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AIDS & Mobility Project: activity report 2001-2002 of the Italian National Focal Point

Italian NFP Working Group

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This report is meant to provide an overview of the efforts made during the period 2001-2002 not only by the Italian National Focal Point (NFP) as a workgroup (existing since 1997), but also by its individual member structures (governmental and private), in terms of their specific activities, with regard to the supply of psychological, social and health assistance to immigrant citizens. The report also includes a study in depth of foreign woman reproduction health and an analysis of the linguistic-cultural mediator role.
Key words: Immigration, Health, Prevention, HIV/AIDS

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AIDS & Mobility Project: rapporto sulle attività 2001-2002 del National Focal Point italiano.
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Questo rapporto intende fornire una visione generale sul lavoro svolto nel periodo 2001-2002 non solo dal National Focal Point italiano come gruppo di lavoro (che esiste dal 1997), ma anche dalle singole strutture (governative e non) ad esso aderenti, con particolare riguardo agli aspetti psicologici, sociali e sanitario dei cittadini stranieri. Il rapporto comprende inoltre un approfondimento relativo alla salute riproduttiva delle donne straniere nonché un'analisi della figura del mediatore linguistico-culturale.
Parole chiave: Immigrazione, Salute, Prevenzione, HIV/AIDS

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Donatella Barbina *(Istituto di Ricovero e Cura a Carattere Scientifico Burlo Garofalo, Istituto di Igiene, Trieste)*
Paola De Castro *(Istituto Superiore di Sanità, Rome)*
Bianca Maisano *(Area Sanitaria, Caritas Diocesana, Rome)*
Nicoletta Orchi *(Istituto di Ricovero e Cura a carattere scientifico L. Spallanzani, Rome)*
Claudia Sala *(Centro per i Diritti Umani e la Salute Pubblica, LILA CEDIUS, Milan)*
Sandra Salinetti *(Istituto Superiore di Sanità, Rome)*
Pia Filomena Savino *(Dipartimento 3D, ASL Frosinone)*
Tommaso Speranza *(Istituto di Ricovero e Cura a Carattere Scientifico L. Spallanzani, Rome)*
Luigi Toma *(Istituto di Ricovero e Cura a Carattere Scientifico Santa Maria e San Gallicano, Rome)*
Maria Vittoria Zaccagnini *(Istituto di Ricovero e Cura a Carattere Scientifico L. Spallanzani, Rome)*

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For further information on this document please address to: tvaids@iss.it

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Presidente dell'Istituto Superiore di Sanità e Direttore responsabile: *Enrico Garaci*
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Redazione*: Paola De Castro* e *Sandra Salinetti*
La responsabilità dei dati scientifici e tecnici è dei singoli autori.

ITALIAN NFP WORKING GROUP

(in alphabetic order)

Laura **CAMONI**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Anna **COLUCCI**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Pia **COVRE**
Comitato Diritti
delle Prostitute
Via del Bruson, 7
33082 Azzano (Pn)

Anna **D'AGOSTINI**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Anna Rosa **FRATI**
Dipartimento Prevenzione
Ministero della Salute
Piazzale dell' Industria, 20
00144 Roma

Pietro **GALLO**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Salvatore **GERACI**
Area Sanitaria
CARITAS di Roma
Via Marsala, 97
00185 Roma

Anna Maria **LUZI**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Rodolfo **MAYER**
Facoltà di Economia
Università La Sapienza di Roma
00100 Roma

Aldo **MORRONE**
Servizio Medicina e Prevenzione Migrazioni
IRCCS San Gallicano
Via S. Gallicano, 25/A
00153 Roma

Nicola **PETROSILLO**
II Divisione Malattie Infettive
INMI "L. Spallanzani" IRCCS
Via Portuense, 292
00149 Roma

Giovanni **REZZA**
Laboratorio di Epidemiologia e Biostatistica
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Enrica **ROSA**
Presidenza
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Giulia **SCARAVELLI**
Laboratorio di Epidemiologia e Biostatistica
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Angela **SPINELLI**
Laboratorio di Epidemiologia e Biostatistica
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Laura **SPIZZICHINO**
Unità Operativa AIDS
ASL RM/E
Via Catone, 20
00192 Roma

Rudi **VALLI**
Telefono Verde AIDS
Istituto Superiore di Sanità
Viale Regina Elena, 299
00161 Roma

Stefano **VOLPICELLI**
LILA Centro Studi
Ripa di Porta Ticinese, 47
20143 Milano

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THE ITALIAN CONTEXT

Introduction

For some years the industrialized countries of the Mediterranean area have been affected by constant migratory flows of persons who, driven by precarious living conditions in their countries of origin, embark on often risky journeys in the hope of obtaining conditions of greater wellbeing and freedom.

Italy has also been transformed from a country of emigration into a "preferred migratory destination" and has been forced to address the problems that arising from permanent, temporary and seasonal immigration.

According to the official data of the Ministry of Internal Affairs, the number of foreigners legally residing in Italy as of 31 December 2001 was 1,362,630, equal to approximately 2.8% of the Italian population, while estimates of the presence of illegal or clandestine immigrants range from 15% to 30% of immigrants as a whole.

The most numerous immigrant communities in Italy are those originally coming from: Morocco (158,000), Albania (144,000), Rumania (75,000), the Philippines (64,000), China (56,000) and Tunisia (46,000).

This migratory phenomenon has given rise to a series of political, economic, social, sanitary and health problems that concern Italy at different levels.

With regard to health care, despite the fact that in Italy a gradual administrative decentralization is taking place in this field, assigning a greater responsibility to the regional and local governments, immigration is going to remain under the State control, according to the provisions of art. 1, paragraph 3, of Law 59/1997.

However, official data for evaluating the health of the immigrant population are not available since Italy does not yet have a national epidemiological observatory.

The sources of information on the types and characteristics of diseases suffered by foreigners are therefore the case histories of public and voluntary structures that provide psychosocial-health assistance to immigrants throughout the country.

Available data show that, generally speaking, immigrants are in good health at the time they leave their own countries but their health deteriorates during both the journey and their stay in Italy.

In fact, the diseases most frequently suffered by immigrants in our country are the non-infectious ones developed in the host country, typical of the hardship in which most immigrants are forced to live.

This is equally true as far as sexually transmitted diseases (STDs), especially HIV/AIDS, are concerned.

In terms of the incidence of cases of declared AIDS among foreigners, the National AIDS Register of the Istituto Superiore di Sanità shows a significant increase over time: from 1.7% in 1993-1994 to 8.9% in 2001-2002.

The majority of cases concerned persons from Africa, South America and Eastern Europe.

At present, despite the fact that Law 40/1998 regulates health care to foreigners residing in Italy, whether legally or illegally, it often happens that foreigners, especially the illegal residents, do not make use of the services of the National Health System.

Fear of contact with public structures and lack of correct information about HIV/AIDS and, in particular, about the test, mean that this group of the population is reluctant to undergo the

clinical examinations aimed at timely diagnosis and adequate, well-monitored pharmacological treatments, with the result of late diagnosis.

Indeed, for many immigrants there is only a small lapse of time between their first test for anti-HIV antibodies and the diagnosis of AIDS, if the events are not actually simultaneous.

Therefore, steps must be taken to improve the quality of services of prevention, care and treatment for foreign populations and strategies need to be adopted for promoting a transcultural form of medicine, willing to recognise cultural diversity and make the most of it.

An adequate, concrete response to the health needs of foreigners must necessarily entail an examination of their needs and an analysis of demand, plus a reorganization of services based on the specific requirements of the target group, planning new strategies and approaches characterized by flexible services, technical and relational training of personnel, a multidisciplinary approach (teamwork) and an integrated collaboration between public services, NGOs and voluntary associations (network activities).

This report is meant to provide an overview of the efforts made during the period 2001-2002 not only by the Italian National Focal Point (NFP), as a workgroup existing since 1997, but also by its individual member structures, both governmental and private, in terms of their specific activities, with regard to the supply of psychological, social and health assistance to immigrant citizens.

Legislative policy on immigration in Italy: recent modifications and additions

On the subject of immigration, the political criteria set by the legislature in force have been characterized by the firm intention to stress legality within the democratic system. In pursuit of this objective, the Government's programme has aimed at giving all foreigners residing in Italy a well-defined legal status by implementing legislative measures designed to legalize illicit work, to set clear-cut and severe rules as regards the expulsion of clandestine immigrants and foreigners guilty of serious crimes, to tie residence permits to the length of job contracts, to strengthen official administrative structures and to make administrative and criminal sanctions harsher. At the same time the Parliament also passed legislative measures designed to:

- favour all the humanitarian organisations engaged in the promotion of social development activities;
- make it possible to facilitate and revise bilateral cooperation and aid programmes for non-humanitarian initiatives in favour of non-EU member countries that collaborate in the prevention of flows of illegal migration.

These countries also participate in the fight against the criminal organizations engaged in clandestine immigration, trafficking in human beings, exploitation of prostitution and drugs and arms traffic and also carry out law-enforcement activities to prevent the return of foreign citizens that have been expelled.

Of noteworthy importance is the Committee formed to coordinate and monitor the measures issued by Parliament and the Cabinet for supervising full enactment of civil, administrative and criminal measures issued on the subject of immigration. This committee will also have control and guidance functions and carry out focused actions.

For a comprehensive view of the aforementioned regulations, reference must be made to Legislative Decree no. 286 of 25 July 1998, with the force of law, containing the Consolidated Act of the measures regarding immigration and the regulations governing the status of foreigners, with the result that practically all the legislation currently in force on the subject is

consolidated in a single text. In the case of applicants for refugee status, article 1 of Law no. 39 of 28 February 1990 remains in force, though it has been extensively modified and supplemented by the recently passed Law no. 189 of 30 July 2002 (known as the "Bossi-Fini-Giovanardi" Law), which contains changes regarding the regulations on immigration and asylum. The most significant innovations introduced in the Legislative Decree no. 286 of 25 July 1998 by the aforementioned Law 189/2002 can be summed up as follows: November 30th of the preceding year was fixed as the deadline for setting the maximum quotas of foreign immigrants to be accepted in Italy; entry visas may be refused for reasons of security without giving the reasons; criminal punishment may be inflicted if an application for an emigration visa made to the diplomatic delegation or consulate in the country of origin is accompanied by false statements; photographs and fingerprints are to be taken of foreigners applying for residence permits; residence permits for work are only to be issued if a contract of residence for dependent job has already been signed; the duration of the residence permit is to be limited to the duration of the employment contract; severe penalties are to be inflicted on persons that falsify entry visas or other deeds or documents regarding residence in the country; the employer must guarantee lodging; the employer must make a formal commitment to pay the immigrant's repatriation costs; the period of residence required for obtaining a residence card is increased from five to six years. The measures against clandestine immigration contain more severe administrative and criminal penalties than previously. Specifically, adequate measures are contemplated for expulsion, escort to the border by the police; in addition, expulsion orders are to be adopted as an alternative punishment to imprisonment.

The immigrant's right of defence is confirmed, although it is not clearly defined in specific cases. The services designed to provide access to employment, provided for under the previous regulations, are replaced by the so-called "pre-emption right" granted to potential immigrants who attend professional training courses in their countries of origin under programmes financed by the Italian Government.

As regards applicants for refugee status, a clear legislative reference is now contained in the abovementioned Law no. 189 of 30 July 2002. In short: a temporary residence permit, which is valid until the necessary background investigation for the granting of refugee status is completed, is issued; the administrative procedures for handling the application are simplified; the system of protection and safeguard for applicants for asylum and refugees is guaranteed. All the provisions above-mentioned, as well as those issued under Legislative Decree no. 195 of 9 September 2002, which contains urgent provisions regarding the legalization of illicit work by "non-EU immigrants" and was converted with amendments into Law no. 222 of 9 October 2002, will be supplemented by implementation regulations and government provisions.

Health policies and immigration: the impact of the new law on immigration

The new law on immigration, known as the "Bossi-Fini" Law after its proposers, came into force on 10 September 2002. The Cabinet approved the bill, announced during the election campaign, the day after the attack against the Twin Towers and on July 27, in slightly less than a year, , it was passed by Parliament under the title "Amendments to the Rules and Regulations governing Immigration and Asylum", Law no. 189 (published in Issue no. 199 of 26 August 2002 of the *Gazzetta Ufficiale della Repubblica Italiana – Supplemento Ordinario* no. 173).

The law met with heated reactions and not even the Government's attempt to make the measure less drastic by permitting the regularization first of family assistants (purview already

considered in the law) and then of illegal workers (Legislative Decree no. 195 of 9 September 2002) succeeded in softening the tone of the discussion.

For years we have been saying that the presence of immigrants in our country is a great occasion and opportunity: not so much in economic and job-related terms – though this is certainly the case as well – but what is even more important in the light of cultural and social considerations and, as a result, organizational consequences as well. As concerns our specific case, the fact that we have had to include in health protection activities citizens coming from more than 170 countries, who bring with them a kaleidoscope of cultures, varied expectations and a different perception of their bodies, health and illness, and who belong to a variety of social situations with different legal statuses, has produced - and still produces – an effort on the part of the system, with a closer examination and a questioning not only about these developments, but also about our own attitude and approach as health workers and the way the services are organized and the relationship that each of us manages to establish with others, be they Italians or foreigners.

This process necessarily involves a reciprocal adjustment to one another's cultures and integration that enriches a society and an organization petrified by too much affluence, economic budgets frequently designed for a culture of desires, appearances and virtual worlds rather than on the basis of fundamental, essential needs and of a standard of living that also takes into account human relations and the feeling of belonging to a community.

No law or regulation can determine this process but it can certainly acknowledge and attempt to regulate this phenomenon in terms of integration and respect by establishing even severe rules, provided that they are justified by manifest conditions that everyone, both Italians and foreigners, must observe.

Limiting the reflection on the new law to topics related to health care, we just cite the remarks contained in the final document of the 7th Consensus Conference on Immigration held in Erice (Province of Trapani, Sicily) in May 2002, an event where approximately 250 health operators working in the public or private social services and in voluntary associations came from all over Italy to exchange ideas and examine the available scientific data on the health of immigrants and on health policies implemented. The final resolution of the Consensus states: "the fact that the residence permit is tied to employment casts foreigners in a utilitarian light, reducing them to nothing more than a work force, with the risk of exposing them to blackmail and harmful exploitation by employers (in fact, being fired would have far more serious consequences than simply losing a job); it also makes it impossible for workers to make durable plans. Furthermore, by creating obstacles to legalization (in particular the "abolition" of sponsorships) it encourages illegal situations, which have been found to represent a significant risk factor for health. The restrictive criteria for family reunification impede the formulation of long-term projects and the emotional and affective stability of the immigrants, with resulting damages for their psycho-physical wellbeing. The adoption of a simplified procedure for asylum, combined with the abolition of fundings for the National Asylum Programme, resulting in a sudden cessation of assistance for asylum seekers and refugees, many of whom find themselves without housing or even the most elementary assistance, will produce (and is already producing) significant damages to the health of these persons, who are the weakest of the immigrants".

In addition, starting from the very first days of implementation, we have already noticed an effect that gives serious cause for concern. Many operators believe that the health regulations guaranteeing access to services both to legal immigrants and, even more important, to clandestine immigrants (the FTP, or Foreigners Temporarily Present) have been abrogated and so they refuse to provide assistance; many immigrants are also afraid of this and so they do not attempt to address to services. It is worthwhile remembering that the rules and regulations

contained in articles 34 and 35 of the Consolidated Act on Immigration (Legislative Decree no. 286 of 1998), in its rules for the enforcement (Decree no. 394 issued by the President of the Republic in 1999) and the Memorandum no. 5, dated 24 March 2000, of the Ministry of Health, are still in force and therefore everyone holding a long-term residence permit must be registered with the National Health Service, while illicit and clandestine immigrants are guaranteed essential, emergency, preventive and permanent care and it is forbidden to report them to the police if hospitalised or cared for.

In confirmation of the above it should be noted that some Regional Governments more or less promptly issued comments/memorandums confirming not only that the right of immigrants to health care remained unchanged, but that foreigners in the course of regularizing their situations (meaning those who had submitted a request to bring their "illegal" jobs onto the legal labour market) had obtained the right to register with the National Health Service (the Regions that took such action were Latium, Veneto, Emilia Romagna, Umbria, Friuli-Venezia Giulia and Trentino-Alto Adige).

The new law on immigration increased the cultural gap, the fears, suspicions and reciprocal prejudices existing between Italians and foreigners; at a time when steps should be put the provisions of the national legislation regarding health care for foreigners into effects at the local level, doing so through initiatives that could make the system truly accessible, the dispute engendered by this new law has practically brought all activity to a stop, if not actually favoured, for the time being, a number of steps backward.

Campaigns for the prevention of HIV/AIDS for mobile populations

As part of the prevention campaigns organized by the Ministry of Health during the period 2001-2002, the Ministry has gone on with the distribution of materials designed for the migrant populations and produced in the course of the 6th Informational-Educational Campaign on AIDS.

In 2002 the procedure for a call for tenders to select the Agency to handle the information campaign for 2003-2004 was completed. The programme chosen includes the production of multilingual brochures targeted to immigrant populations, together with the billsticking of multilingual posters on public transport vehicles and a varied sports programme that has recently attracted a good deal of interest from young foreigners living in our country.

ACTIVITIES OF THE ITALIAN NFP (2001-2002)

Research activities

During the period 2001-2002 the Italian NFP – coordinated by the Istituto Superiore di Sanità (the Italian National Institute of Health), which is characterised by the presence of experts belonging to public structures (Istituto di Ricovero e Cura a carattere Scientifico "L. Spallanzani", Istituto di Ricovero e Cura a carattere Scientifico "Santa Maria and San Gallicano", Università degli Studi di Roma "La Sapienza", the Ministero della Salute and the Unità Operativa of the Azienda Sanitaria Locale RM/E) and non-governmental organizations (LILA and the TAMPEP-Comitato per i Diritti Civili delle Prostitute) as well as voluntary associations (Caritas Diocesana di Roma) – proposed and implemented two projects in Italy:

- *Creation of a national network of the non-governmental psychosocial-health structures that work with immigrant populations suffering from problems related to HIV infection or sexually transmitted diseases (STDs)*

  The general objective of this study, coordinated by the Istituto di Ricovero e Cura a carattere Scientifico L. Spallanzani and still underway, is to provide an updated overview of the actual situation in our country with regard to non-governmental organisations and voluntary associations that work with AIDS and sexually transmitted diseases (STDs) and mobile populations. This is being done in order to favour collaboration among the different services while facilitating access by foreign citizens to the structures in question.

- *ARIANNA – a pilot study for the creation of a multicentre training network for linguistic-cultural operators and mediators, to be utilised in initiatives of information and prevention of HIV infection and sexually transmitted diseases targeted to groups of immigrants at risk of exclusion from psychosocial-health services: clandestine and illegal immigrants, foreign prostitutes and drug addicts*

  The objective of the study, coordinated by the Istituto di Ricovero e Cura a Carattere Scientifico San Gallicano, is to provide specific training to linguistic-cultural mediators and to operators working in psychosocial-health centres accessible also to foreign users.

Training activities

Among the many actions designed to safeguard the health of migrant populations, the Italian National Health Plan for 2002-2004 stresses, *inter alia*, the need for initiatives that facilitate access to services and make them easier to use, including providing specific information that takes the cultural diversity of the target group into account.

Therefore, the Istituto Superiore di Sanità, in its role as coordinator of the Italian NFP and as part of the training activities contemplated under its institutional goals, has proposed, organized and held a training course aimed at psychosocial-health operators, in order to provide them with an integrated, multi-professional approach to safeguarding the health of immigrants.

The training process, designed for the staff of the National Health System, of non-governmental organizations and voluntary associations engaged in providing services for safeguarding the health of immigrants, was held at the headquarters of the Istituto Superiore di

Sanità. The course, which lasted for 40 hours (from Monday, October 7th to Friday, October 11th, 2002), was designed to stimulate, through an analysis of the current situation, reflection on the need to pursue a transcultural health approach aimed at recognising the "diversity" of others and making the most of their human and cultural heritage.

The objective of the course was to provide knowledge relevant to the identification of criteria of fundamental importance in teamwork and network activities, so as to increase the effectiveness and quality of the services supplied to foreign citizens.

An interactive teaching method was employed, with theoretical lessons supplemented with group exercises and discussions involving all the participants.

The group of 21 participants, who work in a variety of professional roles (physicians, psychologists, biologists, social workers and professional nurses) was given educational materials with bibliographic indications and suggested reading. Attendance certificates were also issued, showing the number of hours of training and the number of training credits received from the National Commission of the Ministry of Health for Ongoing Training.

The teachers were members of the Italian NFP and a number of different subjects were dealt with including:

- the epidemiological situation of HIV infection among migrant populations;
- particularly high-risk infectious pathologies among immigrants;
- health policies and legislative aspects regarding mobile populations;
- communication and relational aspects within a transcultural framework.

An analysis of the pre- and post-tests administered to the participants shows a strong growth within the group, with an average increase of 4 points in the score of correct answers.

Finally, the results of the evaluation sheets filled out by the participants regarding the "relevance", "quality" and "effectiveness" of the course showed a high degree of satisfaction.

The programme of the training course designed for psychosocial-health operators in order to achieve an integrated multi-professional approach to the health of migrants considered the following topics:

- *1st session*
  - Epidemiological considerations on HIV/AIDS in migrant populations
  - Infectious pathologies that represent risks for immigrants
  - Infectious pathologies in the Mediterranean area associated with migration
- *2nd session*
  - Health-care policies and legislative considerations regarding mobile populations
  - Legal profile of immigrants with regard to current legislation
  - Information campaigns on HIV infection/AIDS and mobile populations
  - Anthropological and phylogenetic aspects
  - Considerations on the reproductive health of immigrant women
  - Couples in disagreement
  - TAMPEP: prevention of HIV/AIDS in the world of prostitution
- *3rd session*
  - Multi-professional activities: teamwork, network activities
  - Communication, report on professional aid and counselling within a transcultural framework
  - Counselling within a transcultural framework: definition, characteristics and procedural phases
  - Basic counselling skills within a transcultural framework
  - Telephone counselling within a transcultural framework
  - Listening: counselling and mental disorders within a transcultural framework

– *4th session*
  - New technologies and the safeguarding of the health of migrants
  - AIDS and Mobility Project: the Italian NFP

A pre-test and a post-test were also administered to the participants to evaluate the success of the course which included also practical exercises.

ACTIVITIES OF EACH PUBLIC STRUCTURE AND NON-GOVERNMENTAL ORGANIZATION OF THE ITALIAN NFP

Istituto Superiore di Sanità, Rome

Telephone counselling on HIV/AIDS within a transcultural framework

Between 29 November 1995 and 31 December 2002 the Telefono Verde AIDS Telefono Verde AIDS (TVA, Italian National Aids Help-line: 800-861061) (Laboratory of Epidemiology and Biostatistics of the ISS) received a total of 1,682 calls from foreign users: 262 (15.6%) of these calls were from citizens of non-EU countries; 253 (15.0%) from citizens of the European Union; 484 (28.8%) from citizens of African countries; 493 (29.3%) from citizens of the Americas; 174 (10.3%) from citizens of Asian countries and 4 (0.2%) from citizens of the countries of Oceania. In the case of 12 users (0.7%), it was not possible to identify their origin.

Male users accounted for 1,022 (60.8%) telephone calls, while females made 649 (38.6%) calls and information on gender was not available for 11 calls (0.6%).

The geographic areas from which the calls were the following ones: Northern Italy 771 (45.9%); Central Italy 745 (44.3%); Southern Italy 108 (6.4%); the Italian islands 27 (1.6%); no area was indicated for 31 calls (1.8%).

The most represented groups of users were:

- persons who had heterosexual intercourses and were not drug addicts: 1041 (61.8%)
- non-risk factors (NRF): subjects who did not have risky behaviours: 341 (20.3%)
- seropositive persons: 151 (9.0%)
- homo-bisexuals: 111 (6.6%)
- drug addicts: 15 (0.9%)
- persons who had received blood transfusions: 6 (0.4%)
- not indicated: 17 (1.0%)

As shown by the data listed above, the group of persons who had heterosexual intercourses and that of the non-risk factors accounted for the largest number of users of the TVA.

The total number of questions received by the TVA from foreign users was 4,696 and the calls regarded the following topics:

- information on the test: 1,721 (36.6%);
- modes of transmission: 1,131 (24.0%);
- psychosocial topics: 712 (15.2%);
- misinformation: 376 (8.0%);
- prevention: 315 (6.7%);
- virus: 107 (2.3%);
- general topics: 70 (1.5%);
- symptoms: 141 (3.0%);
- therapies and research: 115 (2.5%);
- other: 8 (0.2%).

The telephone proves to be a particularly useful tool in the prevention of HIV infection and AIDS, not only on account of the rapid access offered but also because, since it makes

anonymous communication possible, it overcomes the psychological and social difficulties related to the illness and to the uneasiness felt with topics regarding the sexual sphere.

In replying to the questions asked by the callers, the counsellors of the TVA must keep in mind a series of psychological, social and cultural factors that have a great influence on the outcome of the informative message, making the counselling process extremely complex. This is particularly true for foreign citizens who, in addition to the language difference, have different socio-anthropological and religious customs. Therefore the TVA of the Istituto Superiore di Sanità not only represents a rapid and economical instrument for the supply of "personalized" scientific information, but also a privileged observatory for evaluating the information needs of the general public and for planning more effective prevention actions.

Aspects of the assistance provided to immigrant women as concerns their reproductive health

In response to the increase of female foreign population in Italy in recent years – a total of approximately 636,000 foreign women at the beginning of 2001, compared to 260,000 in 1991 – a number of studies and projects on access to services in the area of reproductive health have been carried out by the Reparto Indagini Campionarie di Popolazione Laboratory of Epidemiology and Biostatistics of the ISS of Rome.

In particular, two surveys were carried out in 1995-96 and in 2001 (the latter was part of a project financed by the Ministero della Salute) to evaluate assistance at birth. In general it was found that non-EU women were found seriously lacking in information about the availability of health more generally of a psychosocial support to pregnant women by public health structures. For example, more than 60% of foreign women had not received sufficient information on the possibility of receiving a prenatal diagnosis, as compared to 31% of the Italian women interviewed in 1995-96. In addition, 67% of the non-EU women declared that they had not received any information on the use of methods of contraception in the puerperium (period immediately following the birth of the child), as compared to 40% of Italian women. 4% of the immigrant women reported that they were not under the care of any professional worker during their pregnancy, while this figure was equal to 0.5% among Italian women. 17% of those interviewed in 2001 stated that they had difficulty in receiving care during their pregnancies, with the highest percentage recorded among women from Eastern Europe. 16% of the foreign women were examined for the first time after the 3rd month of pregnancy. In particular, 2,6% received their first examination in the 8th-9th month and only 15,4% of the women interviewed attended a course of preparation for childbirth, most of them at a family advisory centre. The principal reasons for not participating in such courses were: lack of knowledge of their existence (41.9%) and problems of time (22.0%). What emerged once again was a lack of information and a difficulty in obtaining access to structures, that can have serious consequences for the health of the mother and child. Indeed, as other studies have already pointed out, the percentage of certain negative outcomes at birth, such as premature birth and low weight, was greater among foreigners.

An analysis carried out by the Istituto Italiano per le Statistiche on data concerning miscarriages or spontaneous abortions makes it possible to evaluate whether the increase in the number of miscarriages recorded among foreign women (5152 cases in 1999 compared to 1557 in 1992) was the result of the increase in the overall population of foreign women in our country or the risk of miscarriage was greater in the foreign population: the proportions of miscarriage were calculated (number of miscarriages /number of miscarriages + number of children born + a certain percentage of abortions x 1000) by age group, for Italian women and women coming from industrialized or developing countries. The figure was 101.2 for each 1000 pregnancies

among Italian women and 97-98 for each 1000 among foreign women, showing that the risk of miscarriage is fairly similar for the three groups, with a slightly higher level among Italian citizens, while the increase in the figures concerning foreign women is primarily due to the increase in the population of foreign women immigrants in our country. This conclusion is confirmed by the fact that, in all three groups, the risk increases as the woman grows older.

There was no way of evaluating whether these differences might depend on a different degree of access to services. Based on the figures for hospitalization, it can be observed that foreign women make more frequent use of public structures than do Italian women.

Finally, the incidence of abortions was evaluated. Examining the figures for female foreign citizens, the number went up from 8,967 abortions in 1995 to 13,826 in 1998 and 21,201 in 2000, corresponding to 15.7% of the abortions performed in Italy.

Once again, the numerical increase in abortions among foreign women is undoubtedly due, first and foremost, to the increase in the presence of foreign women in Italy: in fact, the estimated abortion rate per 1000 foreign women residents aged 15-44 in 1995 proved to be 27.4, while the figure was 29.1 in 1996, 26.4 in 1997 and 28.7 in 1998. These figures are far higher (roughly three times higher) than those recorded for Italian women, whose rate during the same years, calculated for women aged 18-49, was approximately 9 per 1000. This result should come as no surprise, given that many foreign women residing in our country find themselves in situations of need, and in addition they may come from areas where abortion is practised more frequently than in Italy. What is more, these women tend to interrupt their pregnancies at a later stage than Italian women (24.3% at the 11^{th}-12^{th} week, compared to 12.3% among Italian women). Once again, this may indicate a lack of information on the legislation regulating abortions or a difficulty in obtaining access to services.

Istituto Nazionale per le Malattie Infettive "L. Spallanzani", Rome

New diagnoses of HIV infection in the post-HAART era. Comparison of the Italian and foreign populations

Many recent studies showed that Black and Latino persons are more likely to receive late HIV diagnosis, adequate treatment and support. Recent advances in the treatment of HIV disease underscore the need to increase the early knowledge of HIV serostatus, in order to give HIV infected people the opportunity to have access to therapeutic and preventive care.

In Italy access to heath services, HIV testing and treatment are free of charge.

Over the last few years, the number of immigrants attending the outpatient clinic for HIV/AIDS of the Istituto Nazionale per le Malattie Infettive L. Spallanzani in Rome, one of the largest centres for the diagnosis and treatment of HIV disease in Italy, was seen to grow.

We set out to describe the epidemiological and clinical characteristics of persons with newly diagnosed HIV infections and compare these characteristics for the Italian and foreign populations (persons from non-EU countries).

The study included all adults attending the outpatient clinic for HIV/AIDS of the Istituto Nazionale per le Malattie Infettive L. Spallanzani in Rome and diagnosed as HIV positive between January 1997 and December 2001. Information on demographics (sex, age, country of origin), clinical stage (CD4+ cell count, viral load), reasons for testing, previous HIV testing and mode of transmission were collected from the individual charts.

A total of 463 HIV infected persons – 358 Italians e 105 immigrants – were observed. 40% of the immigrants were Africans, 40% were Latinos from Central or South America and 20% were from Eastern Europe or North Africa. Over the years there was an increase in the number of HIV diagnoses observed, while the proportion of immigrants among those diagnosed also grew (from 8% in 1997 to 36% in 2001, Figure 1).

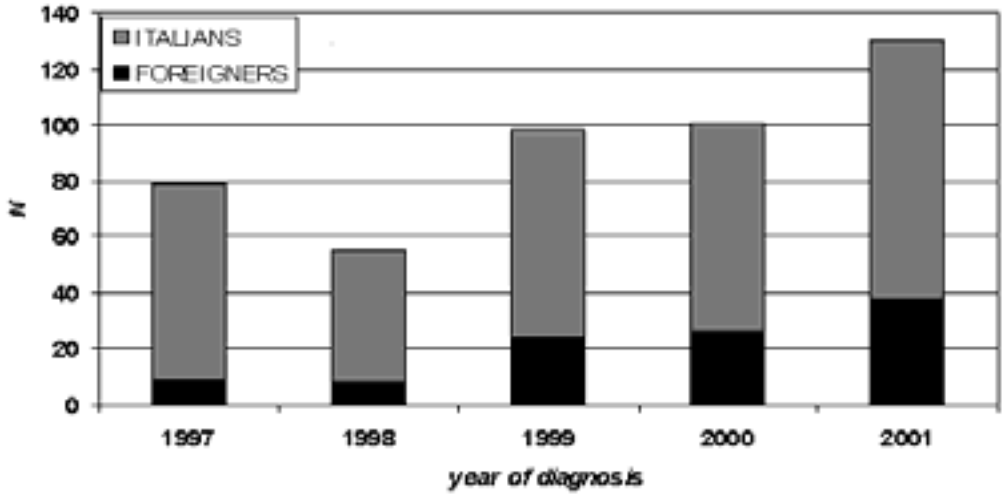

Figure 1. Newly diagnosed HIV infections by year and nationality

There were no clear differences in gender, while immigrants and Italians differed significantly in terms of other epidemiological characteristics (Table 1). The immigrants were younger than the Italians (median age of 30.8 years vs. 35.3 years) and less likely to have had a previous negative HIV test; they were more likely to test as a result of antenatal screening. 64% of immigrants compared to 43% of Italians were infected through heterosexual intercourses, while 2% compared to 10% reported intravenous drug use.

No significant differences emerged regarding the disease stage at the time of diagnosis: the median CD4 cell count was 378/mmc among immigrants and 428/mmc in Italians; among immigrants 24% and 44% had CD4 cell counts <200 and < 350 cells/mmc, respectively, compared to 21% and 39% of Italians.

Our data show that, during the HAART era, immigrants accounted for an increasing proportion of the new diagnoses of HIV infection. There were significant differences in epidemiological characteristics between the populations studied. More than 40% of the persons with a new diagnosis of HIV infection had the disease in a relatively advanced stage, as determined by CD4 cell count. Indeed, more than 20% had a count of less than 200 CD4. No differences emerged between immigrants and Italians with regard to the clinical stage. This can be explained by the fact that we did not consider the inpatients in this report, but only patients seeking HIV testing at an outpatient clinic: it is possible that they may have had greater access to appropriate services or a greater awareness of their status. Strategies to give foreigners the opportunities, information and motivation necessary for being tested must be improved.

Table 1. Comparison of characteristics in immigrant and Italian patients with a new diagnosis of HIV

Characteristic	Immigrants (%) n. 105	Italians (%) n. 358	Overall (%)
Female	38.1	30.4	32.2
Age in years			
18-24	9.5	7.0	7.6
25-34	59.0	40.5	44.7
35-44	28.6	36.6	34.8
45-	2.9	15.9	13.3
Previous negative HIV test	34.7	47.7	44.7
Reason for testing			
Symptoms	16.7	23.0	21.6
Antenatal screening	11.1	0.9	3.2
Partner positive (recent diagnosis)	23.3	27.6	26.7
Patient's request	14.4	14.3	14.3
New relationship	16.7	25.2	23.3
*Other**	17.8	9.0	10.9
Transmission route			
Heterosexual	63.6	43.0	47.7
*MSM***	33.3	38.5	37.4
*IVDU****	1.9	10.1	8.2
Unknown	1.0	8.4	6.7
CD4 cell count/mmc			
<350	44.1	39.2	40.2
<200	23.7	21.1	21.6

*blood donation, sexually transmitted diseases, work, legal reasons, etc.
**MSM: men who have sex with men
***IVDU: intravenous drug use

Creation of an Italian network among governmental and non-governmental psychosocial-health structures

In recent years Italy has gone from being a country of emigration to a destination of immigrants; the prevalent countries of origin of the foreigners are those with underdeveloped economies (54.8%) and the nations of Eastern Europe (23.6%), while the European Union and the countries with developed economies account for a total of 21.6%. Within the European Union, the average figure is 4.7%.

The immigrants are primarily young persons, meaning that they belong to a group of the population that is more sexually active and presumably more at risk for HIV infection and from sexually transmitted diseases.

The objectives of the present project, about the creation of an Italian network which attend to mobile populations suffering from problems related to HIV infection and sexually transmitted diseases (STDs), are:

– the realization of a census and mapping of the psychosocial-health structures that work with mobile populations suffering from problems involving HIV infection and sexually transmitted diseases in Italy;

- the creation of a joined computerized data bank of psychosocial-health structures, both governmental and non-governmental, attended by mobile populations;
- the creation of a network among psychosocial-health structures, both governmental and non-governmental, operating in Italy.

The achievement of these objectives may provide mobile populations with easier access to information, counselling, screening, treatment, hospitalization and follow-up regarding HIV infections and sexually transmitted diseases.

In addition, the research may prove to be a useful tool for the Italian health authorities, making it possible to organize more efficient health-care programmes.

It is held that the first three objectives can be reached in a year's time, while a second phase of the project will be necessary for the remaining three objectives.

Methods

The project is divided into two phases. The first phase, involving the achievement of the first three planned objectives, was carried out during the year 2001-2002 and consisted of:

- identifying the psychosocial-health structures through the offices of the Regional Health Authorities, the Italian Federation of Voluntary Service and the updated archive of the TVA of the Istituto Superiore di Sanità;
- sending out a questionnaire for the collection of information regarding the individual psychosocial-health structures, both governmental and non-governmental, that provide medical assistance to foreigners, in particular with regard to HIV infection and sexually transmitted diseases;
- processing the information collected through the questionnaires to create a data bank;
- creating a network among the Italian psychosocial-health structures that work with HIV infection, STDs and mobile populations.

Preliminary results

Eighty non-governmental psychosocial-health structures were identified and questionnaires were sent to them. 29 of the centres returned the filled-out questionnaires. The geographical distribution of the centres that responded was as follows:

- 36% in Northern Italy;
- 44% in Central Italy;
- 20% in Southern Italy.

The following different types of centres responded (some fall under more than one category):

- 4 oupatients' clinics;
- 1 outpatients' clinic specialized in STDs;
- 3 therapeutic communities;
- 7 day-care reception centres;
- 13 residence homes;
- 1 listening centre;
- 1 family home;
- 1 Caritas centre;
- 2 consulting offices;
- 1 voluntary association.

The respondents were asked to indicate which professional figures were permanently employed and which were not employed inside the structure, calculating the average number of hours of service in a month. The average drawn from the data received from the 24 structures

that gave complete answers to all the questions is shown in Table 2 representing the professional figures both permanently and not permanently employed.

Table 2. Health workers inside and outside the structure and their monthly hours

Health workers	Inside		Outside	
	n. workers	***average hours/months***	***n. workers***	***average hours/months***
Physicians	3	110	25	21
Psychologists	9	76	2	27
Sociologists	2	132	1	14
Social workers	1	72	2	30
Laboratory personnel	5	150	0	0
Pharmacological personnel	1	80	16	35
Nursing personnel	4	160	8	22
Cultural mediators / translators	3	56	2	77
Secretarial personnel	1	93	14	61
Research assistants	7	160	2	33
Administrative personnel	2	34	1	2

An initial analysis shows the following:

1. in 25% of the centres that answered the questionnaire, the personnel had received training during the previous year, to heighten their awareness on topics relevant to the health of foreign users, with the training designed for the above mentioned professional figures;
2. 41% of the centres experienced difficulty in providing assistance to foreign users (mainly difficulty in communicating, in talking about HIV and sexually transmitted diseases and problems involving compliance with the antiretroviral treatment);
3. only 10% of the centres have a cultural mediator;
4. approximately 43% of the users possess valid documents;
5. the centres examine an average of 270 foreigners a month;
6. 65% of the centres offer counselling;
7. 41% of the centres provide services on an anonymous basis;
8. approximately 70% of the centres claim that they are aware of the legislation regarding the access of foreigners to psychosocial-health facilities.

Remarks

An initial analysis of the data shows, in the case of the non-governmental centres, a need for training on the specific themes of immigration and HIV/sexually transmitted diseases (STDs), as well as for items able to improve the communication with migrant populations. The final processing of the information obtained will serve as a useful tool by providing knowledge that can be used to optimize the activities of the structures that deal with immigration and HIV infection.

Istituto di ricovero e cura a carattere scientifico "Santa Maria e San Gallicano", Rome

Activities of the Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology

The services of the Department are specifically aimed at clandestine and illegal immigrants, gypsies, drug addicts, homeless people, victims of prostitution, minors, refugees and asylum seekers, victims of torture, immigrant and Italian transsexuals and people at risk of marginalization because of health problems.

The Department is open Monday to Friday. Patients are registered 8:30 am – 12:30 pm. Patients are examined 9:00 am –2:00 pm. On Tuesdays and Thursdays registration can also be done from 3:00 pm – 6:00 pm, and patients are examined from 3:00 pm – 7:30 pm. Every day 80-100 people are examined. In addition to receiving a general and/or dermatological examination, each individual, after being interviewed, is given a dossier with his/her administrative data, reports and medical information, useful for the processing of statistical data and the production of scientific research.

Since 1996 the Department avails itself of the help of linguistic-cultural mediators, who welcome foreign patients and provide translation services in their own languages. They also facilitate cultural and linguistic interpretation for diagnostic and therapeutic purposes. The main languages spoken are: French, English, Spanish, Portuguese, Arabic, Kurd, Lingala, Swahili, Tigrigna, Amharic, Bantu, Filipino (Tagalong), Tamil, Bangladeshi, Serbo-Croatian, Bulgarian, Polish, Russian, Rumanian and Albanian.

Over the last few years the City Council of Rome has given significant encouragement to a policy of health promotion "without exclusion", through projects co-ordinated by its Health Promotion Policies Department. For the homeless population, this Department has engaged in a number of social promotion activities, aimed at supporting disadvantaged homeless people with health problems, in collaboration with a medical institution able to offer adequate guarantees of scientific reliability and cultural awareness from its experience in the field.

In July 1999 an agreement was made between the City Council of Rome, the Health Promotion Policies Department and the San Gallicano Institute for the purpose of developing social and health services for homeless and resident people, immigrant and gypsy groups in Rome.

The results achieved by this agreement were the following ones:

- the creation, within the Department of Preventive Medicine for Migration, Tourism and Tropical Dermatology, of an Observatory on the homeless, resident, immigrant and gypsy populations in Rome and the creation of a data bank that – based on the information requirements of the Health Promotion Policies Department of the City Council of Rome – provides: a) a census of these populations in the metropolitan area; b) information useful to local agencies/authorities for planning assistance to and social rehabilitation of the homeless;
- an overview – through clinic registrations, interviews and medical examinations – of the lives and the social and health needs of some homeless groups with particular characteristics, such as drug addiction, alcoholism, prostitution, as well as of children and teenagers at risk of falling into the disadvantaged segments of society and/or exploitation etc.;
- the availability of training courses for social and health workers and professionals (special public services, reception centres etc.) in order to examine in depth the social and

medical aspects of the homeless population, the international experiences in this sector, the legislation in force, the techniques of action and the projects for support and social reintegration;
- the use of linguistic-cultural mediators, specially trained for work with the homeless;
- the experimentation of a social administration service that offers referrals and establishes connections between the homeless who seek aid from the Department, the public structures and the social private centres operating in the field.

Scientific and epidemiological research

The scientific and epidemiological research activities of thi Department include:
- Long-term project "Realization of social services for homeless people and resident, immigrant and nomad populations in the City and Province of Rome", promoted by the City Council of Rome and the Department of Health Promotion Policies, in collaboration with day-care and night-time reception centres ("Mago di Oz", "Barone Rampante", "Il Ponte", "Santo Spirito" etc.), Unità Sanitarie Locali (RMA, RMB and RME), voluntary associations (Caritas, Sant'Egidio, Casa dei Diritti Sociali, etc.). (€ 310,000)
- Long-term project involving a "*Desk for counselling and information about health and social problems for the migrants seeking aid from our Department*", sponsored by the Italian Government and the Department for Social Services and Family Policies. (€ 126,531)
- Focused research *"ARIANNA – a pilot study for the creation of a multicentre training network for linguistic-cultural operators and mediators, to be utilised in initiatives of information and prevention of HIV infection and sexually transmitted diseases targeted to groups of immigrants at risk of exclusion from psychosocial-health services: clandestine and illegal immigrants, foreign prostitutes and drug addicts"* in collaboration with the Istituto Superiore di Sanità. (€ 25,822)
- Focused research *"Italian network for the rehabilitation of the victims of torture"* presented by the ICS (Italian Solidarity Consortium), in collaboration with other National NGOs, and sponsored by the European Union. (€ 131,691)
- Focused research *"Network for the health promotion of migrants and gipsies"*, promoted by the Ministero della Salute, in collaboration with the Caritas Diocesana Area Sanitaria of Rome and the Istituto Superiore di Sanità, Laboratory of Epidemiology and Biostatistics. (€ 98,127)
- *"AIDS & Mobility Project"*, research concerning the risks of drug addiction and HIV/AIDS, promoted by the Istituto Superiore di Sanità, in collaboration with the TVA of the Centro Operativo AIDS (COA)
- *Project for two training courses*, promoted by the Latium Regional Government, the Quality of Life Department and the Rome Provincial Government, Department of Social Services and Family Policies (according to Art. 42, Legislative Decree 286/1998) *(€ 310,000)*:
    1. *Intercultural mediators*
    2. *Transcultural integration in social-health services,* for the purpose of promoting proper implementation and transcultural organisation of such services.
- *Alisei* Project *"Health for all, all in health. Experiences and strategies for reducing the exclusion of immigrants from health services",* in collaboration with the Angelo Celli Foundation for a Culture of Health (Perugia, Italy); the Department of Social

Anthropology and Philosophy of the University of Rovira i Virgili (Tarragona, Spain) and the Pope John XXIII Tarragona University Hospital; the Medical Anthropology Unit of the Anthropological-Sociological Centre of Amsterdam University and the Amsterdam University Hospital (AMC). (€ 6,000)

- *Alisei* Project *II "Health for all, all in Health. European network for a transfer of experiences regarding access of immigrants to health services*", in collaboration with the Angelo Celli Foundation for a Culture of Health (Perugia, Italy); the Department of Social Anthropology and Philosophy of the University of Rovira i Virgili (Tarragona, Spain) and the Pope John XXIII Tarragona University Hospital; the Medical Anthropology Unit of the Anthropological-Sociological Centre of Amsterdam University and the Amsterdam University Hospital (AMC); Institute of Social Medicine, Academic Medical Centre, Amsterdam; Department of Social and Cultural Anthropology, Catholic University of Leuven (Belgium); Centrum voor Welzijnszorg – Dienst voor Geestelijke Gezondheidszorg (Centre for Mental Health); Centre for Equal Opportunity and Opposition to Racism, a federal office operating under the Prime Minister's Office (COOR); Skaraborg Institute for Research and Development, Skovde (Sweden) *(€ 9,000)*
- *Project "The ambivalence of reception"* (according to art. 18 Legislative Decree 286/1998), presented by the Quality of Life Department of the Regional Government of Latium, Equal Opportunities Section, with the Department of Preventive Medicine for Migration as medical partner. (€ 9,657)
- *Project "*Transcultural *Promotion of Health of Foreign Children"*, with the "Il Faro" Foundation. (€ 15,494)

Medical, scientific and cultural activities

The medical, scientific and cultural activities include:

- Organization and implementation, with the collaboration of the Rome Medical Association, of the 2nd European Master in International Medicine *'Health for all on the threshold of the Third Millennium'*, a two-year course for graduate and post-graduate students held by qualified experts in interdisciplinary sectors who hail from the most innovative research centres in both industrialized and developing countries who for over fifteen years have been engaged in related field research. The Sessions take place three days a month for six months a year, in order to accommodate as many participants as possible. The objective of this Master'is to address in an innovative way the changing social, cultural, health and psychological conditions that appear to characterise the upcoming millennium. The globalization process has modified the epidemiological and environmental data of the planet. The new outbreak of diseases thought to have disappeared from our countries a long time ago, together with the presence of new types of poverty, call for in-depth research and investigation, as a large number of social and health workers seek to be kept up to date on such transformations.
- Organization of a yearly International Workshop, *'Culture, health, immigration'*, held in November/December at the Consiglio Nazionale delle Ricerche (National Council for Research -CNR) in Rome, attended by a large number of participants, as well as by leading figures from the worlds of medicine, culture, politics, education and social-health services. Over the last five years, the purpose of this meeting has been to trace and highlight, from an interdisciplinary perspective, the cultural, health, social, anthropological and psychological experiences recorded in Europe regarding the world of immigration and persons at risk of marginalization by society, such as homeless people, nomads, non-self-sufficient elderly people and drug addicts. Material for study also comes from the direct experience of our Department, where the joined activities of

doctors, social and health professionals, bilingual mediators and anthropologists helps bring to light social problems that can cause the outbreak of diseases. It has helped to focus on situations of uneasiness and suffering that range from the abandonment of their homelands of people from the southern regions of the world to the complex situations of the "new poverties" in industrialized countries. Of particular interest is the establishment of networks for exchange and communication between public Institutions and many other structures, with special attention being paid to initiatives that make a difference, in an attempt to draw upon them in order to make further proposals, including projects at an institutional level, so as to provide people with better services, more suited to their real needs.

- Organization and implementation of a yearly International Course on Transcultural Medicine, to be held in six-monthly seminars, from January to June, based on a pattern already tested over the years. Organized by the Department of Preventive Medicine for Migration, the City Council of Rome, the Department of Health Promotion Policies, the Local Educational Authority of Rome and the Home of Social Rights Association, this course pursues the general objective of studying health, social and cultural problems related to migration while discussing, from an interdisciplinary perspective, the problems arising from the impact between different cultures. An additional objective of the course is to stimulate study and discussion concerning the issues of homelessness, immigration, criminality, health factors, juvenile problems and abuse, discrimination against women, family and new ecology, all with the help of experts from public institutions as well as from health professionals, anthropologists, sociologists and with the active collaboration of non-medical institutions such as schools, voluntary associations, local authorities and delegates from immigrants' associations.
- Courses at the State Training College for Social Workers, Via dei Genovesi. Theoretical and practical training for pupils and teachers.
- Collaboration with the Rome Local Educational Authority, survey on wastage, a refresher course for teachers and pupils who have attended meetings and seminars.
- Supervision, training and advice to senior-year social workers and university students for degree theses.
- Educational and training courses at San Gallicano for linguistic-cultural mediators (with the 'Silvano Andolfi' Foundation and the CIES).
- Coordination activities with public health services and private welfare centres on immigration problems (Regional Group for Immigration and Health Care (RGIH).
- Implementation of a social-health and educational programme for gutter children in Siem-Reap, Cambodia, in collaboration with ONLUS Continents Project.
- Presentation of scientific reports and researches at international meetings.
- Production of educational and information materials (books, pamphlets, brochures, videos etc.).

Azienda Sanitaria Locale ASL RM E, Rome

Access of immigrants to the AIDS Operational Unit of the Local Health-Care RM/E

The law of 1998 finally extended access to health care also to immigrants without residence permits. As a result this population, which is referred to as the TPF (Temporarily Present

Foreigners), was able to deal with its health needs in those cases where the legislation was applied.

With the passing of the law, the Unità Operativa AIDS of Azienda Sanitaria Locale RM/E, for years one of the landmarks for the local immigrant community in terms of the prevention of HIV infection, became a centre of standard health care for immigrants too. The patients attending our outpatients' unit are not only people who wish to be tested because they have been exposed to the risk of AIDS but also groups of immigrants with health problems under way. The immigrants are offered a routine programme that includes:

- a welcome interview during which the services offered are well illustrated and the needs of the patient determined;
- where the requirements are met, the issue of an identification card and health-care number;
- basic health care with a medical examination, prescription of treatment for the diseases found and prescription for more examinations by a specialist;
- taking of blood samples if necessary.

Everyone is informed of the possibility of being tested for HIV free of charge, with pre- and post-test counselling. A number of observations can be made on the basis of the experience of past years. A large part of immigrants who have attended our service are suffering from diseases that have long been neglected or have become chronic.

The offer of the test was quickly accepted by nearly all the patients, who expressed their satisfaction over being able to overcome their lack of information, up to that point, on the procedures for carrying out the test, as well as their embarrassment over asking about it. During the counselling, most patients expressed significant concern, primarily with regard to the potential risks faced by spouses from whom they were separated for lengthy periods.

The counselling, as often the literature show, has proved to be a useful personalized intervention that provides an opportunity for reflection on HIV infection, on the risks and the adoption of safer behaviours. In addition, it gives the psychologist working at the clinic an important chance to listen to the patients and thus learn about their uneasiness, problems and psychological symptoms. The patient, for his or her part, learns that there is a psychologist who can be contacted in times of need. In fact, contacts with these patients often bring out psychological problems that have long been neglected.

Our experience, though limited, together with the follow-up studies carried out in the centre, show the efficacy both of test and counselling in promoting safer behaviours. Nevertheless, the actions need to be adjusted to reflect factors, such as language, culture, religion, sexuality and cognitive and behavioural problems, that influence the quality of communication and therapeutic relationship.

Comitato per i Diritti Civili delle Prostitute, Pordenone

A short review of the activities of the Committee for the Rights of Prostitutes

In Italy immigration and social policies underwent thorough-going changes in 2002.

The law on immigration (Law 40/1998) was amended and is now much more restrictive and penalising for non-EU foreigners who wish to enter our country.

The penalties provided in case of violation of the law have become very harsh, with clandestine residence punished by arrest and immediate expulsion. In addition, the law calls for

the taking of fingerprints from all immigrants and severe penalties for those found in the possession of falsified or altered documents.

The effects of this law on the people that practise prostitution are extremely serious, given that many of them have not only entered our country clandestinely but have already been subject to expulsion orders and either disobeyed the measures or returned illegally for a second time; other prostitutes are forced by those that exploit them to carry false papers.

All these circumstances result in immediate arrest and imprisonment. Persons caught by the police for the first time are either immediately escorted to the border and expelled or placed in special centres that differ only slightly from jails.

Every day a large number of women are caught during police round-ups. As a result of the repressive measures, there is less prostitution on the street but a rise in prostitution in homes.

The women, who are victims of trafficking and exploitation, are always under the control of criminals; the latter are reorganising prostitution to take place in indoor structures that not even the operators of street projects can reach.

The law on immigration made no changes in art. 18 regarding the fight against the trafficking of persons for the purpose of sexual exploitation, but the harsh repressive practices make it almost impossible for the women involved to be informed of their rights and succeed in requesting aid in entering social programmes. Nevertheless, more than 50 projects have been started up in Italy to support the victims of such trafficking.

Given the slow pace of the Italian court system, at the moment it is not possible to obtain figures on how many traffickers have been sentenced, though there can be no doubt that charges have been brought against many.

In the past, 10 billion Lire (5 million Euro) were allocated each year in support of the law against trafficking in persons. At present there are plans to reduce this expenditure by 50%, a cut that will prevent many social projects and many prevention projects from going on.

The "clean streets" campaign recently launched by the Government through media, though designed to meet the requests of citizens for a greater security, has not addressed the trafficking of persons, as shown by the fact that no funds have been allocated for these victims.

Though the law upholds the right to medical care and preventive treatment for infectious diseases for illegal immigrants as well, there is the risk that the new law will make it increasingly difficult for persons who practise prostitution to gain access to health services.

In the course of 2002 there was a decrease in the number of women prostitutes on the street as a result of the controls by the police and this made it extremely difficult for the street units to carry out their work. At present, the women are hesitant to address to health services or centres for immigrants because they obviously fear the potential consequences; in addition, the operators find it increasingly difficult to arrange for the health services to provide care and treatment (the answer given is often that there are not enough funds budgeted for such services).

During the last two years the national campaigns on AIDS prevention have not taken into account the target group of prostitutes and their clients.

Today the government proposed that a new law be passed on prostitution, calling for obligatory medical examinations for prostitutes.

The situation that has developed in the prostitution sector is bound to lead to a deterioration in the living, health, psychological and economic conditions, both of women who are victims of traffickers and of those who have chosen to be prostitutes.

The Comitato per i Diritti Civili delle Prostitute responsible of the TAMPEP project, carried out its activities in two cities in the course of 2001-2002. The figures for the period between May 2001 and May 2002 are set out below:

– *TAMPEP/Antares TORINO – Project quantitative indicators:*
  - Number of persons contacted on the street in this period: 670

- Number of persons accompanied to health services: 400
- Number of persons placed in social protection programmes: 15
- Number of residence permits obtained for social protection: 9
- Number of persons in shelters: 16
- Number of persons placed in professional training programmes: 12
- Number of persons placed in jobs: 5
- Number of residence permits waiting to be picked up: 6
- Telephone consulting contacts: 295;
- Social protection and integration projects undertaken: 15

– *TAMPEP/Stella Polare Trieste – Project quantitative indicators:*
- Number of persons contacted on the street in this period: 124
- Number of persons accompanied to health services and other: 120
- Number of persons placed in social protection programmes: 7
- Number of residence permits obtained for social protection: 4
- Number of residence permits requested: 5
- Number of persons in shelters: 15
- Number of persons placed in professional training programmes: 1
- Number of persons placed in scholastic training: 3
- Number of persons placed in jobs (with work scholarships): 6
- Number of residence permits waiting to be picked up: 6
- Telephone consulting contacts: 295;
- Social protection and integration projects undertaken: 15

As for the previous years, the majority of the women engaged in prostitution are foreigners, primarily coming from Nigeria, followed by those coming from Eastern Europe and Latin America. Recently Chinese women have been found working in a number of large cities, though not on the street. There has been a significant drop in the number of Albanian women, while the number of women from Rumania has increased. Our female operators are always surprised by how little the newly arrived women know about sexually transmitted diseases.

A Help Line against violence was established in 2002 (a DAFNE VIP project of the European Commission) and a survey on the telephone calls received reporting instances of violence was carried out. Apart from serious cases of attacks and robberies, a significant amount of violence emerged by clients who abuse the women, preventing the use of condoms.

Lega Italiana Lotta AIDS, Milan

A short review of the activities carried out during 2002 in the area of immigration

In the course of 2002 the activities by the Lila CEDIUS in the "immigrant-health" sector were mainly carried out as part of a research project co-financed by the Istituto Superiore di Sanità.

Istituto Superiore di Sanità project

The research project supported by the Istituto Superiore di Sanità focused on primary and secondary prevention, as well as treatment of HIV infection and sexually transmitted diseases among immigrant patients.

The objective of the project was to evaluate the ethnic-cultural, psychological, linguistic and religious difficulties faced by health personnel, foreign users and cultural mediators, in order to draw up communication strategies designed to optimize the quality of the services for primary and secondary prevention and for the treatment of HIV already accessible in the sample cities and targeted to immigrants. This objective was to be achieved by creating and trying out a working protocol designed to overcome the difficulties that hinder a proper communication between health personnel and immigrant patients.

In fact, an analysis of the studies carried out in Europe shows that immigrants know very little about the problems related to safeguarding their health against HIV/AIDS and sexually transmitted diseases, as well as about the social-health services available. In many cities, especially those with the largest numbers of immigrants, special services have been created for treating immigrants. Nevertheless, there is no university or specialized training available about the clinical/cultural approach to immigrant patients. Many studies have been carried out in order to understand the problems of immigrants and ad hoc training programmes have been implemented for immigrant communities and cultural mediators, but nothing has been done to learn about the obstacles encountered by physicians while handling immigrant patients and providing services of assistance, treatment and information on the topics of primary and secondary prevention of sexually transmitted diseases.

The analysis of results of questionnaires points out the factors with the greatest effect on the positive or negative perception of both the immigrant patients and the operators with regard to their reciprocal encounters.

A point highlighted by an initial analysis of both groups involved in the research (users and operators) is the difficulty in communicating and the misunderstandings caused by language, which are seen as the single greatest obstacle to obtaining access to health structures.

Next come problems related to bureaucracy: from the perspective of the users, these consist of difficulties in gaining access to structures, in not knowing the procedures to follow, the documents to be submitted or which structures to go to (for example, they may go to the emergency room for services that are not urgent and are therefore turned away); this aspect, viewed in terms of the sources of information available to them (primarily informal), stresses the need to provide forms of communication that are more specific and capable of reaching as many people as possible. As far as the operators are concerned, the greatest difficulties are caused by a lack of information/training on the legislation regulating immigration and on the approach to immigrant users, since the cultural approach is not a subject included in any type of official training provided to physicians or nurses. The operators themselves say that they would like to receive more information and take part in training courses and they stress the importance of having information material to distribute to immigrants so as to favour a better access.

However, a more in-depth, comparative analysis of the data demonstrates that behind the apparent language barrier there are further difficulties due to the lack of a shared conceptual framework: it is the operators themselves who, though they initially state that cultural differences are of little importance, go on to express the need for the presence of cultural mediators, not merely for the purpose of translation but as a liaison between the two cultures, just like a bridge which could increase the probability of a positive encounter.

Based on the needs highlighted by questionnaires, the working group that met to discuss and plan possible communication strategies, aimed at optimising health services, identified three possible approaches to be developed by the structures responsible for treatment in order to optimise the quality of the existing services, that is to improve the approach with immigrant patients and make their access to the services offered easier:

1. Organizing ECM (Educazione Continua in Medicina, Permanent Medicine Education) courses, within those already started, organized by the local health units and coordinated

both by persons working in these same structures as well as by others from the private social sector, regarding the topics of legislation, health care, interpersonal relations on different levels, depending on whether the courses are meant for administrative operators, nurses or medical personnel.
2. Permanent updating on regional enforcements and memoranda.
3. Distribution and publication of existing ministerial guides in different languages.

ALFA Project

Under the ALFA Project, which is co-financed by the European Commission and coordinated by the French association AIDES, an information brochure for immigrant populations has been published, in order to provide basic information on HIV/AIDS, on the right to health assistance granted to immigrants under Italian law and the rights and basic principles of the treatment of persons with HIV. The brochure is meant to serve as an informative and guidance manual and it will be distributed in some Italian cities between the end of 2002 and the beginning of 2003.

OTHER EXPERIENCES

Prenatal care in high-risk pregnancies: specific needs and special peculiar attention

In 1983, an daytime outpatients' unit Department of the University of Rome was established at the Obstetrics and Gynaecology, for the prenatal care of drug-addicted pregnant women. In the ensuing years, HIV infection has spread in this group, with the result that care and monitoring was extended to HIV-1-positive pregnant women.

In January 2000 the activities were moved from the Università "La Sapienza" of Rome, to the daytime outpatients' unit of the Ospedale Israelitico, also located in Rome.

A large part of our work, before the monitoring, consists of counselling:

– *Counselling for drug-addicted pregnant women*
  Counselling for these particular women and couples has a double goal. First, as with any other counselling activity, to provide the woman and her partner with correct information on the clinical implications of their condition: being pregnant and using drugs; second, the opportunity to shift the focus of attention from the drug-addiction issue to a common woman and man issue: having a child. For what is probably the first time, she or they will have a continuing relationship with a doctor and with a health service, despite their status as addicts. It will be of particular importance to explain any possible effect of the drug that the woman takes and to underline the difference that it makes, depending on the gestational period in which the drug is assumed, always in order to obtain and maintain foetal wellbeing.

– *Counselling for HIV positive women*
  The availability of more effective antiretroviral drugs has affected not only the life span of HIV-1 positive persons but also the hope and desire for a "normal" life.
  So there are many more women and couples wishing to have children.
  There are two main questions that every woman asks us: what will happen to the baby? meaning the HIV-1 transmission rate; and what will happen to me? is there a possibility of the pregnancy accelerating the progress of the disease? There are several mother-related risk factors that can influence the rate of transmission: viral load; CD4 cell count; time of seroconversion and other factors related to delivery: premature birth and a long period of time elapsed between the rupture of the membranes and the delivery are both considered to be risk factors for vertical transmission.
  During counselling, therefore, we have to consider all the above-mentioned factors and clearly explain them to our patients, in order to enable the women to make informed decisions regarding their pregnancies.
  Since 1994, with the results of the Franco–American Trial ACTG 076, the vertical transmission rate has been reduced by two-thirds through chemoprophylaxis with Zidovudine.
  In European countries the transmission rate has dropped from 15% to 5% and, when an elective caesarean section is performed, the transmission rate decreases to 2-3%.
  Nowadays, with the advent of HAART (Highly Active Antiretroviral Therapy), more aggressive combination drug regimens that almost completely suppress viral replication, the transmission rate could be even lower, but we have to be even more careful than in

the past regarding the possible consequences of this kind of therapy on the newborn. Any decision the gynaecologist takes, together with the specialist in infectious diseases, should be discussed with the woman in order to choose the most appropriate therapy for her to reduce the perinatal transmission while taking into account the potential risks of this new therapy for the foetus.

Regarding the potential effect of pregnancy on disease progression, this depends on the mother's condition at the beginning of gestation. A stable immunologic situation with an undetectable viral load is a condition in which pregnancy would not seem to accelerate the progression of the disease.

The management of the pregnant addiction

The abandon of the drug-addition habit and the change to a methadone maintenance programme is the goal of the assistance activities, with the substitution therapy always being chosen and planned for each single woman.

The determinants are mother's condition, the gestional age at which we first begin to monitor her and the development of the foetus.

We have to ensure that any decision that we and the couple may make together during pregnancy will be in the best interests of the woman and her child.

The woman will be monitored more frequently during the first three months of the pregnancy, in order to assess the methadone substitution therapy and evaluate the correct gestational age with an ultrasound exam, while screening for all infectious diseases (TORCH-group), with particular attention to Hepatitis viruses and HIV, tests that will be repeated throughout the pregnancy on the woman and her partner.

This will be followed by scheduled controls with frequent therapy assessments.

In collaboration with the specific health service where a given addict is assigned to take her/his substitution therapy and to be monitored, specific ultrasound controls (echocardiography at 20-22 weeks - Doppler velocimetry at 34-36) will be made up until the last three months, when delivery will be planned.

All patients will be accompanied by a form specifying the terms of the mother's addiction and the exact substitution therapy she has to take until delivery and during her stay in hospital.

In the case of delivery with an elective caesarean section, the anaesthesiologist must be informed of the therapy the mother is taking at the time.

Activities 2001-2002

The goal of this new daytime outpatients' unit was to continue activities that have been going on for almost 20 years, in order to enhance the fundamental aspects of reception and friendliness that we offer to all of our patients while extending counselling and care to pregnant migrant women as well.

During the year 2001-2002, we examined 27 women and assisted with 12 pregnancies, 5 of them involving migrant women: two from Africa and three from Eastern Europe.

Seven out of 12 of the women (58%) were positive to HIV-1 virus, but only two of them were drug users during pregnancy.

All the patients who were HIV-1 positive already knew their condition before pregnancy.

Two of them had a miscarriage and one decided to abort within the third month. Two were treated throughout the pregnancy with antiretroviral therapy, plus zidovudine intrapartum, in addition to which the baby was given ZDV syrup for the first six weeks of life. A caesarean

section was scheduled in both cases around the 38th week of pregnancy; both the babies were tested for HIV RNA and proved not to be infected.

The other two women who were drug users changed to methadone maintenance and their pregnancies are still under way.

Out of the five remaining patients, two had a spontaneous delivery at term; one of these was on methadone therapy up to the end of the pregnancy; the newborn has an abstinence syndrome that requires treatment.

The other three patients are still pregnant and being monitored in our daytime outpatients' unit.

15 other women came to our unit for different reasons: most (10) were HIV-1 positive discordant couples who needed counselling about the possibility of having access to reproductive techniques (when the female partner is HIV-1 + and the male HIV-) or to other techniques, such as the washing of the semen which, to date, as far as Italy is concerned, is carried out in only one public hospital in Milan (when the male partner is HIV-1 + and the female HIV).

The last five patients were HIV-1 positive women who already had one child and wanted to learn of any recently introduced therapies or facilities that might have become available since their last pregnancy.

Reflections on the role of the cultural mediator today

Intercultural mediation as an "environment"

Intercultural mediation aimed at the promotion of health in a multicultural context can be defined as the implementation of strategies of communication capable of facilitating an effective therapeutic relationship between health operators and patients belonging to different cultural systems.

The terms *cultural-linguistic* mediation, *cultural* mediation and *intercultural* mediation simply represent the chronological phases of a process that began to emerge in the health sector in Italy at the start of the 1990's. In other words, reflections on intercultural mediation in the world of health care arose with a slight delay compared to developments in the field of education and in schools.

At present, although projects promoting the health of the migrant population are widespread and include activities of mediation, for the most part carried out by the professional figure of the *intercultural mediator,* a research framework for intercultural mediation has yet to be developed in order to permit the comparison of objectives, strategies and results of the large number of models proposed as part of the existing projects.

During this transition phase, which has not yet brought to light a convincing proposal able to meet with the full approval of the entire spectrum of a multicultural society while, at the same time, the western bio-medical system is passing through a period of crisis, the complexity of the situation must be accepted, without artificially attempting to formulate a single model of intercultural mediation. In practical terms, this means succeeding in proposing policies capable of functioning with the simultaneous presence of a variety of models of intercultural mediation that may or may not call for the presence of intercultural mediators.

Instead, attention should be focussed on identifying the central and indispensable core structure of a new universal or transcultural medical system, accepted by patients and operators whose experience is tied to the medical systems of their different cultures.

Based on this core structure, local projects must subsequently be developed, taking into account the specific contexts, which are constantly changing, as well as the available resources, with the final objective being to promote the health of everyone by following a strategy that entails the creation of *environments of intercultural mediation* (a number of authors speak of *system mediation*) capable of favouring and facilitating interpersonal relations between physicians or health operators and patients of different cultures.

Though the ultimate objective is the creation of "environments of cultural mediation", another positive development that has been experienced widely is the fact that, in certain cases, the presence of a cultural facilitator or even a simple translator can prove to be extremely useful. In emergency situations, for example, or when dealing with patients who have come to Italy without any points of contact and without the resources needed to utilise/adapt their own language-communication skills, or when the patient has undergone an experience of forced migration and needs to understand a set of simple but fundamental elements.

The role is one of transition, given that, over time, it will be filled by the health operators themselves. In fact, it is inevitable (and definitely to be hoped for) that foreigners will gradually come to hold permanent positions in our health services (nurses, physicians, clerical employees, etc.) and that they themselves will step forward to provide cultural mediation when called for. Requests for such assistance could be interpreted as a subtle form of exploitation, but a variety of past experiences demonstrate that it is offered spontaneously and naturally, even with patients of the same culture belonging to the weaker sectors of the population. Examples would be elderly patients or those who speak only a regional dialect but find someone among the operators who is willing to "translate".

As time goes by it will be the operators themselves who adjust and reformulate their approach to suit the new user base. Training is indispensable, but the revision of one's models of interpersonal relations and, more in general, modes of communication is a process that should be grounded in real-life experience, in day-to-day contact with others. In this way it quickly becomes clear that it is unrealistic (as well as useless) to attempt to become acquainted with all the different cultures, all the health-care models, all the languages and all the different communication skills. At the same time, there have been positive experiences in which foreigners carry out cultural mediation for different ethnic groups, including some that are culturally and linguistically very distant from each other.

To return to the figure of the mediator, the element that would appear to be important to the point of proving indispensable is a skill in interpersonal relations and communication, above and beyond knowledge of specific linguistic-cultural situations and ethnic origins.

In short, the mediator must be capable of interpreting the needs found *throughout* the different forms of cultural diversity.

The cultural mediator: towards a definition

The origins of the cultural mediator can be traced to those parental or friendly figures that helped people just arriving in a foreign land. This was the role of the person that welcomed and aided immigrants in the task of adapting themselves and getting to know the local territory and rules so as to be able to satisfy their needs and make their dreams of a better quality of life come true.

Considerations on cultural mediation, relating to a specific professional figure, were first formulated in Italy at the start of the 1990's, in the wake of the massive migratory flows caused by international events (the Gulf War, the breakdown of communism in the countries of Eastern Europe, etc.). Immigration into Italy has now become a visible reality and recognised by the

different social and political forces, meaning that any actions taken must not only deal with the immediate emergency but also provide long-term solutions.

In the light of the social transformations under way in the field of health care, it has been necessary to introduce a new professional into the teams dealing with migrant patients: namely, the cultural mediator, a role that has gradually been defined with increasing clarity. Given the functions performed, it is important for specific, permanent interdisciplinary training to be available for the profession, allowing the individual, with the passing of time, to absorb new contents and skills capable of assisting migrants in claiming their rights, receiving information understanding procedures, initiating a process of health prevention and education, becoming acquainted with and making use of social-health services and integrating themselves into the new social context, all the while maintaining their own systems of values and cultural identities.

To achieve this it is advisable for the mediator to belong to the same sociocultural group as the user, because this makes the linguistic communication easier and helps to overcome any diffidence and to favour a better quality of life. The fundamental role of the mediator, therefore, is to serve as the interface between two cultures, enabling them to communicate with each other, to their mutual advantage. The mediator should be familiar with both cultures, be able to identify the obstacles in the way of correct communication and use a form of language acceptable to all involved.

In dealing with the operators of the different services, the cultural mediator must be capable of explaining what lies behind the decisions and responses of the patients, helping to eliminate racial prejudice and favouring the acceptance of new worlds by promoting reciprocal knowledge.

The cultural mediator, who can also be referred to as a social interpreter is for example the person that, in the context of a multiethnic advisory centre, facilitates the introduction of a foreigner into a new situation. The mediator connects the two worlds, providing information and serving as a guide to aspects of the health, legal and socio-cultural systems likely to prove useful in making adjustments and meeting needs on the part of both foreigners and Italians, engaged in reciprocal exchange and growth as called for by Law 40/1998 and subsequent amendments.

What the mediator must do is to attempt to reduce the distance between the migrant and the socio-cultural context but without eliminating the innate differences that distinguish each individual. This is something more than serving as a mere interpreter, given that, in addition to interpreting the language, an effort must be made to mediate between the uses, customs and habits of the two peoples encountering each other.

During the discussion session held at the Istituto Superiore di Sanità as part of the "Training Course designed for PsychoSocial-Health Operators in order to achieve an Integrated Multi-Professional Approach to the Health of Migrants" organized by the Italian NFP from 7 to 11 October 2002, an effort was made to identify:

a) the human characteristics, abilities, skills and professional problems of the cultural mediator;
b) basic and permanent models for training.

With regard to the first point, the following characteristics were held to be of fundamental importance:

- an excellent level of integration and a migratory process that has been completed
- a medium-high cultural and educational background
- an ability to communicate
- a capacity to empathise, a high degree of awareness and willingness to help
- an absence of prejudice

- knowledge of the socio-cultural situation and of the network of services
- an awareness of his or her own resources and limits
- respect for the expressions of privacy proffered by the user
- ability to stimulate and promote the independence of the user
- ability to mediate in and manage conflicts.

In situations where it proves difficult to determine what the cultural mediator should do/be, it can turn out to be equally useful to establish what the cultural mediator should **not** do/be.

The mediator should **not** be:

- merely a negotiator
- a representative or advocate of a given ethnic group
- an arbiter
- a diplomat, a legal, financial or psycho-educational consultant, etc.

With regard to the second point, opinions were voiced on the advisability of an interactive, interdisciplinary type of training based on brief lessons followed by discussions, workgroups and role playing based on the Gujlbert method adopted by the WHO for operators working in the field of prevention. The training should be offered on an ongoing basis and should be accompanied by initiatives of support designed to improve motivation and work satisfaction while reducing the risk of burn-out.

Lastly, in a health-care setting, the mediator is a figure that deserves to be put to more effective use and given a set definition, seeing that the position is a relatively new one and is not yet sufficiently established within the structure of the National Health System.

Steps must therefore be taken to heighten the awareness of the institutions, so that they introduce this figure in a more systematic manner among the personnel of the services: an especially wise move in the light of the growing migratory flow, given that, in return for a modest investment of resources, it could prove to be an excellent investment in terms of public health.

Thanks are extended to the cultural mediators of the Multi-Ethnic Centre for Consultation in Frosinone, Tlich Rafik and Getachew Mekonen Emebeat (Betty), for their kind assistance, and to the head social worker, Maria Grazia Baldanzi.

CONCLUSIONS

The year-end report of the Italian NFP for 2002 illustrates the activities carried out by the members of the network active in public institutions, NGOs and voluntary associations, which operate in Italy and have participated in the AIDS & Mobility Project since 1997.

The long-term experience acquired by the individual members of the NFP in specific activities involving health care and treatment to foreign users has made it possible, in the course of the last year, to carry out two research projects[1], as well as a training course[2] for operators engaged in services meant for foreign citizens. The shared objective of these initiatives was to identify conditions that can favour easier access and more effective utilization of the psychosocial-health services, considering that the existence of public or voluntary services and the right to access (guaranteed by the laws in force) do not always guarantee the basic levels of assistance for "weak" persons, such as immigrants.

In fact, the National Health Plan for 2002-2004, as part of a series of initiatives designed to safeguard the health of the migrant populations, among other things emphasizes the need for projects that facilitate access to the services and improve their utilisation.

What is more, as has been observed for some time now, the multifaceted nature of migratory activity in Italy, in terms of ethnic and language make-up, age and the differentiation of the migratory project, calls for the identification of easy-to-use access points able to overcome the rigidity of deadlines and procedures. In addition, there is the need to train professional figures that can be recognised by foreign citizens as resources meant to favour a matching of the immigrants' need for health with the services offered. At the same time, the psychosocial-health operators must have access to training courses on the elements of law, medicine and interpersonal relations that come into play during interaction with the foreign user.

Accessibility to the psychosocial-health structures, meaning the possibility for the user to benefit from the necessary service on a timely basis, represents the top priority for those working to promote the health of the migrant population. The end goal is to ensure the highest possible levels of service.

The Italian NFP will pursue its efforts in terms of primary, secondary and tertiary prevention for mobile populations in the year 2003 as well. In particular a meeting is scheduled for the month of May, with the participation of experts and scholars in the sector, plus a training course for transcultural mediators.

[1] "Creation of a network among non-governmental psycho-socialmedical structures that work with mobile populations suffering from problems involving HIV infection and sexually transmitted diseases" and "ARIANNA – a pilot study for the creation of a multicentre training network for linguistic-cultural operators and mediators, to be utilised in initiatives of information and prevention of HIV infection and sexually transmitted diseases targeted to groups of immigrants at risk of exclusion from psychosocial-health services: clandestine and illegal immigrants, foreign prostitutes and drug addicts"

[2] "Training course designed for Psycho-Social-Health Operators in order to achieve an Integrated Multi-Professional Approach to the Health of Migrants", Rome, 7 – 11 October 2002

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