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Culture, religion and gender: considerations in facing migration related health inequalities in Italy

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Abstract
Background. The presence in Italy of a significant foreign population (5-6 million including both formally residents and not officially registered ones) introduces significant transformations in the Italian demography with important challenges on ensuring fundamental rights including work, education and above all, health.
Access to healthcare. Issues common to the entire migrant population concern the difficulty of accessing the health system of the host country due to the lack of knowledge of its rules and its functioning, the linguistic and cultural barriers and the distrust towards a system that is not recognized as his own, as well as the difficulties and misunderstandings encountered in the relationship with health professionals. Religion, culture and gender may even increase these difficulties.
Conlusion and future perspective. Culture and religion should be taken into account when designing and implementing healthcare services and healthcare workers need to be trained in acknowledging these challenges. The National Health Service should become more sensitive to the increasing cultural and religious pluralism of patients starting with investing more in the training of health professionals.

Key words
- immigrants
- religion
- culture
- gender
- minorities

INTRODUCTION

One of the challenges for the Italian National Health Service (NHS) is the fight against health inequalities which also includes the promotion of the health of all fragile minorities present in the national territory. As foreseen by the Italian constitution, the aim is to provide adequate prevention, diagnosis and treatment services to all people. Compared to what happened in other European countries, migration in Italy has some peculiarities: the short period (just over thirty years) in which it developed and took root to become a structural datum of the country; the great diversity of origin of immigrants (over 200 countries from all continents) and the belonging of immigrants to religious confessions other than Catholic.

FOREIGN POPULATION IN ITALY

Key data on the Italian situation (at 1st January 2022)

Italy has witnessed a relevant flow of immigrants in the recent decades. According to the Initiatives and Studies on Multiethnicity (ISMU) Foundation elaborations and estimates [1] on National Institute of Statistics (ISTAT) data [2], the total number of foreigners regularly present in Italy at 1st January 2022 are 6,003,000 of whom 5,194,000 residents, 303,000 non-residents (but with a regular residence-permit) and 506,000 (estimates) non-regular foreigners without a residence permit.

Immigrant women and men are almost in the same percentage in Italy, while minors represent 20.3% of the total. Only about 30% of the foreigners residing in Italy come from a country of the European Union. The largest groups of immigrants are Romanians (1,138,000), followed by Moroccans (408,000), Albanians (about 397,000), Chinese (291,000), Ukrainians (230,000), Indians (162,000), Filipinos (155,000), Egyptians and Bangladeshi (about 150,000), Pakistanis (123,000) *(Figure 1)*.

The foreign population is notoriously young. The age group between 15 and 39 year old accounts for about

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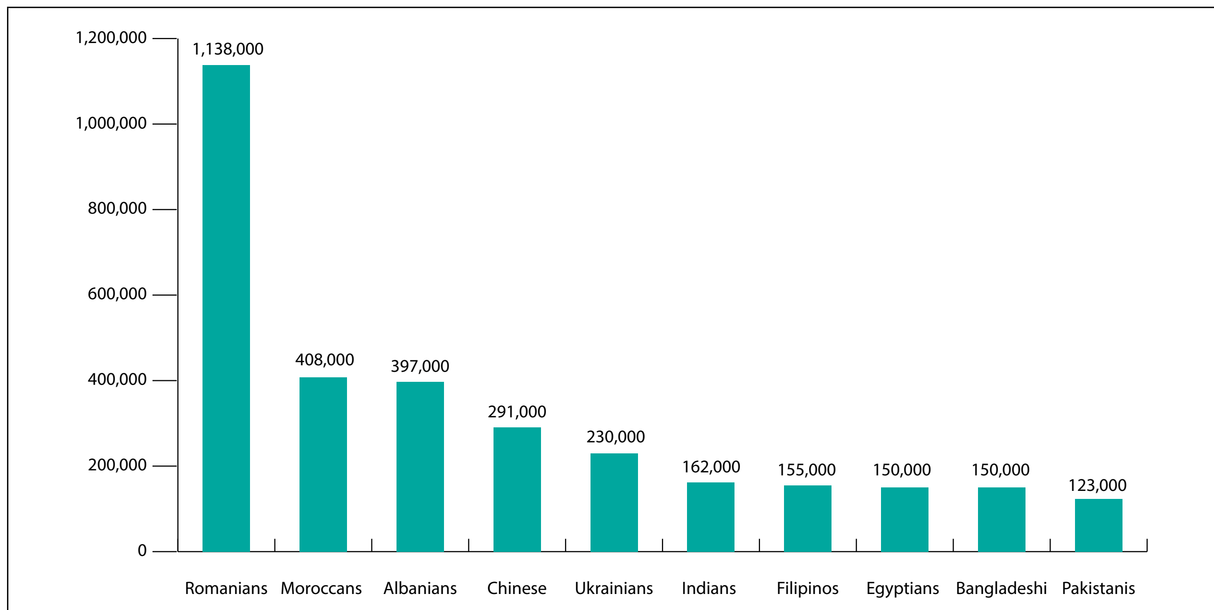

Figure 1
Largest groups of residing immigrants in Italy.

45% of the total foreign population, *vs* 26.2% for Italians. Among residents over 65 years old, 3% is made-up of foreigners and 23.7% of Italians [1].

Non-Italian citizen students

Students with non-Italian citizenship in the 2020/2021 school year are, in absolute values, 865,388, 10.3% of the total, of which 66.7% were born in Italy but did not have access to citizenship. Almost a quarter of the children of immigrants, aged 3-5 years, do not attend kindergarten; 27% of foreign studentsare late in school compared to 7.5% of Italians; 32% of foreign boys between the ages of 18 and 24 drop out of school against 10.7% of Italian boys [1].

Professed religions

Table 1 shows professed religions of immigrants. As reported, it is estimated (1th July 2022) that among the majority of foreigners currently residing in Italy, almost 2,780,000 (53.1%) belong to Christian religions and 1,539,000 (29.4%) to the Islamic religion. Buddhists, Hindus and Sikhs follow with lower percentages between 3 and 2%, then the native religions, while atheists and agnostics are considerably represented (9.9%).

Table 1
Religions professed by immigrants [1]

Religion	% of total	N	Country of origin
Christian	53.1	2,784,000	
Ortodox	29.1	1,524,000	Romania, Ukraine, Moldova, Albania
Catholic	17.1	898,000	Philippines, Albania, Polland, Peru
Evangelic	2.8	145,000	Nigeria, Romania,China, Ghana
Coptic	1.5	81,000	Egypt, Ethiopia
Other	3.0	136,000	_
Muslim	29.4	1,539,000	Morocco, Albania, Bangladesh
Buddhist	3.5	182,000	China, Sri Lanka
Hindu	2.1	109,000	India
Sikh	1.7	88,000	India
Other religions	0.4	22,000	_
No religion	9.9	518,000	China, Romania, Albania

Socio-economic conditions

87% of immigrants are employees, concentrated mainly in some sectors: collective and personal services (642,000 employees), agriculture (584,000), industry (466,000), hotels and restaurants (263,000), commerce (260,000) and construction (235,000) followed by care workers (179,500), domestic collaborators and similar professions (111,500). Temporary contractual forms are preponderant [3].

In the last years, due to the economic crises to the COVID-19 pandemic and ultimately to the war in Europe, the number of destitute, homeless, new poor among both Italian and foreign citizens has increased.

The immigrant population was the most exposed to poverty: today more than one in four families are destitute compared to an incidence of 6% recorded among Italian families.

The unemployment rate of foreign citizens (13.1%) is higher than that of Italian citizens (8.7%), while the employment rate of foreigners (60.6%) fell more intensely [3]. Young people and women are the most disadvantaged groups. More than 9 out of 10 young people are in low-skilled, low-paying jobs. Immigrant women have

suffered the most from the crisis, so much that the reduction in the female employment rate among foreigners is twice as high as that of males [3].

KEY HEALTH ASPECTS OF IMMIGRANTS

Generally, immigrants show a mortality advantage respect to the native population as also found in Italy [4]. However, the literature highlights that many chronic diseases, such as hypertension, diabetes, chronic kidney disease, obesity and metabolic syndrome have a higher prevalence in immigrants than in the native population due to the interplay between genetic and, mostly, behavioural factors.

In Italy, refugees and immigrants from sub-Saharan African and south Asian countries were found to have a higher risk of cardiovascular diseases than native population. In this regard, South Asians, particularly when living in high-income countries, are at a substantially elevated risk of type 2 diabetes (T2DM) compared with white Europeans, and typically develop the disease 5-10 years earlier and at a lower BMI [5]. According to the Italian Diabetes Society, the risk of developing T2DM is 3 to 5 times higher for those coming from Southeast Asia, 2 to 4 times higher for those coming from the Middle East and North Africa, and 2-3 times higher for those coming from Sub-Saharan Africa [5]. Overall, the risk of developing T2DM diabetes among immigrants is 55% higher than in Italians with similar characteristics [5].

Among respiratory diseases [6] as a whole, the prevalence of asthma and allergic diseases in immigrants from less wealthy countries is lower than in high-income host countries, but the risk of developing these diseases increases with the length of stay in the host country, demonstrating that in addition to genetic predisposition, environmental factors also play a decisive role in the development of atopy.

As concern cancer, it should be noted that most immigrants come from geographical areas (i.e Africa, Central and South America, many Asian regions and Eastern Europe) where cancer screening attitudes and services versus a higher prevalence of risk factors are not yet strongly consolidated, e.g., human papilloma infection in Sub-Saharan Africa and Eastern Europe, areas that represent most of the origin countries of immigrants in Italy. Moreover, also chronic infections predisposing to cancers, such as hepatitis B and C, and Helicobacter Pylori infection, have greater prevalence in Eastern and sub-Saharan Africa for hepatitis B, in Eastern Mediterranean and European countries for hepatitis C, in Africa, Eastern Europe, Asia and Latin America for Helicobacter pylori, respectively [6].

Other chronic diseases frequently observed are mental disorders, musculoskeletal and gastrointestinal disorders, genetic diseases and immune-mediated inflammatory diseases [7].

CULTURAL RELIGIOUS AND GENDER ASPECTS OF IMMIGRANTS IMPACTING HEALTHCARE

The right to access health care is a principle that finds its foundation in the Italian Constitution. Nevertheless, there are several obstacles that prevent immigrants from accessing the services they are entitled to: linguistic and cultural barriers, administrative barriers, limited knowledge of the rules and functioning of the NHS, distrust of a health system that is not recognized as his own, as well as difficulties and misunderstandings encountered in the relationship with health professionals.

Culture, religious affiliation, family and social relationships, gender issues, education level, economic situation, degree of inclusion in the host society necessarily shape health seeking behaviors and the access to healthcare [8]. For example, religious beliefs influence the choices regarding procreation, organ donation and transplantation; palliative care and end of life; the compliance with pharmacological treatments and dietary prescriptions, and the prevention attitudes, to cite a few [8].

Also gender inequalities may have crucial implications for health. In many cultures, women depend on males for the interaction with the health professionals (e.g., personal history and description of symptoms) and encounter difficulties to be visited by male professionals. In this regard, Hindu women generally do not go to the gynecologist until the end of their pregnancy [9]; Muslim generally agree to be examined only by same sex professionals; Buddhist women wish to be visited only by same-sex personnel, and monks are prohibited from being cared by female personnel [10]. Furthermore, male individuals belonging to some immigrant groups often avoid seeking healthcare, even in emergency situation, fearing this would diminish their social role in the community.

These cultural customs and systems of values are often unknown to Italian health professionals and stereotypes and prejudices could persist, hampering the patient-doctor communication and relationship nourishing the distrust towards host health systems and sometimes western medicine at a large, resulting in low health services seeking. In addition, the lack of migrant-sensitive information on rights and health services available on the territory was also observed.

Recently, Italy has seen a significant increase in the female share of migratory flows. Previously, female migration was essentially pushed by family reunification. Starting from the 90s, the increasing demand for elderly and home care drew working migrant women, especially from the Eastern Europe. Today, women represent, on average, about half of the immigrant population in the country. The share of women ranges from values below 30% of immigrants from Bangladesh or Egypt, up to over 78% in the case of Ukrainian immigration.

Immigrant women carry out fewer visits during pregnancy and fewer ultrasound scans than Italian women. Moreover, they carry out the first prenatal visit later (11.5% of foreigners carry it out after the 12th week *vs* 2.65% of Italians) risking to fail the early diagnosis and monitoring of potential pathological conditions. An effort by the NHS is therefore needed to promote prenatal care and screenig services offered to immigrant women.

Further, the adherence to screening programs for breast cancer and cervical cancer, even if rising, is still low as the engagement in conscious motherhood and

family planning counselling. Language, cultural, but also administrative and logistic barriers are some of the factors called upon to explain this evidence.

Also noteworthy is the persistence of traditional surgical practices, declared illegal worldwide, often due to misinterpretations of religions, such as circumcisions and partial or total mutilation of the female genitals (FGM) [11]. These practices are still in use mainly in some populations of northern Africa, the Horn of Africa and the sub-Saharan belt.

The United Nations International Emergency Children's Fund (UNICEF) estimates that there are 125 million women in the world living with the consequences of genital mutilations. According to UN estimates, 200 million women and girls worldwide have suffered from various forms of genital mutilation [12]. In Italy, estimates indicate that about 80,000 women and 7,000 minors have undergone FGM [13, 14]. Italy is one of the countries hosting the largest number of excised women, due to the consistent female migration flow from countries with a high prevalence of FGM such as Egypt, Nigeria, Ethiopia and Senegal It is obviously not known if and how many of these practices were carried out in Italy or in the country of origin. Italian law (Law January 9th 2006, n. 7) is particularly severe and provides for imprisonment from 4 to 12 years for those who practice mutilations, even when the operation is performed abroad on an Italian or foreign citizen residing in Italy, increase of the penalty by one third when the victim is a minor. If FGM is performed by medical personnel there is disqualification from the register and suspension of the practice. Article 6 also provides for the obligation for health personnel to report to the competent authorities, an action that can allow immigrant women to acquire refugee status, even if healthcare professionals are often not adequately trained in informing victims of FGM about their right to apply for asylum [15].

However, the records of the presence of FGM in women who have given birth represents the first tool for the protection of newborn girls. The consequent passage of information to the pediatrician allows the latter to maintain surveillance over the time, necessary to prevent repetition of the practice on girls.

Other challenges for the Italian Health Service are male ritual circumcisions, which concern a large segment of the immigrant population, mostly Muslim, and which are partly carried out clandestinely with serious health consequences for the boys and children.

No official data is available on the extent of the phenomenon of ritual non-therapeutic circumcisions in Italy. Some data can be implicitly derived from the numbers of migrants from some areas of Africa reported in the annual Immigration Reports of Italian Caritas and Fondazione Migrantes. According to estimates by the Association of Doctors of Foreign Origin in Italy (AMSI) and the Community of the Arab World in Italy (CO-MAI), around 11,000 children are circumcised each year, 6,000 of which in the countries of origin and 5,000 in Italy [16]. At least one third of the 5,000 circumcision operations carried out in Italy take place outside the structures of the National Health Service in clandestine circuits, at home or in any case in unprotected environments, and often by non-medical personnel despite being a practice with a high risk of damage (early or late) and may even lead to the death of the child [16, 17]. In recent years there have been numerous news reporting the death of children due to the execution of circumcision by unqualified people without adequate medical training and in hygienically unsafe environments.

One of the reasons that drives families to entrust their children to inadequate personnel is the absence of non-therapeutic circumcision within the Essential Levels of Assistance (LEA) so that the surgery, not being paid by the Italian NHS, has prohibitive costs [17]. The economic possibilities of many immigrant families (especially African ones) do not allow them to face the cost of intervention in the health sector or the expense of a trip to their country of origin.

CONCLUSIONS

Access to care for the immigrant population in Italy is protected by one of the most inclusive legislations in the European and global panorama. Despite this, the interpretation and application of the legislation on the access to care for foreign people are highly uneven on the territory, both nationally and within the Regions/Autonomous Provinces themselves. It therefore becomes necessary to reaffirm that the fundamental principles of the NHS (universality, globality and equity) are the basis for the realization of the right to health protection, as foreseen by Art. 32 of the Italian Constitution. The aim is to provide adequate prevention, diagnosis and treatment services to all people regardless of religion, ethnicity, culture of the country of origin, economic and social condition and, last but not least, gender.

Inadequate or insufficient information of immigrant citizens is cause of limited access and improper use of services offered by NHS. The scarcity of cultural-linguistic mediators in most healthcare facilities but also scarce availability of the rules in force in a multilingual version are obstacles for accessing NHS services. It is necessary that all the Regional Health Services standardize, and guarantee detailed information on the services offered to all the people present on the Italian territory.

The religious restrictions, concerning for example the type of food that can be accepted, the type of medicine that can be prescribed, the health problems in the long periods of fasting prescribed by one's religions, the behaviors and the different needs regarding gender belonging, dangerous practices such as "homemade" circumcisions, or even the illegal surgery practices of cultural nature, as FGM, make the immigrant-NHS relationship difficult and find our healthcare workers unprepared for adequate responses.

Cultural realities, traditions and systems of values of immigrants are often unknown to Italian health operators. The lack of knowledge of both the spiritual and cultural expectations of the immigrant patient can lead to difficulties of interaction, misunderstanding, and even of lower levels of quality of care and assistance, poor patient satisfaction, limited adherence to

established care which can even lead to worse health outcomes. It therefore appears mandatory to organize training and updating activities aimed at the plurality of social and health figures who interact in various capacities with the foreign population.

All the critical aspects described here pose particularly complex questions in relation with immigrant populations and imply the need for a specific attention to their Country of origin, their religious belief and their traditional medical interventions (e.g., MGF and circumcision). Hence, personalized strategies should be implemented in order to establish a correct dialogue and a fruitful relationship of trust with patients with such different cultural features and religious creeds. Knowledge of all the critical issues can also offer the necessary tools to guarantee the overcoming of any discrimination. A collective effort is needed to lay the foundations for a public health system centered on the person as a whole, a transcultural health system capable of welcoming and providing preventive, diagnostic and treatment services to all people, regardless of whether they belong to a minority or not. On the other hand, the need to increase communication strategies in order to improve immigrant awarness of the Italian NHS, i.e. how does it works in terms of access and on the rights the immigrants have, also represents a mandatory task.

Authors' contributions

Conceptualization: CG, LGS, WM; investigation: CG, LGS, RM, MAA; supervision: WM, WR; writing - original draft: CG, RM, MAA; writing- review and editing: LGS, WM.

All Authors have read and agreed to the published version of the manuscript.

Conflict of interest statement

The Authors declare to have no conflict of interest.

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