First Aid and Reception Centre *(Centro Primo Soccorso e Accoglienza)*	//	➢ Are arranged near to the main places of landing, where foreigners receive first aid. ➢ They accommodate migrants only for the time needed to transfer them to other centres (within around 24/48 hours)
CDA	Reception Centre *(Centro di accoglienza)*	Law n. 563, 29 December 1995 – called "Apulia Law" (*Legge Puglia*).	➢ Are designed to ensure a first reception to irregular migrants for the definition of administrative procedures relative to their status in Italy. ➢ For this reason, reception should be limited to the time "strictly necessary" to provide first aid and the legal status.
CARA	Reception for Asylum-Seekers *(Centri di Accoglienza per R. Asilo)*	➢ Presidential Decree no. 303/2004 ➢ Leg. Decree n. 25, 28 January 2008	➢ Are facilities where asylum-seekers awaiting identification and access to the refugee status determination procedure ➢ The period of stay should be longer than 20–35 days
CIE	Identification and Expulsion Centres *(Centri di Identificazione ed espulsione)*	➢ D.Lg 92/2008 ➢ TU 286/98 ➢ L.189/2002	➢ Are facilities for the detention of irregular migrants for the time necessary to carry out the expulsion order. CIE regroup two types of migrants in the same facility: those who have been detected in the territory without appropriate residence permit (both at the borders and within the territory) and those who have been arrested for any violation of the law and who, after having served the term of imprisonment, has received an order of expulsion. ➢ Law 129/2011 extended the maximum term of detention in a CIE from 6 to 18 months.
SPRAR	Protection System for Asylum-Seekers and Refugee *(Sistema di Protezione per*	Law n.189 in 2002.	➢ The SPRAR is a secondary reception system based on a joint effort by central and local authorities, also involving civil society organizations ➢ The approach is defined as "integrated reception": alongside socio-psychological support, legal guidance,

	Richiedenti Asilo e Rifugiati)	linguistic-cultural mediation services, SPRAR provides job orientation and professional insertion services as well support in finding accommodations. ➢ The period of stay should be no longer than 6 months.

Source: IOM Equi-Health project.

In 2011, the maximum **length of stay** in the CIE was extended from 180 days (l. 94/2009) to 18 months[47] following the amendment[48] to the Consolidated Immigration Act, which transposed the EU Return Directive (2008/115/CE). This change has worsened the situation of migrants within these detention-style centres.[49]

The assessment revealed that in fact the maximum stay limitation is rather notional, as in reality people in the CSPA remain up to few months[50] and in the CARA up to 1.5–2 years, due, inter alia, to the bottlenecked process of asylum application and processing. Angst is prevalent as most migrants receive little information as to asylum-seeking process hold-ups and its impact on the centre's atmosphere and staff. Those asylum-seekers who have received information about their rights or were able to raise them independently expressed their frustration with the protracted procedure, which according to Italian law[51] guarantees an interview within 30 days after the application is initially submitted, and then the final decision three days after the interview has taken place. Migrants considered six months in the centres as a sort of maximum time to spend in the CARA for the analysis of the refugee status, said an asylum-seeker:

"If this period will end without an answer, I will consider this as a symbol of the conclusion of this agreement, and I will not follow anymore the indications I will receive."
(Migrant)

Reception facilities are **funded** by Central Government through a multilevel mechanism. Responsible for central coordination of all these kind of facilities – including the supply and planning as well as the publication of the tender for the management of the centres – is the Ministry of Internal Affairs (MoI – *Ministero dell'Interno*), whereas MoI local bodies (*Prefetture*) are responsible for local reception process, including the appointment of the manager of the centre, which usually are private entities and NGOs, and the monitoring of the centres. The entity appointed as *manager* of a centre is responsible for its daily management, generic assistance (including linguistic/**cultural mediation**, information on migration law), **medical assistance, psycho-social assistance, hygiene and living conditions**, maintenance of the structure, administrative and financial report and any arrangements with subcontractors (Annex III).[52]

[47] It has to be noticed that in October 2014 the maximum length of stay has been reduced to 3 months.
[48] Law n.129/2011.
[49] According to the association *Medici per I Diritti Umani*, the extension of the time of detention has not produced any tangible effects in terms of effectiveness of expulsions, but it has notably worsened living and health conditions of migrants. Medici per idirittiumani, *Arcipelago CIE,* May 2013.
[50] See Checklists Annex VI, question 5–6.
[51] Decreto Legislativo 28 gennaio 2008, n. 25.
[52] The specifications of the tender and the services required in each centres have been approved with a Ministerial Decree on 21 November 2008.

The specifications for the management of the centres follow a negotiating approach, which gives more responsibility to the manager of the centres to provide the needed services within an annual budget not any more based on a pro-die/pro-capita fee. Selection procedure takes into consideration **the cheapest bid offered. Medical assistance is therefore described, yet not specified nor with specifically devoted budgetary line (left at the discretion of management).** The budget, however, is provided *a posteriori*, therefore the manager of the centre has to anticipate costs for the following three months, which creates obvious difficulties in staff management.

Regarding the SPRAR system, the procedures for accessing the funds, as well as the directions for the proper management of reception, protection and integration services, are indicated in the "Guidelines" attached to the Ministerial Decree of 22 July 2012, and fully described by a special operational manual edited by the *Servizio Centrale*. The average yearly total funding per ordinary place was EUR 4,500, of which 3,500 funded by National Fund and the remaining EUR 1,000 funded by local municipalities.[53] At the moment of the field visit the number of places available in the SPRAR was about 3,000.[54] Following the chief of Department for Civil Liberties and Immigration Decree dated 17 September 2013, the number of places available in the SPRAR system for the period 2014–2016 will be brought to 16,000. According to SPRAR Report for 2012–2013 data**, in the period 2012–2013 there has been an increase of places** by 300 per cent, with 9,356 places been made available at the end of 2013. Sicily has the largest share (over 22%) of total funded places in Italy.

A joint circular of the Ministries of Interior-Labour, issued on 24 April 2013, clarifies the ordinary procedures regarding the protection systems of **unaccompanied minors** and underlines that the placement of the minor in an authorized and accredited reception centre requires his being a ward of the social services of the municipality on whose territory the facility is located. Municipalities have the responsibility over UAM, but to support the municipalities in meeting the housing and accommodation costs for unaccompanied minors, with Art. 23, paragraph 11, of Law Decree n. 95 of 6 July 2012, converted, with amendments, by Law n. 135 of 7 August 2012, it has been established in the Ministry of Labour and Social Policy the "*Fondo Nazionale per l'Accoglienza dei Minori non Accompagnati*" (national fund for unaccompanied minors), which ideally concur with one third of the costs related to UAM. In October 2013 the government increased funding by 20 million[55] while in December 2013, new guidelines for the reception of unaccompanied minors were adopted through the 19 December Decree of the General Director of Immigration and Integration Policies.

I.III Entitlements to and health care service provisions

In its Constitution, Italy does safeguard **health as a fundamental right of the individual and as a collective interest, in addition to** being party to multiple international Covenants committing to

[53] See "SPRAR 2011–2013 categoria "ordinari": Progetti ammessi" for the list of funded municipalities during the period 2011–2013 at: www.interno.gov.it/mininterno/site/it/sezioni/servizi/bandi_gara/dip_liberta_civili/ (accessed 24 May 2014).

[54] 450 of which dedicated to vulnerable persons and 50 to vulnerable persons with a mental disease and 128 were the local authorities involved.

[55] See at: www.gazzettaufficiale.it/atto/serie_generale/caricaDettaglioAtto/originario?atto.dataPubblicazioneGazzetta=2013-12-14&atto.codiceRedazionale=13A10167&elenco30giorni=false

the right to health for all, including those in irregular situation.[56] Moreover, in the same constitutional article (32), the Italian Republic secures free medical care to the indigent. Health professionals cannot therefore denounce and refer the irregularity of a migrant to the competent authorities, since it would obstruct the effective enjoyment of the right to health.[57]

Health Migration policies in Italy started in 1986, when the legislation first attributed to regular migrants a proper status in terms of fundamental rights, including health protection (see Law n. 39/1990 (Martelli), Law n. 489/1995 (Dini). With Law n. 40/1998 (Turco-Napolitano) rights in terms of health protection and of access to essential health care were granted also to irregular migrants, and access to prevention programmes was also included. The National Health (*Piano Sanitario Nazionale*-PSN) 1998–2000 for the first time introduced health protection for migrants as a policy target for the National Health Care Service (*Servizio Sanitario Nazionale*-SSN) introducing the an integrated approach to migrants health and health care services including ethical, psychological and cultural aspects.[58]

Migrants' access to health care is regulated by Art. 34 and 35 of the Consolidated Text. In order to access health care services, **regular migrants** must register with the Italian National Health System in order to obtain their health card. **Asylum-seekers** can register in the health system as well, and receive health care on equal ground with Italian nationals and predicated on the same conditions.[59]

The SSN was established in Italy in 1978 with Law N. 833/1978. The system was designed in order to guarantee to all citizens universal access to equitable provision of health services, in implementation of Art. 32 of the Constitution. The SSN[60] provides to all citizens – for free or subject to co-payments – a number of activities, services, and benefits called *Livelli essenziali di assistenza* (LEA - Essential levels of care),[61] regardless of income and place of residence. Citizens contribute to health-care system through general taxation, based on progressive income tax, if

[56] IOM/OHCHR/WHO recent publication International Migration, Health and Human Rights. Available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=41_7&products_id=976

[57] Art. 35.5 of the Consolidated Text.

[58] A list of regulations over time is available at the website of the Italian Society for Migration Medicine (www.simmweb.it) (accessed March 2014).

[59] See also Art. 27 of Legislative Decree N. 251/2007, which refers exclusively to recipient of international protection. The National Health System (SSN) provides to all citizens – for free or subject to co-payments – a basket of services and benefits called *Livelliessenziali di assistenza* (LEA - Essential levels of care), regardless of income and place of residence.

[60] State budget law determines annually the overall level of resources of the SSN. Sources for overall budget are: State budget; Revenues from general income taxation collected at National and Regional level; Special funding accruing to Special Statute Regions and Autonomous Provinces of Trento and Bolzano; own revenues of Local Health Authorities (ASL) (as ticket and revenues from intramural performances of their employees). www.salute.gov.it/portale/salute/p1_5.jsp?lingua=italiano&id=66&area=Il_Ssn&menu=privata (accessed 27 March 2014).

[61] The Essential levels of care are a positive list of services set at the national level with the Decree of the President of the Council of Ministers 29 November 2001, which entered into force in 2002. The reform of Title V of the Constitution also establishes the possibility for regions to use their own resources to provide additional services or functionality (but never less) than those included in the Essential level of care. Moreover, LEAs are linked to yearly available funding for public health care.

not entitled to be exempted.[62] A system of co-payments, called ticket, has been introduced in 1982 for an increasingly high number of services included in the Essential levels of care.

Irregular migrants[63] are entitled to access preventive, urgent, and essential treatment of illness, as well as care considered necessary for public health reasons.[64]

> *"Foreign nationals staying on the national territory without regular permits of stay have a right to seek medical assistance in public health institutions or accredited private facilities operating with the national health service, for urgent or primary outpatient and hospital treatment, even on an ongoing basis, in case of sickness or accidents, as well as for preventive medical treatment for the safeguard of individual and collective health."* (Consolidated Text, art. 35)

For migrants in an irregular status, access to health care is facilitated trough the assignment of a specific code, the STP.[65] The STP is issued for free by the local health administration (ASL), and is valid for six months (renewable) on the whole Italian territory. Services are provided at no cost for the applicants, but are subject to the expenditure shares (called ticket), with the same conditions as those for Italian nationals. An irregular migrant who finds himself in a situation of poverty can apply for "poverty/indigence status" by submitting a self-declaration to the health authority providing the services.

Children have the right to health care, and to education, psychological, and social services and they can be supported by cultural mediators.[66] Regarding migrants' children, STP is to provide access to "urgent" and "essential" care, i.e. access to family/pediatric counselling, to first aid services, to hospital and local health care facilities.[67] Regarding the reimbursement of benefits paid through the STP, **the competent local health administration must apply to the Ministry of the Interior** for the refund of urgent services provided through the emergency room and of essential services and/or of those requiring continuity of care, provided through inpatient treatment, including diurnal hospitalization (day hospital), or outpatient care. **Regular migrants**

[62] Citizens may be entitled to exemption from payment based on particular situations of income associated with age or social status, and/or in the presence of certain diseases (chronic or rare) or based on the recognition of disability and other special conditions (pregnancy, early detection of certain cancers, detection of HIV).

[63] The STP is valid for third country nationals. EU citizens staying in Italy for a period exceeding three months, with no health care coverage and requirements to be registered as resident have the right to receive urgent and essential care. Ministerial Circular of 19 February 2008. In some regions, such as, e.g., Lazio or Sicily, they can access the SSN through the ENI code ("Europei Non Iscritti" – European not enrolled).

[64] Turco Napolitano law, n. 40/1998 and legislative decree 286/1998, article 35 (3). In particular, are guaranteed: the social protection of pregnancy and maternity with equal treatment with the Italian citizens; the protection of the health of the child; immunizations in accordance with the regulations and in interventions for prevention campaigns collective authorized by the Regions; actions of international prophylaxis; the prophylaxis, the diagnosis and treatment of infectious diseases and eventual reclamation of its focus. Irregular migrants are also guaranteed to the prevention, treatment and rehabilitation from drug addiction, from psychiatric illnesses and, in general, all interventions preventive, curative and rehabilitative.

[65] Temporary residing foreigner.

[66] See the Ministries of Interior-Labour Note, issued on 24 April 2013.

[67] The definition of what cares are considered as "urgent" and "essential" has been done in the circular letter of the Minister of Health n. 5 dated 24 March 2000.

and asylum-seekers are instead signed up for the Italian National Health System, hence costs are under the Ministry of Health responsibility.

Health care assistance is a **shared responsibility between the central, regional and local governments**. Because of its decentralized health-care system, in Italy the implementation of the legislative framework and entitlement to health service provisions **may differ at the regional level**. For example, at the moment not all regions have adopted the State-Regions Agreement containing instructions for a correct implementation of the legislation concerning the health assistance to foreigner populations by Regions and Autonomous Districts,[68] and many still have not granted access to pediatricians to irregular migrant children.

Sicily Region, where the assessment was conducted, has adopted only recently (26 September 2013) the State-Regions agreement, enacted on 20 December 2012, containing instructions for a correct implementation of the legislation concerning the health assistance to foreigner populations by Regions and Autonomous Districts. Before this, the most relevant document at regional level concerning migrants access to health care were the "Linee guida per l'assistenza sanitaria ai cittadini stranieri (extracomunitari e comunitari) della Regione siciliana" (Guidelines for health care to foreign nationals (non-EU and EU) of Sicily Region) issued by the Department of Health of Sicily Region on 17 October 2012.[69]

In terms of social care, at national level Law N. 328/2000 guarantees to individuals and families an **integrated system of interventions of health and social services**. According to Art. 22, the integrated system of interventions and social services is achieved through coordinated policies and performances in the various areas of social life, in order to maximize the effectiveness of resources, prevent duplication of responsibilities and answers too sectorial. However, Law 328/2000 is a framework law, therefore its application varies across regions. During the assessment, this "global approach" has been identified as particularly important, but has also proven difficult to implement, especially for what concerns the identification of responsibility for intervention mainly due to the absence of a fluid and institutionalized exchange between the health services and the social services providers, the scarcity of economic resources and as far as it concerns migrants themselves, the limited or inexistent reference to this group as beneficiary of these actions.[70]

I.IV Discussion Section - I

Asylum Procedure

- The Dublin Regulation creates a situation where migrants who may in fact have a valid asylum claim avoid applying for it in Italy as they believe they will not receive adequate protection or opportunities, as a result of which they remain stuck in the first country of

[68] State-Regions agreement, enacted on 20 December 2012.

[69] Regarding Sicily Region, Law N. 5, 14 April 2009 art. 28 and Decree 4/07/2003 already stated that health care delivery for non EU migrants stating that all people present in the Region territory should be guaranteed with Constitutional rights in terms of equality and right to health, and in terms of free access to health care for indigent people, without any discrimination based on gender, race, language, religion, political opinion, personal or social conditions. The documents indicate as well the structure of the health services to be provided to migrants in view of uniformity with the LEA. Worth to notice the fact that already in the document of 2003, there was a mention on the need of fostering the inclusion of cultural mediators in the health services.

[70] The new guidelines for the implementation of social and social-health policies from 2013 to 2015 in Sicily have been set with the Decree of the President of the Region on 11 November 2013.

arrival, losing the possibility to reach their families or contacts in other EU Member States. During the field visit, it was noticed that many migrants, especially of Syrian origin, have declined to be identified in order to avoid the consequences of the Dublin system. Moreover, they often lack family or community ties in Italy which they may have in other EU Member States. **This situation exacerbates vulnerabilities**[71] **by creating a condition in which persons with valid asylum claims choose not to lodge their application and in practice to be in irregular status, with heightened risk of exploitation.**

- The long **procedure to assess the application on international protection**, due to a limited number of Territorial Commissions[72] in comparison to the number of applications has an impact on the length of period of stay within a reception centre (longer than foreseen by law) and influences the health of migrants, worsening the mental and physical conditions and creating a frustration among migrants and staff in the centres.

Detention and Reception System

- The assessment has highlighted the fact that, at the moment of the field visit, there was not much national "burden sharing" of migrants arriving by sea in Italy so that almost all of them are accommodated in structures in the region of their arrival (Sicily in this case), leading to an acute overcrowding problem within the centres.
- Together with the overcrowding, another consequence of the scarcity of available places is **the shift of the functions of the different centres**: the CPSA and the *ad hoc* centres created to help the migrants in the first hours after the landing become medium-term facilities, while the CARA, where asylum-seekers are expected to remain up to 35 days and remain a year/year and a half, play the role of secondary reception centres. This implying that the centres should respond to the needs for which they were neither designed nor properly equipped (for example, medical care in the CPSA Pozzallo is no longer limited only to the initial health-care needs of migrants, but also assures the necessary treatment for a longer period - 18 days on average, or the CARA Mineo was set up during the Mena crisis when mostly young men reached the Italian shores, a few years later the centre has a baby born every three days, besides being much over capacity in numbers).
- CIEs host two types of migrants in the same facility: those who have been detected in the territory without appropriate residence permit (both at the borders and within the territory) and those who have been served time for criminal offenses and are subsequently awaiting deportation. A documented incongruence in the Italian detention system is the fact that **the identification and processing needed to return a migrant to the country of origin upon completion of a sentence is not done during his or her incarceration,** but afterwards, when migrants are transferred to CIE for additional administrative detention. This is strongly perceived by migrants as an undue and unjust extension of the term of imprisonment.
- The Italian Constitution further provides that personal liberty is inviolable and that no one may be detained without a judicial order of the judiciary bench; according to some

[71] At international level, Italy has ratified the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children; the Protocol against the Smuggling of Migrants by Land, Sea and Air; the 1951 Convention on the Status of Refugees and its 1967 Protocol; the 1954 Convention on the Status of Stateless Persons and the Convention on Action against Trafficking in Human Beings (2010).

[72] In Sicily there are only two Territorial Commissions processing asylum applications, in Trapani and in Siracusa.

prominent legal experts, this in fact renders migrants' detention extrajudicial and therefore unconstitutional.

- Some of the types of centres, however, are used inter-changeably – as is the case with CDA-CARA of Caltanissetta or CPSA-CIE in Pozzallo – with an overlap of structures and functions for the same facility. In these cases it is exceedingly difficult to identify how many places are dedicated to the initial migrant reception and how many are dedicated to the reception of asylum-seekers, and is also challenging to assess if the particular assistance mandated by law is implemented.
- **No legal framework of ad hoc centres means no clear rules regarding withholding and treatment of migrants** within the structure, including reference to health and psychosocial assistance or intercultural mediation or length of stay or the qualifications requested for the Director of the centre. These centres, therefore, do not offer adequate standards of reception, nor medical and psycho-social assistance present onsite. Legal and linguistics assistance is not foreseen neither.
- **In addition, all stakeholders involved – including the institutional ones at the local level such as the Sicily Region and the ASP – are not completely aware of the number, available places and characteristics of the ad hoc centres.**[73]

Reception of UAM

- Unaccompanied minors (UAM), who due to the lack of places in dedicated community and because of a national reception system that cannot identify available places – often remain in CPSA or in ad hoc centres for long periods of time without receiving adequate care. Further, they are exposed to health and social risks (in some cases they are victims of human trafficking).
- Some economic coverage mismatch exists also until the UAM remain in the reception centres: unaccompanied minors are in fact responsibility of the Ministry of Labour and Social Policy and not of the Ministry of Interior, which is responsible instead for the CPSA and the *ad hoc* centre.
- Municipalities, however, cannot often carry the financial burden stemming from UAM care, and so in reality the only steady and reliable source of funding comes from the Ministry of Labour: the end effect being **overall assistance and programme support UAM even less adequate than those for adult migrants.**
- During the assessment many of the stakeholders involved in the reception of unaccompanied minors reported the **absence of a "control room" at the national level** on this issue, citing instead as a good system of coordination between different institutions and different levels (included the national one) the one that had been drawn up in 2011 for the reception of UAM during the North Africa Emergency.[74]
- Another issue related to unaccompanied migrants is the fact that at 18 years old they lose the protection received so far. They therefore risk losing their rights to stay in the country, and in many cases are forced to leave the country.
- It's worth noting that **the Italian legislative framework applied to unaccompanied minors was designed for *Italian* nationality minors** within Italy without assistance and

[73] During the two NCC, the Ministry of Interior representative highlighted that the ad hoc centres have been created out of a concrete need of new places to host migrants, and replied to the indication of missing information and mapping on the centre from the Sicily Region, by saying that from the national level an internal communication to the region on the exact number of ad hoc centres has already circulated.

[74] Circolare del Commissario delegato di Protezione civile – 18 May 2011.

representation by the parents or other adults legally responsible for them. This clearly does not take into consideration additional difficulties with respect to migrant status, language and communication barriers, and asylum application claims, to mention a few.

Access to health care

- In terms of the legal and policy framework related to irregular migrants' access to health care by irregular migrants, the assessment has confirmed that while the access to hospitals and to health care facilities for irregular migrants and asylum-seekers is guaranteed by law, the situation in practice varies significantly among different regions, among different structures and, even among different HPs within the same structure. The high heterogeneity - in law application and in health care provisions among the Italian regions can negatively affect children of irregular migrants. In many regions they still cannot be signed up for SSN, so they do not have the chance to choose a family pediatrician and to receive continuous health care.
- The extremely long asylum application processing times has a direct impact on the access to health care: asylum-seekers need to renew two to three times both their health cards and their extended stay permits (which expire after three months).

- **Lack of knowledge of regulations concerning migrants' access to the health care of the administrative staff of health** organizations is one of the main obstacles detected. In particular, there have been cases where the migrant is not presented the opportunity to sign the declaration of indigence. The assignment of codes STP/ENI (European Not Enrolled) to ensure even to irregular migrants access to health care has been characterized by numerous HPs as a useful and positive operational tool. The main obstacle associated with its use is instead related to the lack of knowledge that irregular migrants have of their rights and duties with regard to access to health services.
  - Migrants staying in detention/reception centres access health care services through the STP code. The assessment noted that this code **is inappropriately used in the CARA**, as asylum-seekers should be in fact enrolled in the SSN. This practice seems to be a conscious choice justified by the intent not to overburden the local health system with high number of requests to join the SSN, especially if revolves around a small city. On the other hand, the use of SSN for migrants in the CIE has been reported as well.
  - The services provided through the STP do not have a high cost and in fact they allow, through prevention, to avoid incurring major expenses for the health-care system further on: *"The cost of STP are low. There are many early visits, but very few tests and hospitalizations. But if I do not give the STP and I do not do the first visit, bronchitis becomes bronchopneumonia then, yes, I have to hospitalize, and the costs go up…"* **(HP)**
  - An example of good practice in the integrated health and social assistance is provided in Catania by the multidisciplinary team constituted by a joint activity of ASP/AUSL 3CT and Penelope association, which works in order to provide an integrated assistance to the migrants, including in the field of ethno-psychiatry. This is made possible thanks to the implementation of a network and a continuous dialogue with the institutions and the associations of the region, including a local University.
  - A recent protocol agreement has been signed between Sicily Region Head of Health Care Administration, Emergency, Red Cross Sicily Committee, Médecins Sans Frontières, signed on 17 April 2014 ("Protocollo d'intesa per la governance delle politiche sanitarie dell'immigrazione in Sicilia") outlined the need for the definition at EU level of a set of standards for essential care to be delivered to migrants in Sicily Regions. The Agreement

follows on Regional Decree 26 November 2013 (on reception of State–Regions Agreement for health care delivery to migrants in Italian regions signed in December 2012) and 6 March 2014 (that regulates for Sicily access to public health care for minors registered with either STP or ENI code).

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

II.I Description of the reception process and coordination

A broad range of stakeholders are involved in Italian migration management. The **Ministry of Interior,** through its Department for Civil Liberties and Immigration, has the key responsibility of civil rights protection, including with respect of immigration, asylum and citizenship.[75] Within the Department, the Central Directorate for Immigration and Asylum Policies is generally responsible for developing migration policies adopted by the Government. Border management falls within the competence of the Central Directorate for Immigration and Border Police (Law No. 189/2002), which is under the Public Security Department of the Ministry of Interior.

The Central Directorate for Immigration and Border Police has the exclusive jurisdiction in maritime activities and gathers and examines information relating to surveillance, and other activities at sea, as well as coordinates interventions (Interministerial decree 14 July 2003). Since July 2004, a specific agreement[76] defines the key procedures and the different competences and responsibilities in coordinating resources regarding irregular migration at sea. Parties to the agreement include *Polizia di Stato* (Police), *Marina militare* (Navy), *Guardia di finanza* (Tax and Customs Police) and *Comando delle capitanerie di porto* (Guardia Costiera).

The **Ministry of Foreign Affairs**, through the Office for Migration and Asylum Policies, is responsible for the development of bilateral agreements[77] in migration matters and for incorporating EU legislation in the field of migration in the Italian legislative framework. The Visa Office of the Ministry is also responsible for determining the relevant visa entry regulations. The Ministry also hosted the Interministerial Committee of Human Rights, which was made up of representatives of relevant ministries in the field of migration policy and has been active till 2012.[78] Reconstituted at the end of 2013, this committee plays, among others, the role of "Focal point" of the national monitoring bodies operating within the international institutions of which Italy is a member, in particular the United Nations and the Council of Europe.

Furthermore, **the Ministry of Labour and Social Policies** – General Directorate of Immigration and Integration Policies works on the protection of unaccompanied minors and integration of third country nationals in the labor market.

[75] Italian Ministry of Interior, See at: www.interno.gov.it/mininterno/export/sites/default/it/sezioni/sala_stampa/notizie/immigrazione/notizia_20088.html (accessed May 2014).

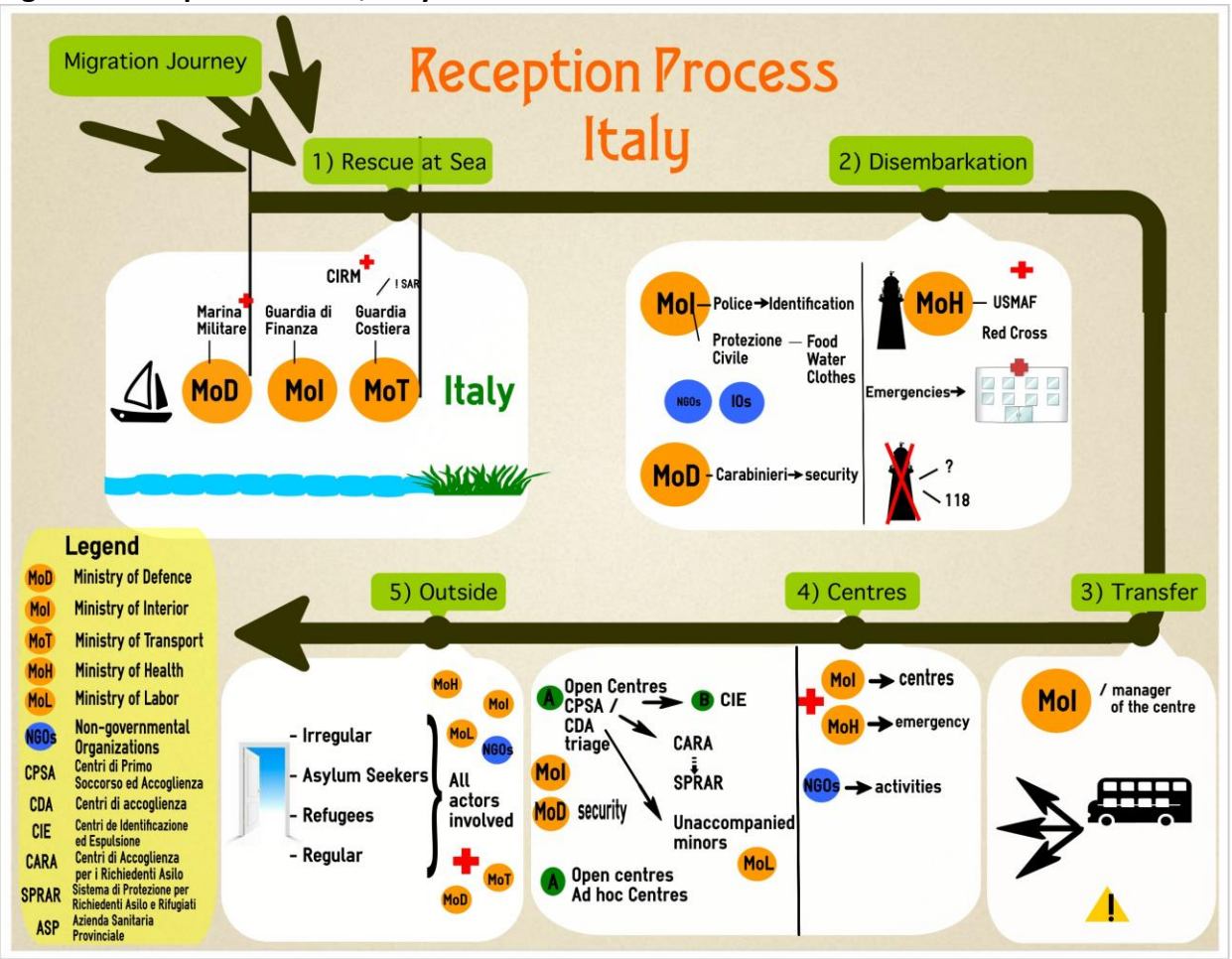
[76] "Accordo tecnico operativo per gli interventi connessi con il fenomeno dell'immigrazione clandestina via mare" of 29 July 2004.

[77] In the interests of externalization of borders, bilateral agreements can contain both measures for readmission, both measures of cooperation between the police forces of the countries concerned. Italy has realized agreement with Algeria, Egypt, Tunisia and Libya. See at: www.integrazionemigranti.gov.it/archiviodocumenti/diritti-fondamentali/Documents/Rapporto%20Access%20to%20Protection_ITALIA_Epim.pdf, pp. 26–31 (accessed 6 March 2014).

[78] It should be noted, however, that Decree n. 95 of 2012 abolished all committees including the Human Rights Committee.

The assessment covered all the phases of the **reception process**, identified as the following segments: rescue at sea, disembarkation, transfer, permanence in a centre, release/integration.[79]

Figure 1: Reception Process, Italy



Source: IOM Equi-Health project.

Search and Rescue

During the **first phase of search and rescue at sea**, a number of entities linked to the MoI (*Guardia di Finanza*), to the Ministry of Transport (*Guardia Costiera*) and to the Ministry of Defense (*Marina Militare*) patrol the sea and intervene upon detecting a vessel with migrants.

The Decree of the Minister of the Interior 19 June 2003 (Measures of activities to counter illegal immigration by sea) allows patrol activities of Italian naval units also in order to postpone boats without a flag in the ports of origin (not in any port), but respecting well-defined procedures and in any case, in any event, all activities must be guided by "the protection of human life and respect for the dignity of the person" (Art. 7), respect for human rights as well defined by national law,

[79] The last phase will be covered in details in another component of the Equi-Health project dealing with access to health care.

European and international level, including the principle of non-refoulement and other rules of the Geneva Convention on the Status of Refugees.[80]

In case of rescue (SAR event), which occurs whenever the vessel is at risk (of sinking or in other emergency), the inter-institutional and overall coordination is guaranteed by the Port Authority (*Capitaneria di Porto).*[81] The port of disembarkment is indicated to the *Capitaneria di Porto* by the MoI. In case of people in need of immediate health care, the maritime army has medical staff already on board, while in the other cases, a first aid is provided if necessary with the support of health professionals from Rome (via radio trough the CIRM, *Centro Internazionale Radio Medico*). In general, all vessels (including private ones) near a boat in distress have the duty to help it, if possible, or to signal the boat's position to the authorities.[82] As reported by the *Capitaneria di Porto* met during the field visit, it happens more and more frequently that migrants equipped with satellite phones themselves send out an S.O.S.

In case of a rescue intervention or boat interception, the *Capitaneria di Porto* alerts the local *Prefettura* and the *Questura* (the police local headquarter) specifying number, sex and age of migrants and their health conditions, especially if an urgent intervention is necessary. Generally is the *Prefettura* to coordinate the first assistance operations and to alert the ER of the near hospitals.

The assessment showed that rescue operations are well regulated and tasks clearly defined for each of the agencies involved. The main difficulty with respect to this first phase is to mediate between different priorities (vulnerable people, unity of the family, health condition). Family members may be inadvertently separated at this stage, with the real possibility that once ashore they end up being sent to different centres.

It has to be noticed that after the field visit, the Mare Nostrum rescue Operation started (October 2013) with the participation of personnel, naval units and aircraft from the Italian Navy, the Army, Air Force, *Carabinieri*, Customs Service, Coast Guard, as well as Police officers on-board the Units, and other national agencies, with the aim to control migration flows.[83]

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[80] Articles so provide. 9:19 of the Additional Protocol against the Smuggling of Migrants by land, Sea and Air of the Convention against transnational Organized Crime, adopted by the General Assembly 15 November 2000 and 31 May 2001, ratified and made enforceable by law 16 March 2006, n. 146.

[81] Since July 2004, a specific agreement specifies the key procedures and the different competences and responsibilities regarding irregular migration at sea. Subscribers of the agreement include *Polizia di Stato* (Police), *Marina militare* (Navy), *Guardia di finanza* (Tax and Customs Police) and *Comando delle capitanerie di porto* (Guardia Costiera) ("Accordo tecnico operativo per gli interventi connessi con il fenomeno dell'immigrazione clandestina via mare").

[82] Art. 18 and 98 of the Convention Montego Bay, ratified and enforced by Italy with the Law 689/1994, and the Hamburg Convention, ratified and implemented Italy with Law 147/1989.

[83] As reported by the Italian Navy Army ("*Marina Militare*") website: "The Italian Navy provides the following:
• 1 LPD Amphibious Ship in charge of Command and Control. The Unit is fitted with first aid equipment, comprising landing craft, and rigid keel boats. The unit can host onboard authorities representing the National Agencies involved in the operation;
• 1–2 Maestrale Class frigates, with an AB-212 helicopter each;
• 1–2 Costellazioni/Comandanti Class Patrol Boats, which can host onboard a Minerva Class AB-212 helicopter, one in charge of surveillance of fishing boats;
• 2 EH-101(MPH) helicopters onboard the Amphibious Ship, deployed on the ground in Lampedusa/Pantelleria/Catania, if necessary;

Disembarkation

Together with *Prefettura* and *Questura*, other actors are involved in the **disembarkation phase**: the ASP and, at the official enter/border point, the USMAF – *Uffici Sanità Marittima Aerea e di Frontiera* (Office of Maritime and Border Health) for the MoH, the *Forze di Polizia (*especially *Carabinieri, Polizia, Guardia di Finanza, Vigili del Fuoco),* the *Protezione Civile* and representatives of international organizations (IOM, UNHCR) or NGOs (such as Italian Red Cross, Save the Children or local NGOs). The *Prefettura* is responsible for the coordination. While *Police* performs a first identification*, Protezione Civile*, international organizations and NGO's representatives would be providing first support to migrants. In particular, staff members of the Praesidium[84] project are present in most points of arrival in order to collaborate in the identification and referral of asylum-seekers, children, victims of trafficking and other vulnerable migrants to appropriate services and procedures in the first phase of arrival.

Procedures for health assistance at arrival differ if the vessel arrives at ports considered as official point of entry or not. In the former case, first medical aid and screening is performed by the USMAF, in collaboration with ASP and NGOs. Migrants in need of specific health assistance are referred to the nearest hospital. If the vessel arrives directly at non–official border checkpoint, an immediate assistance is more difficult to organize and the procedures do not always follow a consistent pattern. The emergency unit intervenes to provide first medical assistance, although an immediate support is rather difficult to guarantee and the management of new arrivals is often carried out with ad hoc measures.

Another distinction to be made is that between places that have long been points of disembarkation of migrants (such as Pozzallo) and places that have only recently become such (Siracusa) or that have only occasional landings (Catania). In the latter cases the absence of standardized procedures is the source of many difficulties in providing adequate first aid to migrants.

Transfer

The **transfer** from the disembarkation point to the centres usually occurs by bus provided by MoI and escorted by *Carabinieri* or Police. The assessment has underlined that in many cases **the list of migrants (drafted by *Questura*) which accompanies migrants to the centres, is not precise,** therefore the personnel of the centres is obliged to revise it and that the manager of the centres is not always promptly informed of the arrival of migrants ahead of time.

A serious concern in ad hoc centres is that the list of medical clearance done by USMAF often gets lost during the transfer and does not arrive at the centre. Furthermore the transport to the centre and from a centre to public hospital can also be a matter of concern for the lack of

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- 1 P180 aircraft equipped with Forward Looking InfraRed –FLIR, deployed on Lampedusa;
- An Italian Navy Coastal Radar Network Automatic Identification System – AIS of merchant vessels.
- A Coastal Transportation Vessel for logistic support;

In charge of the air-sea operations is Rear Admiral Giuseppe Rando from ITS San Marco.

Onboard the Italian Navy units engaged in the operation are also representatives from the State Security Department - Italian Border Patrol and Immigration Main Office, in charge of improving the control procedures on the migrants rescued. Available from www.marina.difesa.it/EN/operations/Pagine/MareNostrum.aspx (accessed 13 September 2014).

[84] In Sicily (Lampedusa and other areas of arrival) and Puglia at major landing sites, the partner organizations of the Praesidium Project (UNHCR, Save the Children, Red Cross and IOM) have assisted the authorities in carrying out part of the functions assigned by law to the services described in art. 11.6 of the Consolidated Text.

resources – and not clear responsibility between the structures involved, especially in the case of ad hoc centres. Sometimes migrants take advantage of the confusion, and in fact escape from custody while being transported to and from the hospital.

The discharge from the hospital, especially if the migrant has been referred immediately after disembarkation, can create obstacles as to allocate the person in the right facility, as he/she was not included in the official list for the entrance in one or another centre, and produce an additional financial burden for the hospital centres.

Detention/Open centres

After their first identification, migrants are transferred in a CPSA, in CDA or in ad hoc centres and, secondary, from there to **different centres** according to their particular needs and migratory experiences.

Special protection and assistance are granted for UAM: while unaccompanied minors who have claimed asylum are accommodated in specific SPRAR projects according to their capacity (which is limited at the moment), unaccompanied minors are most often placed in residential care facilities for children that can accommodate a small number of minors located in the whole national territory or in ad hoc centres for minors. Another possibility is given by placement in foster care, but this is not widely used in practice. However, in practice, due to the **scarce number of available places**, especially relevant for some of the most vulnerable migrants such as unaccompanied minors, people are sometimes housed in those centres that have available places without duly consider their specific needs. NGOs, like Save the Children (Lampedusa), ASGI and ARCI (Siracusa), play an important role in the first reception of unaccompanied minors and in the effort of placing them in appropriate structures along the national territory.

In addition to the centre management staff itself, agencies such as *Polizia, Carabinieri*, Guardia di *Finanza* operate in order to maintain law and order, while the Army as just a surveillance task in the CIE; *Polizia* in Caltanissetta and Mineo centres operates also as *Ufficio Immigrazione* (migration office), and is responsible for identification and asylum procedures.

Outside in the community

Finally, for the last phase of the reception process – **outside the centres** – NGOs and media during the assessment in Caltanissetta expressed worries about **reduction in funding** for projects aiming at the subsequent **migrants' integration** in local community. This not only has a direct negative effect on migrants, but creates a twofold effect in the society: on one side the interaction with the community is reduced and on the other side the information about migrants in the community is mainly linked to negative events, such as episodes of violence or crime, corroborating to create a sort of a *"social scaremonger"* effect. A representative of the media sadly commented that without other integration projects *"good stories to tell ended."*

Another factor that affects the integration of migrants is the kind of reception they receive: if they are inserted in a SPRAR project they can access personalized paths of inclusion, based on job training, language courses and housing opportunities. People released by a CARA instead dispose of fewer instruments: both in Caltanissetta and in Mineo CARA, some activities of job training, language courses are organized but, as reported by migrants and CSO, they are not adequate and the local territory is not prepared to absorb a large number of migrants into the labour market.

II.II Public Health in Border Communities

In terms of public health in border communities, the findings of the field visit show that at the moment of disembarkation local authorities are immediately informed by USMAF in case of relevant risks for public health. USMAF (deferring to Ministry of Health) at the designated point of entry (harbours), is responsible about International Health Regulation, Protezione Civile is responsible for emergencies.

In addition, since 2011, reception facilities are obliged to send a **syndromic surveillance daily report to local health authorities and them to the MoH** (Annex VII). Information sent is collected on the centre of reference (physician in charge, contacts, dates of reporting and date of reference of data reported) and, in aggregate form, the number of subjects for syndrome and age group. In CPSA, CDA, CARA and CIE the registered cases of outbreaks (mainly TB, scabies and meningitis) have not been significant over time, and when occurring were brought under control with prophylactic measures. No system of syndromic surveillance exists in the ad hoc centres where on-sites health facilities are not available.

During the assessment, around fifty potentially infected mattresses (due to cases of scabies) were left for days in the courtyard of the ad hoc centre in Siracusa for a specialized company to collect them. The mattresses, without any cover or other protection/signals, were easily accessible to all migrants, including children who played football in close proximity to the mattresses, even jumping on them. Lapses such as this one and the relatively recent history of migrant flow in the territory, increase fear of an infection epidemic among local authorities. The mayor of Siracusa, for example, has formally requested assistance from regional and national governments in relation to public health risks, although he confirmed this was meant to be a preventive measure as up until now there is no clear indication that there has been an outbreak or that one is imminent. As it was reported by the local press,[85] the Local Health Unit of Modica replied to the mayor that between the 25 April and the 1 May no TB cases were reported among migrants and only one case of suspect Human Immunodeficiency Virus (HIV) infection was reported. From January to May 2014 only 4 cases of TB were diagnosed among migrants in Pozzallo CPSA and Comiso CSA out of 6,000 arrivals.

The field visit reported various degrees of **integration of the public health system** in the different phases of the reception process. The role of the ASP/hospitals is particularly crucial during disembarkation, with noteworthy cooperation of NGOs, such as the Italian Red Cross, and once the migrant is outside the centre. At detention/reception facilities, it can be defined on scale that goes from:

- Continuity – public health system covers the assistance in the centre ensuring continuity of care with assistance grounded on a public health approach (i.e. Pozzallo);
- Integration – health assistance in the centres is covered by a private competent entity, with the integration of some services provided by the public health system (i.e. Mineo);
- Detachment – no structured integration / exchange are in place, besides the referral to hospitals in case of need (i.e. Caltanissetta).

[85] See at: www.vittoriaweb.com/home1/index.php/news/news/51-sicilia/ra...aids-e-due-casi-sospetti-di-tbc-hiv-su-un-totale-di-6000-sbarcati (accessed 12 September 2014).

II.III Discussion Section - II

Need for more structured coordination

- While some places which have been coping with arrivals by sea for a while already, and have as a consequence developed albeit had hoc individual initiative based intervention protocols (i.e. Pozzallo) others facing arrivals less frequently, have registered more difficulties in organizing disembarkation (i.e. Catania). No inter-institutional Standard Operational Procedures are centrally drafted and adopted at the local level to run the landing operations. The current gap not only creates confusion in the division of the roles, but also produces waste of (already scarce) human and financial resources. An example reported in Catania by representatives of NGOs and local authorities indicated that to provide emergency care at the harbour to a migrant in need three ambulances were called. The absence of established protocols and/or standardized procedures also affects the identification of suitable sites to give first aid to migrants.

"It would be appropriate for all entities would set basic shared procedures in which it is established the role of each one and to be adapted to the different moments, for example according to the seasons..." (HP)

"The most important thing is the clarity of roles and responsibilities. Each of us needs to know what is the role and the roles cannot be invented" (HP)

- The role of USMAF as the first medical assistance encountered by migrants in the case of landing at official border point has been assessed as particularly relevant for migrants' health. In the case of Pozzallo, it has been reported that in case of an SAR event, doctors board the vessel to provide assistance. This initiative has been recently promoted as well with the Mare Nostrum Operation. During SAR operation is would be important to always ensure that dedicated medical staff is on board to provide regular first aid training to all the staff of different ministries involved in the rescue. Some cases collected were particularly explicative of the need, as the reported case of providing support for delivering babies, which is rather difficult to accomplish with radio guidance only.

On the different segments of the reception process

- Even if the effort of the authorities to proceed to the identification of migrants is considerable, from the field visit it was possible to ascertain that the number of unidentified migrants that leave the country as soon as transferred to reception centres, including minors, and the number of those who ask not to be identified in Italy is increasing.
- Problematic is the responsibility of transportation to the ad hoc centres, especially when health problems arise. CSO representatives reported the case of transporting of a group of unaccompanied minors released by the hospital with a diagnosis of scabies after a disembarkation event with their private car – on a voluntary basis as no one wanted to cover this responsibility – without being totally aware of the way of transmission of the scabies and of potential risks for their health. In the specifications of the tender and the services required in detention/reception, transportation should be provided by the manager of the centre; however ad hoc centres are not included in these specifications.
- The lack of available places in the Italian reception system spurs the creation of informal settlements at the outskirts of the city, in very precarious health and social conditions,

waiting for a place in a CARA. Among them, there are also asylum-seekers, sent back to Italy in application of the Dublin Regulation.

- Although after 6 months there is the possibility for the asylum-seekers to enter the labour force, there are de facto very little opportunities for actual employment: beyond the few integration measures and services (language, cultural orientation, etc.) reception centres have a high concentration of asylum-seekers in the same place, are often isolated from the other cities. The territories in which they are situated could hardly offer much labour force entry points (for instance the small town of Mineo counts around 5,500 inhabitants, while the CARA near the town hosts around 3,500/4,000 asylum-seekers). CSO and HPs interviewed during the assessment indicated the concrete risk of people living or just out of the centre to enter the informal economy and being exposed to a high risk of exploitation, social marginalization and precarious living conditions.
- Outside the centre, in order to receive any social assistance, refugees need to indicate a valid residence, which is not easy especially during the first months when they most probably are in a condition to still search for employment and with limited financial support. A suggestion would be to use reception centres as reference to provide a valid residence during these first months.

Capacity and information flow

- **The complex management of centres for migrants requires a high-level of professionalism and a broad range of competences to guarantee an effective-management of the structures.** Malpractices as the one depicted, the relatively recent nature of migrant flow in the territory, insufficient coordination and information flows between health and other sectors, including the media all combine to stoke fears of a possible infection epidemic among local authorities.
- Capacity and training in health topics, especially on communicable diseases, needs to be provided for all involved in the reception process, including CSOs.
- As a good practice to mention, the municipality of Pozzallo has created an internal department dedicated to migrants that arrive at the CPSA, especially for the situations of the unaccompanied minors. Two social operators work in this service. From the health and social assistance, the CPSA Pozzallo is therefore a good example of how the existing public services may be capitalized for welcoming migrants.

III. MONITORING MIGRANT HEALTH

III.I Migrant Health

Upholding migrant health is particularly challenging as in the recent landings increasing number of vulnerable groups, including UAM, pregnant women, women having just given birth, infants, elderly and people with disability have been registered. Women and unaccompanied minors might have further being exposed to exploitation as well as sexual, physical and psychological violence and abuse before and during the migration and continue to be at risk after. In addition, conditions in which migrants arrive by sea in the last years have deteriorated (more and more people are embarked on the same vessel).[86]

At arrival, most migrants appear to be exhausted dehydrated, with skin burns, tar and abrasions and with difficulties in moving because of the cramped conditions of their trip (migrants often reported that they had to stay in the same position for days, a week on the boat), but in overall good health condition. Only few cases, as reported by the HPs interviewed, usually need to be transferred to nearby hospitals, often for check-up of pregnant women and for migrants with chronicle diseases (such as diabetes), which arrived particularly exhausted for the journey.

Both physical and mental health is impinged by the overall hygienic and living conditions in the centres. Especially those in the CIE presented self-harm and as general issue in all the centres, disorientation and anxiety for the future. Extended duration of the asylum application and the subsequent uncertainty for migrants' future, coupled with limited opportunities for education, training, meaningful occupation, are considered as major additional factors of concerns for migrant's wellbeing. Legal assistance and cultural mediation are not provided in a systematic way in all the centres. *"People go crazy because they don't have anything to do here."* (Migrant) In Mineo (CARA), some migrants have created social activities – such as mini bazar, internet point, leisure club – to have something to do and to feel engaged. From the interview with HP, in the last five years around 300 vulnerable migrants (with mental health problems) have been followed in the CARA Mineo; 50 out of them were in need of support for self-harm behaviour and two out of three out of this group have attempted to commit suicide.

Some migrants were settled outside the centres, due to the overcrowding conditions of the reception centres. They live in situations of full social marginalization, in very precarious conditions (suffering from insufficient nutrition and scarce hygiene) and very difficult access to health services. Among them there are many asylum-seekers, returned back to Italy per the Dublin regulation. They live in abandoned building or in tents, without toilets or running water.

"I began to be in need of medical care here in Sicily. In that place there are only tents ... nothing was clean, everything was very dirty. I began to have skin allergies, for me it was terrible, I was always itching. I asked for help at the [near] centre, but they told me they could not help me and to call a number, that the ambulance would come..."
(Migrant)

[86] As demonstrated in the Lampedusa's tragedy in October 2013, while approaching the Italian coast, two shipwrecks in few days caused the death of around 500 migrants.

III.II Provision of health care services and social assistance

Health care assistance

As already indicated in the previous paragraphs, in the official border points a first medical screening is done by USMAF medical doctors in collaboration with ASP and NGOs medical doctors; medical assistance proved to be less immediate if the vessels arrives at non-official border checkpoints. The assessment team noticed that **in the disembarkation phase, an appropriate overall communication and psychological support is missing**, while being important for the physical and mental health of migrants, as well as for the possibility to intervene promptly in case of need. Some HP have reported the case of the impossibility of some women to adequately communicate to have had a miscarriage during the journey and which needed to be transferred to the hospital some day after, for an infection.

As indicated, the entity appointed as manager of a centre is responsible for medical assistance, psycho-social assistance, hygiene and living conditions (Annex III).[87] If migrants need to access diagnostic tests and examinations, surgery, dentist or specialist care, they are referred to the nearest hospitals. **Medical assistance in detention and reception centres includes:**

- Screening upon entrance, with the compilation of a health file for each migrant. The screening is also aimed at identifying vulnerable cases (such as UAM, people with handicap, victim of physical and psychological violence…);
- First aid, with a medical unit within the centres, with all the needed equipment for urgent interventions and with medical and paramedical personnel[88] that guarantee the assistance until admission to health care centres;
- Transfer to hospital.[89]

The health services are often offered for urgent and referred emergency assistance (especially when there are evident signals of distress, such as bleeding), but rarely provided on a regular or preventive basis and education/communication. In the case of the CIE visited, a service H24 was supposed to function, but after dinner, it was rather difficult to find any staff except guards available.

The most difficult situation for migrants' health conditions and for migrants' access to health care has been diagnosed **in ad hoc receptions centres.** These kinds of centres are situated in unsuitable structures, especially from a hygienic and medical point of view and have little if any services: no medical staff or on-site health facilities are usually available and therefore neither health assessment nor screening for communicable diseases, for example, are done at the admission in the centres. Basic medical assistance is contracted to NGOs in collaboration with the ASP, outside the centres, though psycho-social assistance for migrants is not however covered within those.

In terms of health assistance, the **SPRAR** visited in Siracusa provided a doctor for the centre in addition to a generalist for each person, plus a psychotherapist within the centre. A urine and

[87] The specifications of the tender and the services required in each centres have been approved with a Ministerial Decree on 21 November 2008.

[88] Annex II to the specifications of the tender and the services required for reception/detention centres indicates the minimal number of personnel in relation to the number of migrants in each centres.

[89] Ex art. 34 del d. Lgv. 25 luglio 1998, n. 286.

blood analysis is done upon entrance and in case the person is allowed to remain longer than six months in the centre. Protocols have been developed with the ASP for specialized visits. Four cultural mediators (contracted by the centre) and another one on demand serve the centre that hosts around 80 migrants.

Mental health is a relevant and touchy issue concerning smuggled migrants and asylum-seekers, especially if detained or hosted in critical conditions, but, despite its importance, this question does not seem yet to receive adequate attention and resources. Besides the (few) psychologists, in the Mineo CARA the figure of a psychiatrist is planned, but only for two/three hours a week, while people who needs more attention are addressed to the ASP Department of Mental Health. The same happens in the CARA of Caltanissetta and in CPSA of Pozzallo.

"In the past years PTSD are increased…this mainly due to the increase of victims of violence or number of refugees…In the first eight months of this year (2013), we have already exceeded by 20 per cent the total number of people registered last year."
(HP)

No systematic screening of HIV or communicable diseases such as TB are performed in any centres (beside the syndromic surveillance), and HPs confirmed that there is not an epidemiological need for such a screening, although both the community and at times migrants in the CARA request form it as they fear to be at risk of infection.

According to both the HP and the CSO**, a group considered particularly vulnerable is women**, especially as regards reproductive health. Migrant women, especially those who live outside the centres, often lack the information necessary for the protection of their pregnancy (which tests should be done and when, for example). CSOs have raised, in particular, the risks associated with misinformation regarding the possibility of access to the national health system for the voluntary interruption of pregnancy. In the absence of this information the women resort to other means, with high risks to their health. Also HPs underlined as the type of assistance needed has changed over the time, as recently more and more minors and women arrive in Italy.

Social assistance

Overall, the major distress factor for migrants in CARA centres is confirmed to be the uncertainty in the length of their stay in the centres and the lack of **legal information and support**, especially related to their future permanence in the territory. Moreover, migrants indicated to have access to legal assistance only if the asylum application has been rejected (CARA), while in the other cases, access to overall orientation and legal information and assistance is minimal. In the CARA of Caltanissetta, a migrant said *"but if I am in a centre for refugees...I am a refugee then!"* Higher even frustration and requests of legal assistance were detected in the CIEs where most migrants are not able to understand the real reason for their detention, as most if not all have already served their term of imprisonment. Basic information about migrants' rights and conditions of stay are dramatically missing in the ad hoc centres, as the Equi-Health team experienced when acting as interpreters, for the lack of such, for a group of migrants (adult men) already in the centre for 1.5 days who posed questions in English such as: *"we escaped from war…are we in prison? Can we go out? Why are we here?"* **The assessment revealed a significant role played by CSOs in providing assistance, especially social to migrants.**

Migrants in the CDA and in the CARA have a badge, credited every day with EUR 2.5 to use for coffee machine, cigarettes and credit for phone calls. Migrants do not have the possibility to receive money in cash and thus to be free to use it as they wish, this being a motivation of great frustration for migrants.

"I do not smoke, I do not drink coffee…why I cannot have the possibility to save this money for me?"
(Migrant)

Despite to this attempt to discourage the circulation of money in the CARA, in Mineo migrants have started many informal business activities (some repairs bicycles, some sells clothes or food). These activities, informal but tolerated by the managers of the centre, can be read as an attempt to escape the situation of uncertainty and inactivity that characterizes the lives of asylum-seekers in the CARA and that is a leading causes of malaise of migrants.

A significant obstacle to providing **adequate health and social assistance** are the insufficient health and supporting (mediators, interpreters, legal advisors) staff levels, who themselves recognize and criticize not having enough time to dedicate to every migrant given the fact that the number of dedicated staff is often much too low in relation to the number of people hosted in the centres. As indicated in previous paragraphs, in the tendering process the management of structures shall be awarded to the offer "most economically advantageous", the provision of health services being furthermore very broadly indicated (Annex III), without a dedicated budget line (as mentioned in the first section) and a large autonomy is then left to the manager; there ensues, also as confirmed by some respondents HPs, that the number of recruited HPs and supporting staff is more often than not lower than the actual needs of the centres. In addition the ratio of HPs available in the centre in comparison with the number of hosts does not increase proportionally to the increase of the hosts.[90]

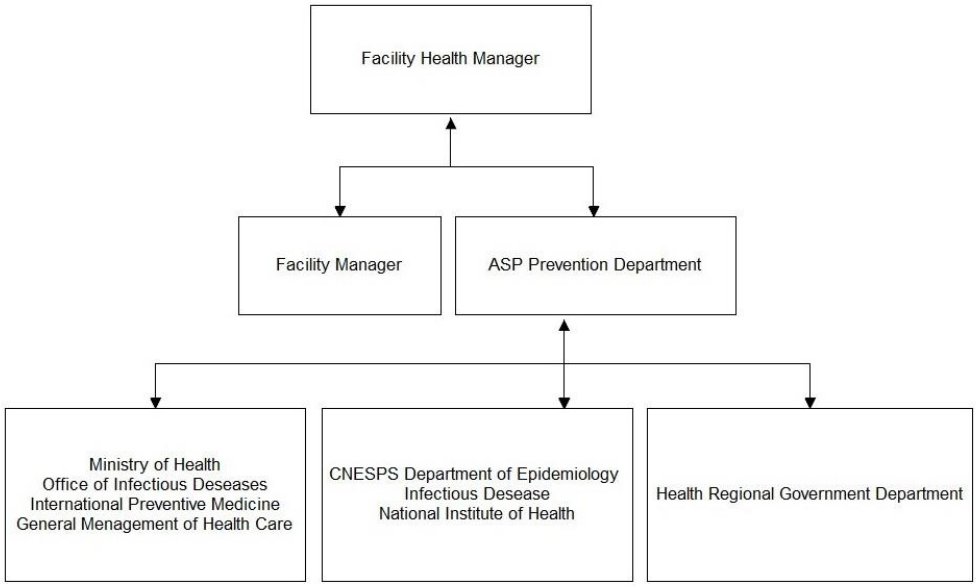
III.III Data Collection

No standard criteria for **assessment, collection and ordering of the health-related data** for migrants are available. At local level, the only activities of systematized collection of data are linked to the syndromic surveillance. The surveillance syndromic procedure is described in the following figure.[91]

[90] See Annex II.

[91] See The protocol for Syndromic surveillance : Ministero della Salute – Dipartimento della Comunicazione e Prevenzione – Direzione Generale della Prevenzione Sanitaria Ufficio V, Protocollo operativo per la sorveglianza sindromica e la profilassi immunitaria in relazione alla emergenza immigrati dall'Africa settentrionale.

Figure 2: Flow syndromic surveillance



Source: Italian Ministry of Health Protocol for Syndromic surveillance.

The MOH stated that syndromic surveillance should not act as a substitute for notification of Infectious Diseases that in Italy is made compulsory by the Law (Ministry of Health Decree 15 December 1990 "Sistema informativo delle malattie infettive e diffusive"). The Decree states different protocols for the transmission of infectious diseases to the Ministry of Health. **Doubts as to the specific relevance of this surveillance** have been reported by HPs during the assessment: on the one hand, the data collected are not further processed at the national level,[92] on the other hand only few centres correctly compile the dossiers and forward them to the competent authority. The results of the data collection are indeed often equal to zero (no alarm) but this could be linked to a different range of factors: from the data collected (not all the centres apply the surveillance), to the health status of migrants (no alarm to report) or to the tool used as questionnaire for syndromic surveillance (not relevant/targeted to the migrant population).

Moreover, **USMAF's report** is compiled after every disembarkation event when a document that authorized the disembarkation with health-related data for migrants at the first screening is sent to the Local Health Unit (ASP) and to the judiciary authority. As already discussed, the data are presented in aggregated form and do not always reach the reception facilities where migrants are to be hosted; the absence of medical personnel in some of the cases (i.e. ad hoc centres) worsen the situation. Staff at ad hoc centres confirmed the case of a group of migrants affected by scabies being transferred to the centre without any previous communication to the management of the facility.

The collection of health-related data is left to the autonomous initiative of the reception facilities, once again with many differences among the different realities. Standardized system for health related data collection (and referral) is missing, and requested as an important improvement. A promising practice example in terms of data collection is the electronic database used in Mineo and developed by the Red Cross. The software allows the registering of the health record once the migrant enters the centre as well as the health history in terms of visits (general

[92] The Epi-south project ended in 2013.

and specialized), diagnosis, and therapy. The system, however, **is only used within the centre and is not linked with the local health system.**

At the moment of the release into the community, **migrants receive a paper copy of their medical file. However, as reported by some CSOs this document might be very generic and not informative, with quite general indications.**[93]

III.IV Discussion Section - III

Worsening of health conditions

- Findings from the assessment confirm significant concerns about worsening physical and mental health of migrants due to the conditions and length of reception. Long stay in the centres, more often than not much longer than the maximum time indicated by law and the overcrowding conditions, are some of the main causes that concur to the worsening of the quality of services and provisions of health, and ultimately to migrants' health: on one side services and living conditions provided are tailored for a limited number of days, and not developed enough for a longer period of time; on the other side the number and type of staff available, including health staff, are not adequate to the need of the population of the centres in terms of number and competences covered.
- While urgent and basic medical assistance is usually provided during the reception process, migrants' mental health continues to require attention and is insufficiently addressed from the very first reception on. The relevance of a psycho-social assistance and cultural mediation are of particular importance to assuage distress at the first arrival linked to the traumatic experiences occurred before and during the journey, and moreover during their protracted stay in short term and long term facilities and would much facilitate integration and also improve the working environment for all staff.

Shortcoming concerning available HPs

- Shortcomings concerning the availability of specialized personnel are exacerbated when centres have to respond to higher number of requests and/or longer-term care needs in view of the extended duration of stay.[94] **Shortcomings of health and psycho-social services** generate four obstacles to health and well-being: 1) a perceived non-performance/ and long wait for health assistance, synthetized by migrants with the slogan *"Come tomorrow, come tomorrow"*; 2) even when the assistance and the medical visit happens, migrants sometimes do not recognized it as such. Within centres, although health professionals informed us about the procedures followed during the first arrival of a new migrant, including the medical screening, migrants declared that they did not have a 'medical visit/check-up upon entrance, but only a quick look; 3) perception of a lack of interest for their personal/health situation, which generates high level of frustration and may boost aggressiveness against health professionals *"you feel annoyed, these people do not want to help me!"* (Migrant); 4) this contributes to the creation of a climate of antagonism between HP and migrants. In Mineo, for example, health professionals from Red Cross often need to request the support of the law enforcement officers within the

[93] Such as the fact that the person was hosted in the centre, that he/she looks in good shape but that further analysis might be needed to ascertain the health status.

[94] In the CARA Mineo, for example, for an average of 3,000 people reached in summer 2013 there were four physicians and five nurses.

centres in order to enter the clinic where they perform assistance, and it was not unusual to witness crowding and episodes of (verbal/physical) violence at its entrance.

- Specific protocols between the local health authority and a number of NGOs (Doctors without Borders, Emergency Onlus) have been promoted as an urgent measure to cover medical gaps especially for the assistance in the ad hoc centres. These types of solutions, however, need to be reconfirmed every two-three months and are heavily based on NGOs capabilities, therefore not structured in the system.

Monitor Migrants' health data

- The lack of standardized health assessment of migrants and of availability of migrants' health related statistics limit the assessment of migrant's health conditions and the responsiveness in provision of adequate level of services.
- Collection of data and referral mechanisms has been also assessed as uneven and not always fluid. A critical example is when migrants entering the CIE: if they are transferred from the prison, they do not have any medical file for continuity of care. At the same time, migrants detained in the CIE are expelled with short notice to the management of the centre, so no health record can be prepared for the exit of the migrant from the centre.
- The syndromic surveillance is not applied in ad hoc reception centres, where on-site health care services are not available and where no medical screening is performed at migrants' admission. The absence of structured HP in the ad hoc centres creates concerns for the monitoring and access to health for migrants.
- HPs respondents indicate the usefulness of an integrate data collection system not only within the reception system but with the SSN in order to guarantee continuity of care for migrants so as to be able to follow and support their conditions when they move within and outside the centres and the regions.
- A standardized document for the discharge from a reception centre has been as well highlighted as currently lacking and much needed as there are doubts on the specific indications to be reported as of migrant's health-history (i.e. if positive to the Mantoux test, there is the risk that the secondary reception structures do not accept the migrant).

IV. MIGRANT – SENSITIVE HEALTH SYSTEM

IV.I Infrastructure and physical conditions

Infrastructure and physical conditions much vary between centres, and in relation to the type of centre and its function (Annex V).[95]

A common trait of reception centres is that they are overcrowded. Of particular relevance the case of CARA Mineo (Catania), one of the biggest reception centre in Europe with a capacity of 2,000 people. A critical element in this centre was linked to the **high number of people living there, far beyond the limit.**[96] This produces a deterioration of reception conditions, especially in terms of services and assistance provided, but also creates tensions between different nationalities and/or against the law enforcement officers.[97] The integration with the local territory is made difficult also by the fact that there are no towns nearby. Migrants often use bikes (this being dangerous, especially by night as demonstrated by the numerous accidents reported) or a bus available for the centre.

Source: IOM, CARA Mineo.

[95] Infrastructure and physical conditions of detention/reception centres in Annex III.

[96] In September reached 3,400, and in October 4,000 plus, as reported by the staff in the centre, migrants leaving in squatters: migrants who enter and live into the centre without being registered.

[97] For this CARA the MoI authorized the video-surveillance.

At the SPRAR, living conditions of migrants are of higher quality: this is especially due to the number of hosts,[98] the assistance provided and the limited permanence in the centre (maximum six months). Vocational trainings provided by the centre in coordination with other local entities are particularly important for the well-being of the migrants and their future inclusion in the territory. A **good practice** detected is weekly meeting between the staff of the centre and the migrants with the assistance of a cultural mediator, to share any potential problems encountered during the week.

Migrants interviewed during the assessment, especially at CPSA/ad hoc centres, have evidenced difficulties in communication with the staff. The **presence of interpreters and of cultural and linguistic mediators** in many situations is reported as not been always guaranteed or to be quantitatively and qualitatively inadequate (i.e. at the moment of disembarkation), or intermittent (i.e. in ad hoc centres), or totally lacking (i.e. in hospitals, especially at emergency).

"Migrants return from the Emergency at the hospital with confused information, because during the night there is not a cultural mediator available"
(CSO)

During the assessment, one of the most common complains detected among migrants is frustration with the diet, which was reported to take into consideration religious observances, but it doesn't vary during the week that is *"always the same: rice – pasta – pasta – rice"* (Migrant) and quite different from their usual food. Other complaints are related to the living conditions such as hygiene, and lack of social activities.

Resources could be optimized, for example in the reported continuous refurbishment of the entire kit of hygiene supplies (including toothbrush, sponge, litre of bath soap and shampoo), which usually do not reflect the real migrants' needs; or also the inscription in long-term trainings for minors hosted in structures meant to house them only for short term; or the number of meal in the Extraordinary Reception Centre (CAS) (often trough away as migrants escape from the centres). Similarly training, involvement of peer mediators would increase efficiency of service provisions and moderate demand.

IV. II Occupational health of staff

Regarding the perception of **staff**, differences were reported between health professionals and law enforcement officers. While the former did not indicate particular safety concerns in assisting a migrant *"sick persons are all the same, regardless from the nationality"* **(HP)**, law enforcement officers (LEOs) expressed some apprehension with respect to their own health and safety.

During the assessment, **the use of personal protective equipment (PPE) varied from one person to the other**, although tasks performed were the same. LEOs working at each step of the reception system are said to have received some training on the main rules of occupational safety and on first aid during their basic training. During the field visit no cases of law enforcement officers contracting infectious disease were indicated and LEOs exposed to undiagnosed migrants with infectious diseases, have been promptly submitted to prophylaxis. Despite this fact, **many**

[98] Only few SPRAR project in Italy hosts more than 100 people (maximum 200). Most of them 0–20 or 20–100.

among the LEOs interviewed declared to be worried about their potential contact with infectious diseases.

Some episodes of tension among migrants and LEOs have occasionally been reported in ad hoc centres, **especially due to the lack of clear communication.** CSOs reported an example of tensions occurring when a group of migrants was isolated without giving any explanation in order to be tested for TB. Migrants turned against LEOs as they did not understand the situation and were afraid to be identified, while LEOs were worried about getting in touch with people potentially affected by TB. In case of the CIE, law enforcement officers are sometimes victims of hail of stones by migrants who try, in this way, to cover another migrants escaping from the CIE.

LEOs and staff working in the centres do not report to have undergone to particular vaccination due to their duty station.

IV.III Health knowledge, attitudes and practices

Complaints about xenophobic or discriminatory attitudes among doctors and other HPs were not indicated. Migrants' main perception about health assistance is mostly to be too superficial and thus they declare to receive just a quick "look-see" and not a health assessment or check-ups and, as to therapy they claim to receive *"always the same pill"*- usually pain killers. HPs, from their side, indicated that the requests of assistance and their frequency sometimes do not correspond to health problems, but that health care is often *"the only door they always find open"* **(HP)** so migrants ask to be seen *"also for a little scrape"* **(HP)**.

While trainings on first aid and on occupational health were organized at time for LEOs, none are instead organized on specific aspects relating to migration (for example in the field of migration law, intercultural interaction or phenomena such as trafficking). The organization of this type of courses is regarded as useful by the interviewees *"there is a need of refresh courses on the legislative framework: it is a topic that changes over the time"* **(LEO)**. In addition, scarce information about communicable / non communicable diseases was detected among LEOs, this concurring to produce at times unfounded fear, as the following reference shows *"there are risks as you are in contact with people with HIV… you need to be careful and keep… a distance"* **(LEO).**

IV.IV Discussion Section - IV

Extended stay in the centres

- Infrastructure and baseline conditions are quite varied and a number of other factors contribute to **the critical overcrowding situation and excessive length of stay**, which eventually produce a sub-optimal standard of living and reduced health assistance. Some of these factors could be summarized as:
    - steady arrivals of a complex flow of migrants;
    - shortcoming in availability of places for reception;
    - limited burden sharing at the national and international levels;
    - long asylum procedures / and waiting period.
- The long period spent in the centres appears also to increase dramatically the demand for health services due to both physical and psychological problems and that coordination and collaboration with the health system becomes even more crucial.

- Access to health care, guaranteed by law for migrants inside and outside the centres, from the assessment results is, in fact, very limited: accessibility is impeded in the centres because of limited numbers and skill mix of health and support staff (interpreters, mediators, etc.), the latter also missing within the health system and, to the scarce information available to migrants.

Communication

- Some frustration is due to communication, divergent perceptions, understanding and expectation about medical services (for example that if a test is not done and blood sample taken, the migrant tends to consider the visit null). This could be managed better by having more orientation activities, mediators. A roster of cultural mediators have been prepared in Siracusa; however, this service is foreseen only on demand therefore cultural mediators could be not available at the time of demand and in any case are not to be considered as structured in the health system.
- The difficulty in understanding the language of the migrants, even if English, can increase misunderstanding and tension between migrants and law enforcement officers and lower the quality of support provided by health professionals.
- According to the results from interviews conducted with HPs and CSOs, the main obstacle in accessing health care services for irregular migrants residing in the territory appears to be misinformation, particularly acute for women's health issues, as well as the access to maternal and child-care.
- A good initiative as mediation and communication within the centre and between staff and migrants is the creation in the CARA Mineo of a community of elected representatives and spokespersons from the various nationalities in the centre. Their role still need to be better framed in the daily management of the centre, but can already be considered a positive step toward an amelioration of communication and a channel to mitigate tensions and proposal changes.

Training needs

- The need and interest in having more training on topics related to health protection or inter-cultural competences has been registered from the various profiles interviewed.
- Moreover, both HPs and LEOs pointed out that they do not necessarily know foreign languages, were not trained on how to deal with people from different cultures, and – most significantly for HPs – how to read and translate signs, symptoms or perceptions of illnesses to their foreign patients. Speaking of mental health, the knowledge about cultural and experiential past of the patient is even more crucial and overall lacking. Therefore, one of the main difficulties reported are related to problems of linguistic and cultural communication. For this reason they would ask for a greatest number of interpreters and cultural mediators available, and to be trained in a transcultural approach to health.

5. CONCLUSION AND RECOMMENDATIONS

V.I Conclusions

Mindful of the sovereign rights and national security concerns which accompany our actions, the International Organization for Migration (IOM) feels it is a collective responsibility – States, institutions and organizations alike – to respond to these challenges in a humane, effective and sustainable way. The first priority is to save lives and uphold human rights, including the right to health.[99] IOM therefore welcomes action by the Italian Government to rescue migrants through the Mare Nostrum operation (as of October 2013). The cost of the operation is around 9.5 million per month. Acknowledging the challenges related to implementation of search and rescue operations, together the Union needs to find more innovative and concrete ways to share responsibilities among all its Member States, and support countries of origin and transit, to respond collectively to migratory flows. The Frontex Plus operation (September 2014, still not operational), will support the Italian government however needs to be backed of other EU Member States.[100] The Parliamentary Assembly of the Council of Europe also "*acknowledges that important efforts have been engaged by member States, Italy in particular, towards saving more lives at sea. The left-to-die boat incident clearly highlighted the urgent need to guarantee fundamental rights, while respecting the legitimate security imperatives of border controls*".[101]

Second, cooperation and dialogue within the EU and with countries of origin and transit is essential. Because some EU countries are undoubtedly under heavy pressure due to the large number or arrivals and asylum requests they receive, the concept of "responsibility sharing" needs to move from principal to action at all levels of international cooperation. Family reunification, adequate integration measures, relocation within the EU, and resettlement from third countries are efficient means to share responsibility and provide safe avenues for those seeking international protection within the EU.

By way of a relevant update, on 10 July 2014 the national plan of reception (July 2014) promoted by the Ministry of Labour, Ministry of Economy and Finance, Regions, National Association of Municipalities (ANCI) Union of Provinces (UPI) was approved.[102] The agreement foresees three levels of reception: 1) first aid (CPSA), first reception with the creation of "Regional hubs" for migrants who had been identified, had asked for protection during the rescue phase and had their first health screening. Regional Hubs should house migrants only until their application will be concluded for international protection/asylum and a place in SPRAR centres identified where to transfer them eventually. The Agreement also foresees an increase of SPRAR network and a financial commitment from the Ministry of Labour for the reception of unaccompanied minors.

[99] International Migration, Health and Human Rights, IOM/WHO/OHCHR http://publications.iom.int/bookstore/index.php?main_page=popup_image&pID=976&zenid=8igbf19ipge04pmj5ne28ij9c6

[100] It has to be noted the scope of the EU Agency Frontex is not rescue at sea, being its mission broadly to promote, coordinate and develop European border management.

[101] Paragraph 3, Resolution 1999 (2014).

[102] See Accordo Piano Nazionale Accoglienza (10-07-2014). Sicily Region is mentioned as being in a particularly difficult situation.

V.II Recommendations

The following policy recommendations are the results of the assessment done in Italy (September 2013), integrated with the outcomes of the inter-ministerial table promoted under the Equi-Health action in Rome (December 2013) and with the comments/validation collected at local level in the three local consultative committees (Caltanissetta, Catania, Siracusa) and one national consultative committee (Palermo, July 2014).

I. Political and Legal Framework

- Developing common and resolute EU operational responses will be critical to achieving the social cohesion and development embedded in the EU 2020 strategy objectives, as well as addressing root causes of forced and irregular migration.

- The Dublin regulation – devised to prevent "asylum shopping" – has increased the pressure on resources of border member States. Potential asylum-seekers consciously prefer not to be identified to avoid the application of the regulation, this putting them in a vulnerable situation and at-risk of exploitation and trafficking. Burden sharing among EU Member States is advisable not only during the first phase analysis of the applications, but at the later stages of resettlement as well.

- EU level – Further to the EP resolution in response to the Mediterranean Sea tragedies[103] to expand and promote all existing EU legislation and procedures allowing safe entry into the EU.

- At national level, *one of the main priorities out of the NCC is* related to the promotion of **a structured response, involving multiple sectors and levels, while solutions characterized by urgency/emergency mode should be avoided and used only for limited period of time**.

- Speed up/shorten the administrative procedures required for asylum-seekers and irregular migrants, with a spillover effect on the length of stay at the reception centres, which would ameliorate migrants' conditions in terms of health and well-being, alleviate pressure on staff, and reduce the cost of accommodation. Many measures could be promoted to this aim, such as cutting down on bureaucracy, increasing the number of territorial commissions,[104] centralizing at EU-level the information system and promoting the use of information and communications technology (ICT). Investing in an integrated information system and ICT is crucial in ensuring migrants have access to accurate and up to date information on the status of their cases and applications and on their rights to services and health. This would allow monitoring waiting times and waiting lists at EU level and set performance measurement for institutions responsible for the procedures and waiting times abatement targets.

[103] European Parliament resolution on migratory flows in the Mediterranean, with particular attention to the tragic events off Lampedusa (B7-0476/2013).

[104] L. 97/2013, art. 30 already provides for the constitution of additional Territorial Commissions in case of particular need.

- A general lowering of reception, care and living conditions has been due to the absence of precise legal framework and the urgency related to the **identification of places to host migrants** (ad hoc centres). It is of extreme relevance to ensure that any activities or services developed during the reception process follow a clear legal framework and a revised selection/management provisions as indicated at the national level, coordinated with health and social authorities.

- While alternatives to detention should be sought as a win-win for the well-being of migrants and to reduce pressure on reception facilities, it is further important not to inflict an additional administrative detention in the CIEs for those who have already served their sentence in prison. Identification should be already processed within the period of the first detention, thus avoiding an extra punishment that deprive the person of his/her freedom and as well decreasing the number of people in the CIE and the co-habitation of different categories of migrants within the same structure.

- The secondary reception system promoted with the SPRAR is conceived to stimulate an integrated approach with the territory. Increasing the number of places in SPRARs should be fostered, while also reducing/eliminating the use of ad-hoc structures.

- **Funding for centres should be based on capitation and standard costs across regions estimated specifically taking into consideration as well a basket of essential provision of health and social care to be linked to LEA in Italy.** Continuous monitoring of effectiveness of management and quality of services provided further implemented, to allow a prompt substitution of the management of the centre if considered not adequate.

- **Guidelines for the border management, detention and reception centres should be promoted and implemented,** with special reference to securing a public health perspective.[105]

- Particular concerns are related to UAM, for whom placement in dedicated centres is not always found as prescribed by Italian, but due to the paucity of places in these structures and the difficulty to find a reception municipality, they remain in adult reception /temporary centres with minimal support, and/ or are hosted in other centres for minors (which do not foreseen any assistance to specific needs of migrants such as interpretation, culturally adapted psycho-social assistance) or they are temporary left to the cure of social assistance of the first municipality of arrival, which usually are only few. Taking also into consideration the voluntary departure of migrants from reception centres – especially particularly vulnerable groups as minors, when the voluntary nature of the departure is sometimes not evident[106] – a steering committee should be created at the national level to ensure and coordinate the reception of UAMs in suitable facilities for their stay and for identifying responsibilities and resources for their care keeping them more safely.

[105] Please refer as examples to the UNHCR/IOM on Collective Centre Guidelines (2010) and IOM Guidelines for border management and detention procedures involving migrants: a public health perspective (2010).

[106] This was also reported by the press report: "Il dramma dei piccoli immigrati In Sicilia 500 spariti nel nulla - Inchieste - la Repubblica", http://inchieste.repubblica.it/it/repubblica/rep-it/2013/10/10/news/immigrazione_il_giallo_dei_minori_scomparsi_in_sicilia-68316108/ (accessed 26 May 2014).

- Taking into consideration the best interests of the child, a prompt access to the asylum procedure and the insurance of a fair procedure should be promoted especially for UAM. This is in light of a recent European Court of Justice recent judgement[107] and as indicated as well by the EC Commissioner for Home Affairs Cecilia Malmström: "*the rights of the child must always come first. We need clearer and more predictable EU asylum rules for unaccompanied minors.*"[108]

- To mitigate negative effects on children in the context of international migration, additional efforts are needed to ensure smooth transition to adulthood and identify durable solutions from an early stage. Alternatives to detention should be sought as a win-win for the well-being of migrants, particularly children, and to reduce pressure on reception facilities. As recently indicated as well by the Council of Europe Parliamentary Assembly Resolution n. 1996/2014, the establishment of a transition category, between the age of 18 and 25, it is advisable to help young migrants and take political measures for the access to health care among other support measures for welfare and education; access to information on the relevant administrative procedures; extension of housing assistance. This should be done also by specific training measures for both migrants and social workers dealing with them while local authorities should demonstrate empathy and creativity in order to design policies aiming at young migrants' social integration.[109]

II. Partnerships, networks, and multi-country frameworks

- EU-level: Dialogues, exchanges of practices and **effective cooperation and solidarity at Regional, EU level** and globally between countries and with International Organizations are to be urgently intensified. Some of the relevant topics indicated to be explored are specific guidelines or innovative instruments and procedure for age assessment (considering the psycho-social aspects related to this procedure) or Standard Operational Procedures (SOP).

- Although vertical protocols might exist within a specific institutional body, further efforts are to be given to **developing shared/horizontal protocols** common to all the actors involved in the reception process, aiming at clearly identifying the tasks of the actors involved in the process of reception, better coordination, to standardize services provided along the different steps of the reception process making them homogeneous throughout the whole system; *this recommendation has received wide-ranging approval and support among stakeholders involved in the assessment*.

- Reinforce cooperation and inter-institutional interaction, in order to develop an integrated system of responses.

- Fostering the effectiveness of the development of reception process could, also, mean to **improve communication**:

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[107] Case C-648/11 MA and Others vs. Secretary of State for the Home Department delivered on 6 June 2013.

[108] EC Press Release: *Clearer EU rules for unaccompanied minors seeking international protection,* Brussels, 26 June 2014. Available from http://europa.eu/rapid/press-release_IP-14-723_en.htm

[109] See: Parliamentary Assembly- Resolution 1996/2014 (provisional version) : Migrant children: what rights at 18?, Doc. 13505, report of the Committee on Migration, Refugees and Displaced Persons, rapporteur: Ms Mailis Reps.

- among different levels involved (between national and local level, between decision-makers and operational ones);
- among different institutions (between ministries at the central level and between various institutional actors at local one, particularly between ASP, *Prefetture*, Municipalities and NGOs);
- among different structures (between hospitals and reception centres, detention and CIEs);
- among stakeholders.

Instruments such a technical tables as well as ICT are recommended in order to create or maintain coordination and to share experiences, best practices and critical points.

- To improve the reception system at the national level, increasing its efficiency, accountability and capability it is important to foster national burden sharing, in order to reduce situations of overcrowding and the use of inefficient ad hoc structures. On a practical side, for example common national, regional databases with current information about available spaces by types of facilities could be envisaged.

- To create and maintain coordination and networking for the exchange of information and good practices between all structures and services involved, particularly between ASP and NGOs health care facilities/services.

- Reception conditions and procedures should fully respect migrants' dignity and fundamental rights. To complement the Council Directive 2003/9/EC on Minimum standards on the reception of applicants for asylum in Member States, it is recommended at EU level to develop more specific indications as to provisions of health care and minimum standards to be applied during the reception process, such as what type of personnel should be guaranteed in the detention/reception centres or ratio between health professionals and migrants.

- At national level, the reception system should ensure respect of human rights and be responsive and adaptable to migration flux/numbers based on the recognition that migration is a steady phenomenon and responses characterized by urgency/emergency mode should be avoided and used only for limited period of time.

- Notwithstanding the reduction of projects for the integration of migrants in the country, and in a way for this very reason, a promotion of constructive discourse and reporting on migration and public health are even more important to address misperception in the community and promote integration. Malpractices and miscommunication combine to stoke fears of infection epidemics both among local authorities and the public. In this respect, the socially responsible collaboration of the media is key and information campaign on the positive contribution that migrants make to the community should be promoted.

III. Monitoring Migrant Health

- Although urgent and basic medical assistance is generally provided, psycho-social needs continue to require attention, especially for vulnerable groups or whenever living

conditions in the centres are particularly difficult due to overcrowding or long period of staying in the centre.

- **The involvement of the public health system at the local level in continuity with the first arrival, transfer, detention/reception centre** to guarantee a migrant and public health approach to the assistance is considered a positive practice to promote and further institutionalize so to guarantee an optimal level of assistance and facilitate referral mechanisms, continuity of care, with the outside facilities. **Health care direct and indirect oversight is ultimately the public health authorities' mandate and responsibility**.

- Health assessment, including screening for communicable disease, is not systematic though MOH guided syndromic surveillance is done in some of the locations. Data collection of health-related information is not standardized, and every centre records and stores data differently. **Improving migrant health data collection from first contact on** (starting perhaps with a specific health code for example since landing on linking existing or to be developed database with a national health information system), analysis, sharing and referrals mechanisms would further support planning of adequate and appropriate health services for migrants, staff, and communities in the border areas. Developing of templates/adapting existing database for comprehensive standardized health assessments of migrant for both communicable and non-communicable diseases, consensus about screening for communicable diseases in detention/reception centres, and their piloting and implementation could be promoted, in order to strengthen the information related to migrants health, promote quality and continuity of care; *a shared and standardized template for migrants' health data collection has been indicated as a priority action under this pillar.*

- Comprehensive data on migrants' health should be collected and regularly monitored. Disaggregated data based on migrants' status could be promoted to anticipate needs and analyze service utilization.

- To encourage, as much as possible, the sharing of health-related data locally, nationally, and at EU level. This implies the setting up of an informational system able to better encourage a more "global" take on responsibility and a better continuity of care to the migrant who should decide to move to other parts of the country (online access to medical records related to the codes STP could be an example) or to other EU countries;

- At present, no on-line system for the sharing of the health data related to every STP code is available, but it should be an important support in guaranteeing continuity of health cares of irregular migrants, especially considering that the STP code can be used in the whole territory of the country;

- It could also prove useful to issue all migrants a "social status" ID (where they live, with whom), to be shared among agencies involved in the reception process at least locally in situations of particular fragility. This would allow to intervene with a global approach and to avoid overlapping of services.

IV. Migrant-Sensitive Health Systems

- Reception facilities should be prepared to assist and provide care to migrants and the personnel should have the right competences to manage this type of centre, in all the phases of the reception process. They should guarantee the minimum standard for reception in terms of infrastructure and especially in terms of social and health assistance, which should be clearly defined in coordination with health authorities and monitored. Such facilities need to ensure humane and dignified conditions in line with international, CoE and, in Member States – EU standards.[110]

- Small (but perceived as significant) changes are suggested by migrants for better living conditions in the centres are: Wi-Fi (to communicate by internet with their families and to have the possibility to read news about their countries of origin), washing machines, sport facilities and the possibility to receive the pocket money in euros rather than in a badge that allow limited choices. To provide more possibilities for sport, cultural activities, training courses, media in multiple languages (TV, newspapers, and internet) and, more in general, activities which could improve the well-being of migrants in detention centres/second reception and foster their subsequent integration into society.

- The number of HPs available in the facility should remain flexible so to reflect the real number of person hosted and therefore guarantee the capability provide adequate levels of support to cover migrants' needs as well as to ease the workload of the staff and overall foster common wellbeing.

- *The highest priority as policy recommendation under this pillar has been given to* the **creation of adequate health and social support systems, including interpretation, cultural mediation, psychosocial assistance and trained staff need to be reinforced throughout the reception process** (in the centres and also within the national health system). One of the main difficulties reported are related to problems of linguistic and cultural communication. HPs would ask for a greatest number of interpreters and cultural mediators available and to be trained to a transcultural approach to health. It is strongly advised to develop standardized procedures in order to guarantee the presence of competent interpreters and cultural mediation for all the steps of the reception system. Interpretation via telephone/PC could be considered as an alternative to cover several location and timeframe.

- To provide migrants information about their rights in relation to health and the means of access to health care according to their different legal status, at all stages of the reception process and also once out of centres, with capillarity and in a systematic way. A good practice to promote information sharing could be identified in developing materials on these topics, and ccapitalizing already existing ones (as in the case of the leaflet prepared by the Praesidium project) by translating it in different languages and making them available from the disembarkation moment and for the whole reception process (at the very entry in the centres, at migration offices, in the hospitals etc.).

[110] For example Decisions 2119/98/EC and 2000/57/EC Council Directive 2003/9/EC on minimum standards for the reception of asylum-seekers.

- A broad range of topics for potential trainings for health professionals and law enforcement officers, but also for CSO have been collected, including inter-cultural competences, language competence, project management and fundraising, health-related courses on first aid, infection diseases, safety and security at the workplace. It would also be beneficial to create and circulate staff training curriculum content on the these aspects and to offer training for HPs and LEOs as it would be beneficial for providing better health services to migrants in terms of: communication skills and how to handle prejudices and cultural gaps working with people from different cultural and risk backgrounds; understanding of global migration patterns, deeper understanding of the public health implications of migration, as well as self-protection and occupational health issues; sensitizing to physical and mental health issues of vulnerable persons, including victims of trafficking, smuggled migrants, and minors.

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ANNEXES

Annex I. Equi-Health topics covered under the assessment, out of Conceptual Framework IOM/WHO/Spanish EU Presidency, 2010

Monitoring Migrant Health	Policy and Legal Frameworks
Assess with multi-stakeholder perspective how health of migrants is determined from the borders onwards; the accessibility to health and support services; the quality of care and of data collection analysis, storage and dissemination; health status perception and knowledge of the epidemiological situation. The IOM assessment focuses as well on routine information gathered from the borders on data collection, processing, analysis, dissemination, storage.	Information collected under this section is related to policies, laws and legal frameworks concerning health rights of migrants, taking into consideration how they are implemented, monitored and evaluated. A special focus is also devoted to division of responsibilities and roles as well as financing aspects. Assess the adoption and implementation of relevant international standards and policies on the protection of migrants and the right to health in national law and practice, the development and implementation of national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless of their status.
Migrant-sensitive health systems	**Partnerships, networks and multi-country frameworks**
Assess existing health and support services preparedness for diversity, human resources, infrastructures including physical and living conditions, hygiene and safety, referral institutions; and occupational health of staff working at the borders and in open/closed centres, including health concerns, work conditions, perceived health risks, health knowledge, attitude and practices. Also, the information collected under this section aims at understanding the quality of health services provided to migrants and collect information inter alia, in the migrant sensitive health system component (routinely available medicines, equipment, vaccines, PEP kits, etc., as well as PPE). Workforce issues are included in several components of the IOM assessment (types and numbers, preparedness of staff). The IOM focus is on personnel working from the borders on and in related communities/settings with specific focus	Information collected under this section looks at partnership in the area of migration and health among various stakeholders. The IOM assessment focuses on institutional cooperation between actors involved in the migration management process in the country, with special focus on the referral mechanisms in place, personnel management, partnerships, network and multi-country framework, exchange of good practices. Links to EWR, IHR as well as information of critical events, incl. emergency situations and issues of public health concern, public health promotion and prevention campaigns are also included.

on cultural competency and also on their occupational health.	

Source: IOM Equi-Health.

Annex II. List of participants to the NCC Italy

NCC Rome 5th July 2013

Governmental Actors

- Ministry of Health - Department International Affairs
- Ministry of Health - Department of the General Prevention
- Ministry of Interior - Department of Civil Liberties and Immigration
- Sicily Region - Health Department

HP, CSO, IO and others

- Associazione Ramodoro
- Federazione Rom e Sinti Camminanti
- Fondazione Bracco Milan
- Fondazione IntegrAzione
- Health sector expert FEDERSANITA
- IOM Italy
- IOM Malta
- IOM RO Brussels
- Italian Red Cross
- National AIDS Centre, Istituto Superiore Sanità
- National Centre for Epidemiology, Surveillance and HP
- National Roma Integration Strategy Focal Point
- NIHMP, National Institute for Health, Migration and Poverty
- PIN Polo Universitario Città di Prato – Tuscany Region
- San Camillo Forlanini Hospital
- WHO

Local Consultative Committee Caltanissetta 1 July 2014

Governmental Actors

- ASP Caltanissetta

HP, CSO, IO and others

- ANFE - Associazione Nazionale Famiglie Emigrati
- ARCI GIRASOLI
- Caritas
- CEFPAS - Centro per la formazione permanente e l'aggiornamento del personale del Servizio sanitario
- Cooperativa Auxilium (CARA, CIE, Pian del Lago)
- Fer Rivita
- IO PERVOI PER IO
- IOM Italy
- IOM RO Brussels

Local Consultative Committee Siracusa 2 July 2014

Governmental Actors

- ASP Siracusa

HP, CSO, IO and others

- AMNESTY INTERNATIONAL
- ARCI Siracusa
- ASGI/ Accogliere
- Centro Accoglienza
- CPA Papa Francesco
- EMERGENCY
- IOM Italy
- IOM RO Brussels

Local Consultative Committee Catania 3 July 2014

Governmental Actors

- ASP Catania
- USMAF, MoH

HP, CSO, IO and others

- ARNAS GARIBALDI ISTITUTO MALATIE INFETTIVE
- AZIENDA OSPEDALIERA CANNIZZARO
- Consorzio CARA Mineo
- SVES 118
- IOM Italy
- IOM RO Brussels
- Servizio Edpidemiologia
- SPRAR VIZZINI
- University of Catania

NCC Palermo 8 July 2014

Governmental Actors

- ASP Caltanissetta
- ASP Catania
- ASP Siracusa
- Ministry of Health
- Ministry of Interior
- Ministry of Labour
- Sicily Region
- USMAF, MoH

HP, CSO, IO and others

- ANFE
- ARCI Siracusa
- ASGI Siracusa
- ASP3/UNI Ct
- Auxlium
- Caritas

- CEFPAS- Centro per la formazione permanente e l'aggiornamento del personale del Servizio sanitario
- CPA Papa Francesco
- Croce Rosa
- Emergency
- IOM Italy
- IOM RO Brussels
- Migranti Solidali
- CARA Mineo/Calatino
- Ospedale S.Elia
- Policlinico Catania
- Policlinico HSR Cefalu
- RI.VITA
- SIMM
- UNIPA
- Vizzini SPAR

Annex III. Services to be provided according to the type of centre

Centre	Sanitary Services	Social Support Services	Other
Tender	Medical screening at the entrance with psycho-social evaluation; filling od sanitary files; first-aid assistance to be provided in the centre and transportation to the public facilities in case of need; transportation to public hospitals in case of need.	Cultural/linguistic mediation; information service about migration law, rights, duties and conditions of foreign people; orientations about rules and functioning of the centre; meals distribution, conservation and control; cleaning and waste management; bed sheets, products for personal hygiene, comfort items, clothes, laundry service and barber (see tender).	
CSPA	(In addition to those provided in the tender) **Administration of drugs prescribed by the physician; in case of injuries, first-aid assistance and transportation to the hospital; constant updating of the nursery register and conservation of all medical documents and certifications; updating of patients' physical status to the physician; reservation of medical examinations and visits with specialists; if necessary, accompaniment and assistance in the specialist visits or in the hospitalization; meal service for those in the nursery.**	Cultural/linguistic mediation; information service about migration law, rights, duties and conditions of foreign people; orientations about rules and functioning of the centre; meals distribution, conservation and control; cleaning and waste management; bed sheets, products for personal hygiene, comfort items, clothes, laundry service and barber (see tender). (Beyond 48 hours of stay, the centre manager will replace items like shampoo, toothpaste, soap, etc.)	A EUR 15 - phone card and every two days, a EUR 5 coupon to spend in the centre for stamps, phone-cards, snacks, non-alcoholic drinks, cigarettes, books, magazines, newspaper, etc.
CDA	See CSPA	See CSPA + **psycho-social support + organization of leisure time**	See above
CARA	See CSPA/CDA	See CDA + **Italian language teaching; orientation in the territory, information about the protection system for asylum-seekers and refugees; information about the Assisted Voluntary Return programmes.**	See above

CIE	See CSPA/CDA/CARA	Same as in the CDA	See above
CAS	**Sanitary assistance to be provided in the local health centres or by generic physicians.**	Registration of hosts and drafting of a daily report for the "prefettura"; orientation about rules and functioning of the centre; information service about migration law, rights, duties and conditions of foreign people; **Orientation in the territory, information and assistance in dealing with the local police headquarter for the insertion in the protection system for asylum-seekers and refugees;** cultural and linguistic mediation ; laundry service ; cleaning and waste management; **psycho-social support**.	See above

Source: IOM Equi-Health elaboration on Italian Ministry of Interior "Specifications of the tender and the services required in each centres", approved with a Ministerial Decree on 21 November 2008; Italian Ministry of Interior- Dipartimento per le Liberta' civili e l'Immigrazione "Circolare 19 Marzo 2014".

Annex IV. Services to be provided by law according to the number of hosts

Number of hosts	Sanitary assistance	Psycho-social support and cultural/linguistic mediation
Up to 50 persons	Ambulatory: nurse h. 24 Medical assistance: Doctor: 8h/day, 6 days/week	Psycho-social support 18h/week Social assistant 18/week Linguistic mediation 54h/week Information on Migration law* 24h/week Language teaching** 8h/week
From 51 to 150 persons	see. < 50	Psycho-social support 24h/week Social assistant 24h/week Linguistic mediation 78h/week Information on Migration law* 54h/week Language teaching** 24h/week
From 151 to 300 persons	Ambulatory: Nurse h. 24 Medical assistance: Doctor h24 6 days/week	Psycho-social support 54h/week Social assistant 36h/week Linguistic mediation 108h/week Information on Migration law* 72h/week Language teaching** 36h/week
from 301 to 600 persons	Ambulatory: Nurse h. 24 Medical assistance: Doctor h24	Psycho-social support 72h/week Social assistant 36h/week Linguistic mediation 156h/week Information on Migration law* 108h/week Language teaching **: 54h/week
More than 600 persons	Ambulatory: Nurse h. 24 + 1 h72/week. Medical assistance: Doctor h24 Ambulance: h24	Psycho-social support 90h/week Social assistant 60h/week Linguistic mediation 204h/week Information on Migration law * 144h/week Language teaching ** 72h/week

* Including orientation to the territory and assisted Voluntary return whether applicable ** if applicable

Source: IOM Equi-Health elaboration on Italian Ministry of Interior "Specifications of the tender and the services required in each centres", approved with a Ministerial Decree on 21 November 2

Annex V. Equi-Health sub-project Southern EU borders, centres visited

Place	Typology and name of centre	Relevant Information	Management and Health care assistance	Comments
Caltanissetta	CIE "Contrada Pian del Lago"	The CIE is located far from the town centre, and counts 96 places.	The CARA is located in the same compound of the CIE and is run by the same managing authority. At the time of the field visit was taking place a transition between the management by the cooperative Albatros 1973 (which has run the centre since 2002) and the new management of the cooperative Auxilium. Health assistance is provided by the managing authority and local health services when is needed. The staff available in the centre is represented by four Medical Doctors, one Health Manager of the centre, six cultural/Linguistic Mediator, one expert in international humanitarian protection and auxiliary personnel. H24 health assistance should be provided.	The CIE is a prison like structure with the area surrounded by tall fences, various gates before entering the area and a high number of law enforcement officers outside the facility. It is within the CARA compound which is otherwise dry land and containers. Dormitories do not have metallic bed bases, but stone blocks to sustain mattresses, placed in very close proximity each other ; while toilettes are not always functioning and the areas, including the canteen, are not perfectly cleaned; also the use of disposable sheets was for more than one or two days. A service H24 was supposed to function, but after dinner, it was rather difficult to find any staff available. While approaching the CIE the reaction to the IOM team visit was at first rather negative with some shouting '*are you coming to visit the zoo? We are like animals here'*. This shows the high level of frustration of the detainees. At the end of the visit, migrants were very welcoming and some particularly eloquent in explaining their angst once we went in.

	CARA/CDA women / family "Contrada Pian del Lago" CARA/CDA men "Contrada Pian del Lago"	There are two CARAs in the compound: one accommodates men and another women and families with children, although during our visit half of this second CARA was populated with single men. The CARA counts 96 places to add to the 360 seats of the CDA, because the centre carries out both functions.	See above	The CARA for men is structured with similar characteristics of the CIE; the area dedicated to women and families is structured with containers for 6 people. In the latter, there is one hand of the containers area were men are hosted and they have access to common toilets; living in the same area has an impact on the perception of safety amongst different vulnerable groups, as women and children. The two CARAs visited presented generally better living conditions especially in terms of activities organized (access to TV and language courses) and overall less tension among migrants and centre staff was reported. The quality conditions of the toilets still remain something to be improved. In the CARA the worry of the hosted was more related to the uncertainty of their stay *"I only want to know about my application…"*
Mineo (CT)	CARA	The CARA Mineo was set up for families of NATO's officials and used as a reception centre for refugees during the so called Emergency North Africa in 2011. It became a reception centre for asylum-seekers in 2013. It lies 64 km southwest of Catania, and 22 km from Caltagirone and it can host up to 2000 people.	From the 1st January 2013, for the administration of the CARA is responsible the consortium of municipalities "Calatino Terra d'Accoglienza" while the consortium "CARA Mineo", that collects some social cooperatives and private companies, is entrusted for the management Italian Red Cross is in charge of the health services in the CARA. The medical staff is composed by 3 medical doctors and an health manager. Every Friday a gynecologist is available at the CARA. Thanks to an agreement with the local ASP, a psychiatrist and a dermatologist are available for some hours a week and a pediatrician, always in collaboration with the ASP, is there every day. The CARA is also equipped with two ambulances with crew (one operating also by night), two drivers for	Infrastructures were of high standard: two floor bungalow with a kitchen and a private bathroom. The type of population housed is quite diverse from the previous years, with increasing number of families, women and children (one birth every three days was reported). The critical element in this centre was linked to the high number of people, far beyond the limit (in September reached 3,400, and in October 4,000), this producing a deterioration of reception conditions, especially in terms of services and assistance provided, but also creating tension between different nationalities and/or against the law enforcement officers. Cases of deaths within the centre or continuous fights were reported.

			transfer at the hospital (if one does not need a gurney the transfer is made by car) and five nurses. The hospitals near the CARA have not interpreters or cultural mediators, so CARA accompanies migrants with their own mediators. Vaccinations and sample taking are done in the CARA health care facilities, while diagnostic examinations and specialized visit are made into the hospitals.	
Siracusa	Ad hoc centre mix "Umberto I" Ad hoc centre "Papa Francesco" in Priolo	The centre Umberto I is an *ad hoc* structure, opened during the North Africa Emergency in 2011 and reopened in the early summer of 2013 at the request of Prefettura. The centre Papa Francesco hosts unaccompanied minors.	The centre, Umberto I is run by the cooperative Clean Service. The centre Papa Francesco has been opened on August 8th 2013 by the association Papa Francesco. The association has formalized to Prefettura of Siracusa its willingness for the reception of migrants, hoping for an invitation to tender that would accredit it later as a centre for minors and vulnerable subjects. No medical assistance is provided within the centre. In an attempt to address this shortcoming Prefettura and ASP have signed a protocol with the NGO EMERGENCY in order to offer medical assistance to migrants in these ad hoc centres: a special bus, equipped as an health care facility, moves from a centre to the other and works parked outside them. Health and social assistance is provided by one medical doctor, two nurses, one logistics coordinator.	Infrastructures and hygienic conditions were considered grave in the ad hoc centres visited. Cases of promiscuity were detected, while hygienic conditions were only partially covered (toilets locked during the day in the centre for minors and only external toilet available; matrasses moved into the terrace by the migrants and moved back in the structure so to have some fresh air). Some waste in the use of economic resources was registered as well, for example in the reported continuous refurbishment of the entire kit of hygiene supplies (including toothbrush, sponge, litre of bath soap and shampoo) do not reflect the real migrants' needs; or also the inscription in long-term trainings for minors hosted in structures meant to house them only from approximately one month. Four mediators have been mentioned to be available for the centre, but at the time of the visit none was on site.

Ragusa	Pozzallo	The CPSA in Pozzallo exists from 12 years and it is located in a structure close to the harbour once dedicated to the customs. Part of the centre is used as well as CIE, for identification and expulsion of irregular migrants, according to the particular moment and need.	The CPSA is managed by the municipality in agreement with *Prefettura.* Health services within the centre are provided by the ASP. A nursing service is available in the centre H24. A medical doctor (sometimes two) is available on site every day for eight hours a day. An ambulance and a minibus are available for the transport of migrants to the hospital or from the hospital to the centre.	The centre for the first reception of migrants is meant for a stay of just few days; this explains the presence of only one large space used as a dormitory, with the conjoining mattresses lined on the floor as bedding. No areas for activities (besides the bare courtyard), nor other activities foreseen. It can host 150/200 people, but at the moment of the field visit the migrants inside within the centre were 340. Reception conditions become critical when the stay in this type of centres is higher than only few days, as it is the case during the months of summer when migrants remain in the centre also for few months, including some unaccompanied minors. The area within is monitored with video camera, although migrants are not necessary aware of it.

Source: IOM Equi-Health.

Annex VI. Open / Closed Centre Checklist

1	a. Name of the centre	**Papa Francesco, Priolo (SR)**	**Centro Polifunzionale Pian del Lago (CT)**	**CARA Mineo (CT)**
	b. Type of centre (short term, long term, open, etc.)	Extraordinary centre of first reception	Long term	Long term
	c. Under whose authority is the centre?	Ministry of interior/ministry of welfare	Ministry of Interior, *Prefettura* of Caltanissetta	Ministry of Interior
	d. Under whose management is the centre?	Social association ONLUS	Social Cooperative "Auxilium"	A cooperative
	e. Type of the staff	Civilian	Civilian	Mixed
2	Total number of employees at the centre:	11		350
3	Short description of the centre's environment:	The centre is in a city called Priolo Gargallo in the province of Siracusa, situated in the north of the city and it is closed to the city's centre	In the same building, there are two CARA and one CIE. It is 5 Km far from Caltanissetta	It is in the "Residenza degli aranci" (a former residence for families of American NATO soldiers), very close to Mineo. The small village in the countryside looks very clean, new and comfortable.
4	How many stayed in the centre last year?	87	1,269 (both from CARA and CIE)	3,500
5	What is the average time spent at the centre?	5 months	From 8 to 10 months	9/15 months
6	What is the maximum time that a migrant can spend at the centre?	3 days	12 months	More than one year. It depends on the commission decision.
7	What is the maximum capacity of the site?	95	542 (both CARA and CIE)	2,000
8	What measures are taken when the available premises are insufficient?	It depends on the decision of the ministry	Eventual transferals in other centres (i.e. CAS) are decided by the	

			Migration Office in Caltanissetta	
9	Is any pre-screening done for identification of most vulnerable groups of migrants before admission to the centre?	Yes	No	Yes
	a. Who is responsible for this pre-screening of migrants?	Health service of Sicilian region		Ministry of Health
10	Are then migrants separated by:			
	a. Gender?	Yes	Yes	Yes
	b. Family status?	No	Yes	Yes
	c. Age? (Unaccompanied minors from adults)	Yes	No	Yes
	d. Vulnerability? (I.e. pregnant, elderly, etc.)	Yes	No	Yes
	e. Nationality?	Yes	No	Yes
	f. Religion?	No	No	Yes
	g. Healthy and ill?	Yes	No	Yes
	h. Suspected contagious and non-contagious persons?	Yes	Yes	Yes

Health care provided at the Open/Closed Centre

		Papa Francesco, Priolo (SR)	Centro Polifunzionale Pian del Lago (CL)	CARA Mineo (CT)
11	a. Do migrants undergo medical examination before being admitted to the centre?	No	Yes	Yes
	b. Is there a protocol/template for the medical examination/check-up	No	Yes	Yes
	c. If yes who does the screening /medical examination?		The medical service	The first reception centre
12	a. Is there a health care facility available at the centre?	Yes	Yes	Yes
	b. Short description (e.g. facility/ equipment, permanent/non-permanent staff, etc.)	Every Wednesday a team from Emergency comes in the centre with mobile clinic and stay all day long to visit people. The staff of the emergency is composed by 2 doctors, 2 nurses, and 4 cultural mediators. For the rest of the days, in case of need, migrants are referred to the nearest local hospital.	There is a nursery equipped for emergency care. The medical service is available 24h.	There are two out-patient visit points, one for adults, one for children. Both working 24h. In the first one there are 2 physicians and 5 nurses, in the second one there is a pediatrician.
	c. Is the health care facility servicing the staff of the centre?	Yes	Yes	Yes
	d. If yes, are there prevention programmes (vaccinations, etc.) for the staff?	Yes	Yes	Yes
	e. Is the same health staff providing	No	No	Yes

	care for both migrants and staff?			
	f. Does the staff report to (is hired by) public health or border authorities?	No	Staff is hired by the managing entity	
	Number by types of staff:			
13	a. # Nurses:		0	10
	b. # Physicians		12 + a health manager	4
	c. # Social workers			
	d# Psychologist (working with staff)		0	
	e. # Psychologist (working with migrants)		2	
	f. # Others /specify:		Social service (2), Legal assistance (4), Mediation/interpretation (8)	
14	a. Are there NGOs or international organizations working with the centre?	Yes	Yes	Yes
	b. List/short description.	Emergency for health related issues. Terre des Hommes for the psychosocial support	IOM, Save the Children, UNHCR	Italian Red Cross
15	Can migrants consult with a specialist:			
	a. Dentist	Yes	Yes	Yes
	b. Optician	Yes	Yes	Yes

	c. Specific hospital services (i.e. infectology)	Yes	Yes	Yes
	d. Psychologist	Yes	No	Yes
	e. Other /specify		All those visits with specialists for solving specific diseases	
16	Who do you inform first in case of critical health incidents (events) at the centre (e.g. hunger strike, violence, emergency)?	The emergency unit of the local hospital	The staff working in the centre (doctors, psychologists, social workers, lawyers) is always aware of every situation. In specific cases, also the Migration Office and/or the *Prefettura*	
17	a. Are there any regulations for handling "health incidents (events)" at the centre? If yes, please provide a copy.	No		
	b. Is there a protocol or procedure in place in case of outbreaks? (e.g. SARS or Avian Flu procedures?). If yes, please provide a copy.	No	Yes	Yes
	c. Is it practiced/ researched?	No	Yes	
18	Have you been trained/ informed as to the lines of responsibilities in the centre as to the WHO IHR (International Health Regulations) health event notification procedure?	No	Yes	Yes
19	a. Is there a possibility to quarantine and observe persons displaying symptoms of infectious disease on	Yes		

	site?			
	b. If yes: Where? Describe:	There is a room for quarantine. Every week the room is disinfected by our staff		
20	a. Location of the nearest emergency services/ambulance station:	Priolo Gargallo	Ospedale S. Elia (CL), 118	On site
	b. Distance (in km and in time) from the centre:	2 km, 5 minutes by car	8 min/5 km	
	c. How much time (estimated) does it take for emergency services to arrive?	5 minutes	5 minutes	
21	a. Location of the nearest physician's office:		In the same centre	On site
	b. Distance (in km and in time) from the centre:			
22	a. Location of the nearest out-patient facility:		S. Elia Hospital (CL) and Health Centre “via Malta” (CL)	Caltagirone Hospital
	b. Distance (in km and in time) from the centre:	15 minutes	5/3 km	
23	a. Location of the nearest in-patient facility:	In the centre	S. Elia Hospital (CL)	
	b. Distance (in km and in time) from the centre:	In the centre	5 km	
24	a. Location of the nearest public health service/office station:	Priolo Gragallo	ASP Caltanissetta	Caltagirone Hospital

	b. Distance (in km and in time) from the centre:	2 km, 5 minutes	6 km	

Conditions at open/closed centre

		Papa Francesco, Priolo (SR)	Centro Polifunzionale Pian del Lago (CL)	CARA Mineo (CT)
25	Are scheduled hygiene inspections (premises, pest control, water quality and food preparation) conducted?	Yes	Yes	
26	Do you have cleaning regulations at the centre?	Yes	Yes	
	a. Do you have cleaning staff at the centre?	Yes	Yes	
	b. If no, who performs the cleaning?	Yes		
	c. Is cleaning also performed by migrants (in sleeping quarters for example)?	Yes	Yes	Yes
27	a. Does the cleaning staff use protective gear?	Yes	Yes	
	b. If yes, please list:	Gloves, masks, apron	D.I.P.	
28	How often are the premises cleaned?	Twice a day	Every day	
29	a. Does the staff possess protective gear against infections?	Yes	Yes	Yes

	b. If yes, please list:	Gloves and masks	Gloves, masks, glasses	Gloves and masks
	c. Are these easily accessible for all the staff?	Yes	Yes	Yes
	d. Is there a regulation/training regarding their usage? If yes, please provide a copy.	There are specific regulations but there are no written copies available		
30	Has the staff received training on personal hygiene? If yes, please provide further details.	Yes	No	
31	a. Are disinfecting substances used for cleaning?	Yes	Yes	
	b. Where are the disinfectants stored?	In a closed store	In a closed store	
	c. Are these easily accessible for all the staff?	Yes	Yes	
	d. Is there a regulation/training regarding their usage?	Yes		
32	Is disinfection performed after the discharge/transfer of a migrant with an infectious condition?	Yes	Yes	
33	Has the staff received training on infection control and prevention?	Yes		Yes
34	a. What is the minimum area ensured for migrants in the sleeping quarters?	3 square meters for each person	One container	

	b. Short description of the sleeping quarters (e.g. Dormitory-style, individual rooms, rooms for families, private or shared lavatories/showers):	Dormitory for 5 or 10 people. In an extern area there are toilets with 5 shared showers and 5 shared lavatories. In the other hand there are 4 intern toilets.	Container (CDA) Prefab (CDI/CIE)	Small houses with two flats upstairs for families. Downstairs, at the main floor, there is a room for 5 people with their bathrooms.
35	Is there any extra room in the facility, which is used for disciplinary confinement? If yes, please provide a short description of it.	Yes, there is a big room for the Italian language lessons and for other uses like TV, internet point, etc.	Yes, there is an external pavilion under the Migration office management.	
36	Is potable water permanently secured and available in migrants' areas?	Yes	Yes	
37	Is hot running water permanently secured and available in migrants' areas?	Yes	Yes	Yes
38	Which basic hygiene supplies are available in the lavatories?			
	a. Liquid soap	Yes	Yes	
	b. Bar soap	Yes	No	
	c. Paper towels	Yes	Yes	
	d. Cloth towels	Yes	Yes	
	e. Hand dryer	Yes	No	
	f. Toilet paper	Yes	Yes	
39	Is constant electricity supply assured in the centre?	Yes	Yes	Yes

40	Is there ventilation in the facility? Describe (e.g. windows, vents)	Yes, we have the air conditioners in every room.	Yes	
41	a. Short description and number of lavatories in the centre:	There are 10 lavatories in the centre, 6 in the extern area and 4 in the intern area		
	Ratio in relation to hosts (question 7)	**9,5 people per lavatory**		
	b. Are there separate facilities for women and men?	No	Yes	Yes
42	a. Short description and number of showers in the centre:	We have 5 boxes shower, every one with a single door with hot and cold water		
	Ratio in relation to hosts (question 7)	**19 people per shower**		
	b. Are there separate facilities for women and men?	No	Yes	

Conditions for staff

		Papa Francesco, Priolo (SR)	Centro Polifunzionale Pian del Lago (CL)	CARA Mineo (CT)
43	Location and short description of staff's sleeping and hygiene quarters and offices?	The staff don't sleep in the centre, they have an intern area where they can eat and relax, therefore there is one bathroom for the staff for both women and men	The staff doesn't sleep in the centre	
44	a. Is a separate lavatory unit ensured for the staff?	No	Yes	
	b. If yes, short description and number of lavatories for the staff:		8	
45	Number and types of hand wash stations for staff:	2 lavatories		
46	Number of showers for staff:	0		
47	a. Is there a possibility to clean the uniforms of personnel on site?	No	No	
	b. Are there washing machines?	Yes	No	
48	Short description of the social area.	There is a park with trees, tables and chairs, and a living room	In each centres there are football and volleyball fields, a place for prayers, TV room, recreational area	

Living conditions of migrants

		Papa Francesco, Priolo (SR)	Centro Polifunzionale Pian del Lago (CL)	CARA Mineo (CT)
49	Do all migrants receive:			
	a. A plastic dinner set?	Yes	Yes	Yes
	b. A mug?		No	
	c. Duvet cover?	Yes	No	
	d. Sheets?	Yes	Yes	
	e. A blanket?	Yes	Yes	
	f. A bed?	Yes	Yes	Yes
	g. A towel?	Yes	Yes	
	h. Night clothes?		Yes	
	i. Slippers?	Yes	Yes	
	j. Extra clothes?	Yes	Yes	
	k. Soap?	Yes	Yes	
	l. Tampons? Sanitary pads?		Yes	Yes
	m. Toilet paper?	Yes	Yes	
	n. Toothpaste? A toothbrush?	Yes	Yes	Yes
50	Do you ensure the weekly change /every two weeks or according to needs of:			

	a. Shaving foam? Razor blades?	Yes	Yes	
	b. Night clothes?	No	Yes	
	c. Duvet cover?	No	No	
	d. Sheets?	Yes	Yes	
	e. Towel?	Yes	Yes	
51	Is there an obligatory daily routine in the centre?	Yes	Yes	
	a. If yes, are migrants obliged to follow the daily routine programme?	Yes	They have to sign while leaving/entering the CARA. They are obliged to observe the time schedule for meals, therapy distribution, Italian language courses, etc.	
	b. Can migrants do routine activities outside of the scheduled programme?	Yes	Yes, football/volleyball/cricket matches, bingo, cards, etc.	
52	Does the centre provide any of the following facilities?			
	a. Library	Yes	No	
	b. TV room	Yes	Yes	
	c. Sport facility	Yes	Yes	
	d. Kitchen	No	Yes	
	e. Room with PCs	Yes	No	Yes
	f. Other / please specify?		No	

53	Does the daily routine include:			
	a. Time for washing?	Yes	No	Yes
	b. Time for meals?	Yes	Yes	Yes
	c. Time for open air walks?	Yes	No	Yes
	d. Time for medical examinations?	Yes	Yes	Yes
	e. Time for education?	No provision for education	Yes	Yes
	f. Time for social activities?	No	No	Yes
54	Is access to daily showers guaranteed for migrants?	Yes	Yes	
55	How do you deal with communication/linguistic problems? (I.e. with interpreter, mediators, NGOs, other migrants, etc.)	We have one cultural mediator in the centre present every day from Monday to Friday with a part time contract	Interpreters and cultural mediators	Through the support of mediators
	Do you organize common programmes for migrants, such as:			
	a. Sport activities?	Yes	Yes	Yes
	b. Cultural events?	Yes	Yes	Yes
	c. Training courses?	No	Yes	Yes
	d. Other / Please specify?	No	No	
57	a. Is there a possibility for migrants to practice their religion?	Yes	Yes	Yes

		Please describe	Muslim migrants have an area inside the centre for their daily prayers, while Christians go to	There are areas devoted to the prayers, both for Muslims and Christians	They have spaces to practice their religion
58		Is there a possibility for migrants to keep their dietary requirements and cultural and religious eating customs?	Yes	Yes	Yes
59		Can migrants prepare their own food at the centre?	No	No	No, but they do it.
60		Are there special conditions, caring instructions and trained staff to assist particularly vulnerable people, such as elderly, persons with disabilities, pregnant women, unaccompanied minors, victims of trafficking, etc.	yes	Yes	
61	a.	Are migrants informed about the administrative /legal measures and procedures related to their case?	Yes	Yes	Yes
	b.	Do you have written information sheets?	Yes	Yes	Yes
	c.	Are information sheets available in multiple languages?	Yes	Yes	Yes

Source: IOM Equi-Health.

Annex VII. Syndrome under surveillance and case definitions

Syndrome	Case definition
Respiratory tract disease	Fever (>38˚C) and at least one of the following: – Cough – Sore throat – Pharyngitis – Bronchitis – Pneumonia – Bronchiolitis – Chest rales – Breathing difficulties – Bloody sputum – Lung infiltrates on X-ray
Tuberculosis (suspected)	– Productive cough lasting more than three weeks – Low-grade evening fever* – Night sweats* – Weakness, AND – Weight loss in the last 3 months
Bloody diarrhea	Blood in stool and at least one of the following: – Frequent diarrhea (at least 3 loose stools a day) – Mucus or purulent material in the stool – Abdominal pain – Gastroenteritis with vomiting
Watery diarrhea	At least one of the following: – Frequent watery diarrhea (at least 3 loose stools a day) – Abdominal pain

	– Gastroenteritis – Vomiting
Fever and rush	Rash and fever (>38˚) OR Clinical diagnosis of measles, rubella, varicella, erythema infectiosum (fifth disease), exanthema subitum (sixth disease, roseola Infantum)
Meningitis/encephalitis or encephalopathy/delirium	Fever (>38˚) and at least one of the following: – Meningitis – Encephalitis OR one of the following: – Encephalopathy – Confusion – Delirium – Altered consciousness
Lymphadenitis with fever	Fever (>38˚) and at least one of the following: – Enlarged lymph nodes – Lymphadenopathy – Lymphadenitis
Botulin-like illness	Absence of known chronic conditions causing the syndrome (e.g. myasthenia gravis, multiple sclerosis) and at least one of the following: – Paralysis or paresis of cranial nerves – Ptosis – Blurred vision – Double vision (diplopia) – Speech impediments (dysphonia, dysarthria, dysphagia) – Descending paralysis OR Diagnosed or suspected botulism

Sepsis (with or without shock) or unexplained shock	At least one of the following: – Sepsis – Sepsis shock – Severe Hypotension not responsive to medical treatments AND absence of the following conditions: congestive heart failure, acute myocardial infection or traumas causing the syndrome
Hemorrhagic illness	Fever (>38˚) and at least one of the following: – Hemorrhagic rash – Hemorrhagic enenthema
Acute jaundice	– Jaundice – Fever (>38˚) – Malaise – Myalgia – Enlarged liver (hepatomegaly) AND – Exclusion of chronic or alcoholic liver diseases
Parasitic skin infection	– Skin lesions caused by scratching – Papules, vesicles or small, linear burrow tracks AND – Presence of parasites
Unexplained death	Death of unknown cause

Source: Italian Ministry of Health. Protocollo operativo per la sorveglianza sindromica e la profilassi immunitaria in relazione alla emergenza immigrati dall'Africa settentrionale [Operational protocol for syndromic surveillance and prophylactic immunity in relation to emergency immigrants from North Africa].