

The health of asylum seekers and unaccompanied minors. What needs and what protection?

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This paper enquires the health conditions of two groups of migrant considered to be more at risk due to their legal status – neither legal nor illegal. These groups encompass diverse people – asylum seekers, refugees and unaccompanied minors. These categories considered are far from being representative of the actual spectrum of people at risk of social exclusion. However, the paper builds on the lack of literature on the matter at the Health and welfare section of the ISMU Foundation and to the relevance of the topic being within the EU public debate (e.g. the refugees crisis) and in the international agendas.

Each case study opens with an overview of the legal provisions and moves on to describing how the reception system works, with particular attention to healthcare services. The analysis focuses on health not by simply looking at healthcare services, but rather by seeing it as strongly linked to other important elements such as nutrition, education and social security. “Personal health is essential to enjoy human rights, and underpins participation to the social, political and economic life” (Abbondanti, 2013).

In Italy health is enshrined as a fundamental rights by art. 32 of the Constitution, which forbids all kind of discrimination on the basis of on citizenship. This applies to regular registered migrants (including refugees), asylum seekers and undocumented migrants, and all irregular categories. Everyone has the right to receive emergency and essential healthcare, but also specific treatments if necessary. Dependant family members regularly residing in Italy can also access healthcare services.

1. Asylum seekers and refugees

For the sake of linguistic clarity, a definition of refugee and asylum seeker is needed. A refugee is someone who, “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (Geneva Convention, 1951). An asylum seeker is someone who, having left his own country, asks for international protection until the authorities in the reception country issue the final decision on their status.

1.1 Legal context – what rights?

Italy still lacks clear guidelines on definitions, legal procedures, reception procedures and integration. By transposing the Geneva Convention in 1954 (legge n. 722/1954), Italy grants these groups equal treatment, although this was not matched with a clear definition of what healthcare services refugees could request. In the early 2000s Italy starts focusing more on the issue by implementing EU provisions on the basic healthcare and emergency services all Member states must provide to asylum seekers¹. National *ad-hoc* legislation on immigration introduced later formally protected asylum seekers and refugees. Asylum seekers can access the same emergency services as registered migrants and do not have to pay any fee for the first six months after the registration of their application (by being *de iure* compared with unemployed people). After six months asylum seekers have the same rights and duties as Italian citizens, as they get access to the labour market. This means they can access any service against a fee and can apply for reduction if they do not have an income– like unemployed people. SSN's healthcare services also cover the time of appeal in case asylum is denied and last until the final decision is taken, which can lead to the residence permit being issued.

Refugees have equal access to healthcare services as Italian citizens and registered immigrants, as they are given an *ad-hoc* residence permit. Therefore they have the same rights and duties - access to the National healthcare service (Servizio Sanitario Nazionale, SSN), obligation to pay the fee and possibility to apply for reductions.

In terms of operational procedures, the SSN is entirely charged with refugees' health through the Regional healthcare services (Servizi Sanitari Regionali, SSR).

Asylum seekers are given healthcare services at several stages of their application. Services are provided upon identification, at the Reception centres for asylum seekers (Centri di Accoglienza Richiedenti Asilo, CARA) and on the territories where they are eventually distributed and where regional authorities provide services. CARA are centres where asylum seekers are temporarily hosted for a variable amount of time, from the minimum time required to identify them to the moment when asylum is granted. Here people are provided with personal services, healthcare, psychological and social assistance, linguistic and cultural support, food, cleaning services.

¹ Directives 2003/9/CE and 2004/83/CE, that provide recommendations on health issues as these fall outside the scope of EU competence.

1.2 Operational issues – what needs and what responses?

The so-called “North-African emergency” broken out in 2011 in the wake of the Arab spring (end of dictatorships, civil wars) has contributed to asylum seekers and refugees ending at the top of EU governments’ agenda. In terms of health, much of the debate has focused on the risks mass migration could entail for general health, while little has been said on the need to provide those people with adequate services or to establish a structured and coherent system”.

Over the past few years, public communication has focused on migrants reaching the Italian shores in a very alarmist way and often mentioning the risk of massive epidemics. By monitoring the major Italian newspapers, Associazione Carta di Roma has shown that between April and September 2014 67% of the articles on migration and health linked the emergency with the chance of epidemics. Viruses, diseases and epidemics (mainly ebola), but also TBC, smallpox and much more (Meli, 2015). However, scientific data support an opposite theory. In light of the massive migration fluxes, the Italian Ministry of Health established epidemiological monitoring system to detect any possible health emergency. Between 2011 and 2013 the service signalled a few cases that could lead to outbreaks with a serious impact on public health. However, it emerged that none of the cases observed escalated in an actual health emergency, but were rather minor cases where morbidity was due to the difficult conditions of migrants’ journeys (Ministero Salute, 2014).

Although states of health emergency have been avoided, most of public opinion is still convicted of the opposite and many politicians still use this as a political argument, with the result that refugees’ health condition is still addressed in an unstructured and incoherent way.

The healthcare services take refugees through their legal and bureaucratic steps to receiving asylum. After receiving the first clinical screening in the reception centres, they are distributed throughout Italy and provided with further services at the local level (ASL).

Despite the widespread medical checks offered, some bureaucratic and practical issues remain and this endangers the success of healthcare initiatives.

To begin with, the system does not take full consideration of the health conditions of the population. The precarious travel conditions, the lack of services during the journey, the life conditions in the reception centres - all these factors are likely to compromise migrants’ collective and individual well-being.

Secondly, the emergency-oriented approach to the issue of refugees has an impact on the efficiency of services. The local set-up is very inconsistent in terms of practices and clear rules, as both of them vary considerably from region to region. Inconsistency can be seen at both the governance and the administrative level. Confronted with the

wave of migrants, regions have launched different reception programmes at different times, with all programs showing an overall lack of staff and financial resources. Some regions offer diverse screening tests by putting in place ad-hoc emergency units; others outsource activities to external organisations or devolve part of its staff. Some regions make use of local resources (health departments, general practitioners) (Geraci, 2014). At the administrative level the picture is even more ambiguous. In some cases asylum seekers are given an STP code, in others they get enrolled to the SSR with or without a general practitioner. There are also cases where asylum seekers are given fake or temporary tax numbers in line with the Italian Revenue Agency (Geracy, 2014).

A third issue relates to those asylum seekers who reach Italy overland, as highlighted by Gruppo Immigrazione e Salute (GrIS) in the Friuli Venezia Giulia region. In these case people reach Italy through Austria by circumventing checks in a third neighbouring country and entering the Schengen area. People usually come from countries torn up by civil wars or high political instability (Afghanistan, Pakistan etc.). Besides not making use of any kind of reception programme, during their journey these people often are sheltered in temporary places that are overcrowded and with bad hygienic conditions. This can facilitate the development and spread of diseases (GrIS Friuli Venezia Giulia, 2015).

To address the issue of inconsistency of health policies against an increasing presence of refugees, the Department of health of Regione Sicilia has taken the pioneering decision to develop a set of operational guidelines boosting the implementation of good healthcare practices. For the first time the role of life conditions in the reception centres in the individual and collective health is acknowledged, and a monitoring and an evaluation of the health conditions and the services is proposed. The core assumption is that collective health is also dependant on individual health.

Another innovative practice comes from Società Italiana di Medicina delle Migrazioni (SIMM), a very active and politically influential lobbying group that has had a big impact on public policy so far. The organisation has recently started lobbying to address the lack of organisation in protecting the health of asylum seekers. Together with the GrIS in Tuscany and Piedmont, Federazione Nazionale e Ordini provinciali dei Medici Chirurghi e degli Odontoiatri (FNOMCeO) has urged policy makers to include asylum seekers in the healthcare system by making services actually accessible, namely by:

- Exempting asylum seekers from paying the service fee until the definitive ruling on the asylum application or the certificate of legal employment,
- Enrolling asylum seekers to the SSR,

- Coordinating early healthcare, reception and integration procedures with primary healthcare e prevention services in hospitals,
- Monitoring the services provided in the reception centres,
- Streamlining asylum procedures and the time required by the local commission,
- Assessing migrants' fragility and vulnerability resulting from their journey.

As the FNOMCeO document says², Italy needs to shift from an emergency-oriented approach to a concrete, effective and timely strategy resulting from a rational, inclusive and far-reaching planning able to protect migrants' health.

This issue is still being debated and the political pressure from the third sector has not been fully applied. Considering the past achievements³, this process is likely to be acknowledged and internalised by the appointed authorities.

2. Unaccompanied minors

Foreign-born unaccompanied minors (Minori Stranieri Non Accompagnati, MSNA) are minors coming to a host country with no parent or primary carer. They are often referred to as *grands enfants* (grown kids) as their family in the country of origin entrusts them with a project where all family members are involved and on which the (in)succes of the whole family depends. This practice is widespread among Egyptian migrants. These young men are very independent and generally have a high level of personal maturity compared to their Italian peers. Their "adulthood" is due to their potential to produce income (Working group on the Convention on the rights of the child, 2015). Because of their expectations, families often hinder the will these young men to go back home (Working group on the Convention on the rights of the child, 2015).

Young migrants have therefore a hybrid identity, as they are both lonely minors and migrants (Luzi, Pasqualino, Pugliese, Schwarz, Suligoi, 2013), and this increases their fragility.

In 2014 more than 26.000 minors have reached the Italian shores, half of which unaccompanied (2.5 times more than in 2013). They were mostly young people aged 15-17 coming from Eritrea (3.300), Egypt (2.000), Somalia (1.500) and Syria (900)⁴ (Dipartimento Pubblica Sicurezza del Ministero Interno, 2015). In the case of EU

² Document accessible at (IT):

http://www.fnomceo.it/fnomceo/showArticolo.2puntOT?id=134483&utm_source=emailcampaign79&utm_medium=phpList&utm_content=HTMLemail&utm_campaign=n.+28+Filò+Diretto+con+FNOMCeO+

³ SIMM was behind major achievements, including the application of an agreement between the State and the Regions (20/12/2012) that protected migrants' rights to health and gave minors the rights to a paediatrician, or the abolition of the obligation for the medical staff to report undocumented migrants accessing hospitals and clinics.

unaccompanied minors, Romanians young migrants were 281 by April 2015 (Working group on the Convention on the rights of the child, 2015).

A considerable part of unaccompanied minors remains unsearched and includes all those who transit through Italy hiding under lorries or on ferries coming from Greece, thus evading State controls and care programs (Working group on the Convention on the rights of the child, 2015). The choice of not being identified is due to both migrants lacking knowledge of national legislation and fearing the unknown. Another explanation, however, is to be found in the idea that being enrolled to national integration programmes would disrupt their original mission, i.e. the family/community project they left their home country for. They cannot waste time staying in communities, as they have to be fully operative and produce most income over the shortest time.

2.1 A legal overview – what rights?

At a first glance, the international scene looks complex and inconsistent. An international study carried out in 2011 on eight countries (Spain, France, the UK, Greece, Hungary, Italy, Romania and Sweden) highlighted considerable gaps in national legislations and practices resulting from the lack of a EU common approach to the issue. Despite the several provisions of binding International and EU Law, the legal framework has failed to reduce the gaps in reception and care among countries (Italian Council for refugees, 2011). Social care, for instance, is provided in line with EU provisions on the rights of the child in some Member states (Italy, Greece, Romania, the UK), while is provided under special programmes tailored on unaccompanied migrants in some other countries (Spain, France, Hungary, Sweden)⁵.

According to the Italian legislation, unaccompanied minors cannot be expelled and have the right to a residence permit covering foster care, family affairs, asylum application⁶. They also have the rights to access care services for minors, namely:

- being sheltered in a safe place;
- being granted some kind of guardianship;
- being temporarily assigned to an appropriate family or community.

In cases where parents or appointed guardians cannot exercise their parental duties, foster care can be arranged by the Juvenile court (judicial fostering), the social services of the Municipality.

⁵ More in-sights can be found in the 2011 Report of the Italian Council for refugees and the 2014 ANCI-Cittalia report (IT): Giovannetti M. (2014), *I minori stranieri non accompagnati in Italia. V Rapporto ANCI-Cittalia*.

⁶ Art. 19(2), DLvo 286/98.

Before turning 18, minors can ask the Juvenile prosecutor to either extend their community stay to be extended by 3 years (until they turn 21) or convert their residence permit for minors into a residence permit for work.

Some major procedural changes into the reception of unaccompanied minors have been introduced in 2014 in the attempt to improve the system. The new system gives more responsibilities to the Ministry of Home affairs compared to the Ministry of Labour and social policies. It also establishes temporary reception centres throughout the country, that will host minors for a very short time (60 days extended to 90 days in exceptional and certified cases) for identification, age and status verification. Secondary reception is to be planned in the spots available in the SPRAR system (SPRAR, il Sistema di Protezione per Richiedenti Asilo e Rifugiati), that will be improved.

All unaccompanied minors, with or without a residence permit, have equal right to access preventive and health care and must register to the National healthcare system (SSN). Individual Regions and local health authorities (ASL) provide services such as vaccinations in line with regional prevention campaigns, preventive medicine, diagnosis and cure of infectious diseases and decontamination of outbreaks. Services are free of charge if people do not have sufficient financial resources. People also have access to emergency care and services both at clinics and hospitals, as well as to long-term care in case of illness and injury⁷.

When requesting services and getting medical prescriptions, unaccompanied minors use a regional STP code (Straniero Temporaneamente Presente) like adult migrants. Many human rights organisations advocating for the rights of the child see this practice as a big limitation to the rights to health, as it is in breach of the UN Convention on the Rights of the Child. The Convention lays out that all minors shall have access to healthcare with no discrimination.

Unaccompanied minors who have applied for the residence permit can be granted free health insurance upon registration to the SSN⁸, as in this case they are treated as asylum seekers.

2.2 Operational overview – what needs and what responses

Unaccompanied migrants have become a common trait of the world's migration phenomena over the past ten years. Their number has so massively increased that now constitute an important share of asylum seekers and refugees.

Over the past century youth on the move has become an actual migration entity, increasingly drawing attention because of their growing number. Policy-makers, social

⁷ Article 35(4) onwards ; Art. 42(4) onwards, d. P. R. 394/1999, Regolamento di attuazione del Testo Unico sull'immigrazione.

⁸ Articoli 34(1)(b), Testo Unico sull'immigrazione.

workers, lawyers, members of the judiciary and the police are now confronted with this issue and have to reflect on how protecting this group of people.

Under the current procedures, unaccompanied minors have to take a general medical and hygienic check to assess their eligibility for access to a community. After that, minors are moved to temporary accredited communities providing them with (Gruppo Nazionale Enti e Servizi di Pronta Accoglienza Minori - Save the Children Italia):

- A welcoming, inclusive and respectful family environment
- An adequate support to education. Minors should not be assigned to any shelter without an adequate educational support.
- Custody, to avoid damages to and from minors.
- Adequate and decent life conditions to support physical, moral and emotional development.
- Support by professional workers throughout procedures involving them (residence permit, repatriation etc.) or their access to services (healthcare, school etc.)
- An approach respectful of their cultural and religious needs.

Social workers and tutors are key figures to unaccompanied minors, as these latter will know them and trust them best and will be affected by them to a large extent. In order for the support to be effective, tutors and social workers need to take training courses that take into account the rights and material needs of minors, as well as their psychological needs, namely those of asylum seekers and the victims of trafficking and exploitation. It should be noted that many unaccompanied minors being brought to Italy are victims of trafficking. Trafficking is usually sexual, but also working trafficking (forced begging) or of other kinds (organ-trafficking, illegal adoption etc.). In other cases, exploitation started after the minor has come in touch with criminal organisations in the host country.

Well-trained workers are key to educating unaccompanied minors, although their training and expertise is a concern (Working group on the Convention on the rights of the child, 2015) and have some implications on the current care system.

According to the law, the appointed tutor has to act as a role model and provide the minor with a specific programme in order to support a sound individual development. Today the number of operative tutors is not sufficient to meeting all the demands. The procedural requirements to staff training leads to a same one-size-fits-all approach that does not consider the geographical specificity and the specificity of individual minors.

At the same time, it makes it harder to recruit volunteers, who now accounts for most of the people local authorities recruit.

At the local level there is a great demand of volunteers. These are sometimes under-qualified workers selected through inconsistent criteria by organisations (and not authorities) and do not receive a proper training (Working group on the Convention on the rights of the child, 2015). This lead to a two-fold problem, i.e. a system that lacks tutor and that at the same time is inhomogeneous and fails to provide quality services.

These shortcomings have an impact on the users of the system, i.e. the unaccompanied minors. The high rate of minors leaving communities after a short time can be linked to the lack of organisation and proper follow-up by tutors. However, there are other causes contributed to this trend. Dropouts are more frequent among minors victims of trafficking and exploitation, due to the ultimate goal of their journey, i.e. working. Municipalities surveyed reported having improved their performances thus reducing dropouts (i.e. minors fleeing from centres, from 62% in 2006 to 26.6% in 2012) and increasing the number of migrants staying in the first reception centres (i.e. minors staying at least one month, from 34.5% in 2006 to 69.7% in 2012). However, some issues have not been addressed and this is likely to hinder care services (Giovannetti, 2014), namely:

- the difficulties to identify minors,
- the lack of specific reception centres and services,
- the difficulties to plan and implement voluntary repatriations,
- the difficulties to find foster families,
- other general issues relating to fostering.

Along with these effectiveness issues, another issue relates to how services are organised, as financing has been increasingly reduced in a scenario of financial unpredictability and high managing costs. Around 20 Municipalities reported having spent more than 700.000 euros in 2012 on minors” (Giovannetti, 2014).

Despite showing signs of improvements, the system has still some structural limits. A suggestion for improvement could be issuing guidelines on unaccompanied minors as part of a structured national strategy to support standardisation and quality of services (Giovannetti, 2014).

In order to improve communication and help building sound partnerships with the tutors, it is suggested to:

- Employ cultural mediators and social workers in communities on a continuous basis,

- Promote street daytime programmes accessible to the greatest number of people on the model of youth centres and their high informality,
- Provide services that protect the psycho-physical health of the minor and that take full account of the traumas they have been through (separation from their parents, exploitation, xenophobia),
- Consider the impact cultural aspects have on migrants psychological conditions by promoting ethno-psychiatry and ethno-psychology,
- Consider increasingly more frequent trends such as drug addiction, alcoholism and addressing them through ad-hoc services.

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Dipartimento Pubblica Sicurezza del Ministero Interno

Federazione nazionale e Ordini provinciali dei Medici chirurgi e degli Odontoiatri
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SIMM, Società Italiana di Medicina delle Migrazioni

www.simmweb.it.

The ISMU Foundation is an independent research centre funded in 1992 promoting research and training activities on migration, integration and the ever-growing ethnic and cultural diversity of contemporary societies.

As an independent scientific body, it proposes itself as a service provider open to the collaboration with national and European institutions, local administrations, welfare and health-care agencies, non-profit organisations, schooling institutions, Italian and foreign research centres, libraries and documentation centres, international agencies, diplomatic and consular representations.

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