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Exploring global needs of migrants with disability within a community-based inclusive development perspective

Marco Tofani[1,2], Anna Berardi[1], Silvia Iorio[3], Giovanni Galeoto[1] and Maurizio Marceca[4]

[1]*Dipartimento di Neuroscienze Umane, Sapienza Università di Roma, Rome, Italy*
[2]*Sviluppo Professionale Infermieristico e delle Professioni Sanitarie, la Formazione Continua e la Ricerca, Ospedale Pediatrico Bambino Gesù IRCCS, Rome, Italy*
[3]*Dipartimento di Scienze e Biotecnologie medico-chirurgiche, Sapienza Università di Roma, Rome, Italy*
[4]*Dipartimento di Sanità Pubblica e Malattie Infettive, Sapienza Università di Roma, Rome, Italy*

Abstract
Introduction. Limited evidence exists on migrants with disability. A comprehensive assessment is mandatory required to organize specific services within the community and reception centers. The present study explores needs of refugees and asylum seeker within a community-based inclusive development framework.
Methods. To interview migrants, in this study we used the Community-Based Rehabilitation Indicators (CBR-Is) developed by the World Health Organization.
Results. The sample consisted of 41 people with disability and 59 without disability. Sample was homogeneous for gender and age. Our findings reveal how migrants with disability experienced poor outcomes in each domain of CBR-Is, namely health, education, livelihood, social end empowerment.
Conclusion. Differences between migrants with and without disabilities have some distinctive features. However, both groups are influenced by the social determinants of health: in addition to health issues, challenges in social life, livelihood and empowerment also clearly emerge. Different stakeholders are invited to promote inclusive communities, facilitating access to social and health services.

Key words
- migrants
- refugees
- disability
- community-based rehabilitation
- community-based inclusive development
- rehabilitation

INTRODUCTION

Disability is part of the human condition. The UN Convention on the Rights of Persons with Disabilities (UNCRPD) recognizes disability as "an evolving concept" [1]. It is therefore not an attribute of the person, but rather the result of the interaction between biological, psychosocial and environmental contingencies.

The World Health Organization (WHO) estimates that over one billion people – about 15% of the world's population – live with some form of disability [2]. Recent studies have shown that people with disabilities experience worse health outcomes than people without disabilities. Moreover, people with disabilities experience greater difficulty in accessing higher levels of education as well as the labor market. In addition, as far as the health component is concerned, people with disabilities quite often do not receive the health services they need and about half of people with disabilities cannot afford health care [3]. Among the barriers that most affect access to services are prohibitive costs, limited availability of services – especially in rural and suburban areas – and architectural and environmental barriers. Lastly, several international bodies note a lack of disability mainstreaming policies, as well as a lack of funding and specific data [2].

To date, the problems encountered are more evident when compared to migration. Being a migrant with a disability – due to economic, political, or environmental reasons – determines an even greater level of vulnerability both in structural and adaptive terms. Moreover, already in 2016, the EU Agency for Fundamental Rights stated a general lack of formal procedures to identify migrants with disabilities, with a negative impact on the possibility of support and assistance. This lack of strategies for territorial care imposes a collective reflection on how to succeed in intercepting the needs and vulnerabilities of migrants with disabilities [4].

Globally, there are 271.6 million migrants [5]. As mentioned above, considering that 15% of the world's population lives with a condition of disability, it is possible to consider with some approximation that, out of 271 million migrants, 40.65 million are people with

Address for correspondence: Marco Tofani, Dipartimento di Neuroscienze Umane, Sapienza Università di Roma, Viale dell'Università 30, 00185 Rome, Italy. E-mail: marco.tofani@uniroma1.it.

disabilities. Of the 30 million people who migrate each year, 4.5 million have that condition and that, out of 22 million refugees, 3.3 million are refugees with disabilities [6]. In addition to purely numerical data, the dynamics that produce migration are fundamental, as are the migratory experiences of individuals, as well as the heterogeneity of the individual's adaptive capacities within the country of arrival. At the European level, the latest available data, updated as of May 2020, report that 2.4 million people from other non-EU countries entered the borders of the European Union (EU). 21.8 million people (4.9%) of the 446.8 million EU citizens as of January 2019 were non-EU citizens [7]. This percentage inevitably includes not only people who have just entered EU borders, but also those who have been residing in an EU country for some time. Consequently, when considering the disability of migrants, we should also focus on a percentage of foreigners who now live within the European communities. In this macro-category, for example, consideration should be given to persons who acquire a disability as a result of accidents at work, or all those persons who, as they age, experience the same health issues as all the elderly, encountering lack of self-sufficiency or the development of co-morbidities [8].

In Italy, the latest available data report the presence of 6.3 million migrants [5]. In spite of recent political debates, the percentage of migrants entering our country has undergone a sharp decline in recent years. The reasons behind this decrease vary, however this fact is likely attributable to the agreements between Europe, Turkey and Libya. Although in different ways, these agreements aim to discourage the departure towards the EU borders. Nevertheless, the documentation supporting the inadequacy of these policies is starting to be preponderant, as well as reports on the inhuman conditions in which migrants are forced in detention camps. In addition, some scholars argue that the reception process in Italy and Greece, as well as the lengthy detention of asylum seekers in other host states, does not alleviate health problems, but rather contributes to the exacerbation of illness and trauma [9].

Limited evidence exists regarding the prevalence of disability among refugees and asylum seekers, with an estimated rate of disability between 3% and 10% [10]. Moreover, it is estimated that 1 in 6 migrants experience some form of physical health problems [11], while the proportion increases for mental health to 2/3 of the population [12]. As seen above, in most immigration centers, there is the challenge of successfully "recognizing" all those forms of disability that are less evident and, consequently, proposing specific services on the community or targeted activities within the centers for asylum seeker and refugees. It is also worth reflecting on the condition of "institutionalized" migrants with disability. In some circumstances, these migrants see the exacerbation of certain problems that have remained silent until then. This is the case of victims of torture, of people with mental disorders or cognitive disabilities, who experience the onset of psychotic disorders [13].

If the well-being of these people is affected by this dualism – a migrant and person with disabilities within "protected structures" – their quality of life is challenged once they leave the international protection system. Consequently, there are many cases in which these people are unable to request housing assistance or they experience barriers to reaching a satisfactory level of livelihood in society. The result is an increase in social marginality, discrimination, and significant deterioration of their health [14]. A comprehensive assessment of individual needs and living priorities should be undertaken in the field [15]. Therefore, the objective of the present investigation is to evaluate the needs of migrants with disability within a community-based inclusive perspective, with a particular focus on asylum seekers and refugees.

RESEARCH PROCESS

Study overview

The research group was formed by professionals affiliated with Sapienza University of Rome and Rehabilitation & Outcome Measures Assessment Association, a non-profit organization with a great deal of experience in outcome measures and disability studies. In the last few years, the research group was involved in the validation of different projects, also with particular interest focused on disability and global health education [16-19]. The research was carried out from November 2018 to March 2019, involving different stakeholders in Italy. However, due to the COVID-19 pandemic, data collection was interrupted in March 2019.

Study setting

In Italy, the reception system for asylum seekers and refugees has changed many times. Particularly in the years 2018-2020, several reforms have been made that have had an important impact on procedures and requirements for access to the international protection system. In order to better understand the Italian landscape, a brief overview of the Italian legislative context is reported below [20].

In 2001 the ANCI - Associazione Italiana Comuni Italiani (the National Association of Italian Municipalities), UNHCR (the UN Refugee Agency) and the Italian Ministry of the Interior signed a memorandum of understanding to set up the National Asylum Programme (PNA). The PNA was the first public system for the reception of asylum seekers and refugees, throughout the Italian territory and instituted the sharing of responsibilities between the Ministry of the Interior and local authorities.

Then, in 2002, the Law no. 189 of 30 July institutionalized the PNA by setting up the SPRAR – Sistema Protezione Richiedenti Asilo e Rifugiati (Protection System for Asylum Seekers and Refugees). Subsequently, the Ministry of the Interior established a central co-ordination office (called Servizio Centrale), and appointed ANCI to manage it.

In 2018, SPRAR was renamed SIPROIMI – Sistema di protezione per titolari di protezione internazionale e per minori stranieri non accompagnati (Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors) (Decree-Law no. 113 of 4 October 2018, enacted as Law no. 132 of 1

December 2018). The new legislation sets out that access to SIPROIMI's integrated reception services can also be provided to holders of a residence permit for special reasons: as victims of violence, trafficking, domestic violence, labor exploitation or calamities, or for poor health, or for acts of particular civic value.

In 2020, SIPROIMI was renamed SAI – Sistema di Accoglienza e Integrazione (Reception and Integration System) (Decree-Law no.130 of 21 October 2020, enacted as Law no.173 of 18 December 2020). The new legislation sets out that access to SAI's integrated reception services can be provided to refugees, asylum seekers, unaccompanied foreign minors, foreigners entrusted to the social services on reaching majority age. Moreover, SAI can also accommodate victims of disasters, migrants whose special civil value is recognized, holders of a residence permit for medical treatment, holders of a special- protection residence permit (recipients of social protection, victims of domestic violence, victims of labor exploitation). The primary objective of SAI is to provide support for each individual in the reception system, through an individual program designed to enable that person to regain a sense of independence, and thus enjoy effective involvement in life in Italy, in terms of employment, housing and access to local services and social interaction as well as scholastic integration for minors.

Data collection measure

In order to obtain data on a Community-Based Inclusive Development perspective, the research group decided to use the Community-Based Rehabilitation Indicators (CBR-Is) developed by the WHO [21]. The CBR-IS are available in different languages, such as English, French, Spanish, Arabic. An Italian version is also available, thanks to a previous translation and cross-cultural adaptation process of the same research group [22]. The survey consists of an introductory part containing personal details and socio-demographic information. There are 13 base CBR indicators: health (2); education (6); livelihood (3); social (1); and empowerment (1). Base CBR indicators are broad enough to capture the difference CBR makes in the lives of people with disability. For comparability among settings, countries, and over time, WHO recommends these 13 base CBR indicators be consistently included in all monitoring and evaluation procedures. There are 27 supplementary CBR indicators that provide more specific coverage of the elements of the CBR components. From these users may select those that match the specific goals and strategies. Considering the objective of the study, the working group included all the questions related to the five components of the CBR matrix: health, social, education, livelihood and empowerment, excluding those questions related to developmental age. For more information on CBR Indicators, please see information on WHO CBR-Is Manual [23].

Sampling, procedures and data analysis

The sample population was selected in order to respect the following criteria: women and men, healthy or disabled people, age 18 or more, status as a refugee or asylum seeker in Italy. The only exclusion criterion was the refusal to participate in the study. To be considered person with disability, the research group asked if the person considered him/her self as person who live with a condition of disability or if the person had a disability certificate. To recruit participants, the research team engaged different stakeholders working on the topic of migration. First an email was sent out explaining the project, its objectives and expected results, then the staff involved and data protection system. Subsequently, the willingness to participate was requested, asking for the availability of working group members within the SIPROIMI centers. Considering that these centers are directly appointed by the Servizio Centrale (please see above the Italian legislation within the Study Setting sub-section), an official communication was sent to request permission to proceed with the interviews. Once the response was received from the Servizio Centrale, and permission was obtained from the organizations managing the SIPROIMI centers, the working group began interviewing asylum seekers and refugees in the centers.

However, before starting, the research group participated in an internal training course in order to level out confidence with the CBR-Is, and to ensure consistency on administration and scoring. The first investigator (MT) led the training: learning modules, organized into theoretical and practical activities, were based on the information available on the WHO website and within the CBR-Is manual. To measure how the training was effective, at the end of the training session, the research group participated in a practical test and discussed the case study together.

In order to obtain preliminary evidence on how the IT-CBR-Is can properly capture the differences between migrants with and without disability, an independent sample t-test was applied for those questions in which it was possible to transform nominal variables into numerical, as provided in the original manual produced by WHO. Therefore, some questions of a descriptive nature were excluded (e.g., H06 and H09 "Which reason(s) explain(s) why you did not get that health/rehabilitation service?") or other questions related to the use of assistive technologies. Significance was set for a $p<0.05$ with 95% confidence intervals. All data were collected on android tablets using a mobile application and transferred daily to a secure cloud-based server. All analyses were then performed by using Statistical Package for the Social Science (SPSS) version 20.0.

Risks of bias

As already mentioned, CBR-Is are available in several languages. However, in order to minimize comprehension problems – even where respondents did not have a very good command of the available languages – the research team made use of language mediators when necessary. These, prior to the interview, attended a one-day training and were able to view the CBR indicators manual.

Due to the COVID-19 pandemic, and in order to have comparable and reliable data, the research group decided to stop collecting data during the national lock-

down. Continuing the interviews during this period could have affected the validity of the results because the possibilities to socialize, work, etc. were rather limited, paired with the fact that access to specific social and health services could be reduced.

RESULTS

The research project was carried out in cooperation with a few reception centers in the Lazio and Apulia regions. 103 people met the inclusion criteria and were eligible to participate in the study. However, 3 people decided not to participate. Consequently, the CBR-Is were administered to 100 individuals: 41 people with disability (mean age 35.75, SD 11.72) and 59 without disability (mean age 29.08, SD 7.07). No significant differences between groups were found for age and gender. The majority of women (73.68%) lived with a condition of disability, while among men only 20.96% defined themselves as persons with disabilities. The majority of people with disability (65.85%) came from the Near and Middle East (Libya, Syria, Iraq, Afghanistan), while among people without disability the majority (69.50%) were from North and West Africa (Tunisia, Morocco, Nigeria, Ghana, Gambia). *Table 1* summarized sample characteristics.

Significant differences between migrants with and without disability were found: one for education, two for social and two for empowerment component. However, both groups showed poor outcomes in each component of the CBR matrix. *Table* 2 reports mean scores, differences between two groups and reference values considered as good, for each question.

DISCUSSION

This investigation reports one of the first attempts to analyze global health needs for migrants with disability in Italy. A person forced to migrate, and who is also living with a disability, represents a double vulnerability and requires a multifaced approach in order to propose adequate support in different aspects and domains of life [24]. The sample consisted of both people with and without disabilities and it allowed to analyze differences between the two groups. The subsample of persons with disabilities was predominantly female; this can be explained for two main reasons: firstly, because refugee women have a higher risk of experiencing violence [25], and secondly because some of the centers offered services specifically for women victims of violence.

According to the Community-Based Inclusive Development framework, for migrants with and without disability, our findings reveal poor outcomes in each domain of CBR-Is, namely Health, Education, Livelihood, Social end Empowerment. Among these, migrants with disability have a lower educational level than migrants without disability (p=0.03), and they cannot make decisions regarding personal assistance (p<0.01) and their relationships (p<0.05). Regarding Empowerment component as well, migrants with disability feel they cannot make big decision in their life (for example who to live with, where to live or how to spend money) (p<0.01) and they are discouraged on the effectiveness of policies for the rights of persons with disability (p<0.05). Asylum seekers and refugees experience prejudice on an institutional level as a result of the asylum system and interpersonally from host communities. Moreover, they often report stigma and discrimination [26]. Results showing how they experience barriers to personal assistance and relationships are in line with the World Report on Disability [2].

Interesting topics emerged from a qualitative analysis of outcome scoring. Migrants – regardless of disability condition – are met with challenges in all domains of the Community-Based Inclusive Development framework. For example, regarding the "Health component" migrants are not satisfied with the level of respect with which they are treated. Moreover, during their last visit to healthcare providers, they did not feel to be involved in making decisions for their treatment. A recent study [27] reveals how healthcare providers face important challenges in providing care for refugees and migrants and risk not being able to ensure equal access to quality care for these vulnerable groups. Lack of funds, as well as a shortage of trained and stable human resources, paired with organizational malfunctioning and poor coordination among the different players, are all mentioned as factors hindering the provision of healthcare for migrants and refugees [28]. Migrants may also face obstacles arising from lack of cultural awareness by those providing care or due to language barriers, even though there is now considerable experience on how to overcome these challenges [29].

Table 1
Socio-demographic characteristics of refugees and asylum seekers (sample n 100)

	People without disability	People with disability	T-Student
Age mean (SD)	**29.08 (7.07)**	**35.75 (11.72)**	**0.341**
Gender			
Female	10	28	
Male	49	13	
Total	59	41	0.778
Country of origin	N (%)	N (%)	
Horn Africa	9 (15.26)	0 (0.00)	
Nord Africa	26 (44.07)	11 (26.83)	
West Africa	15 (25.43)	3 (7.32)	
Near East	8 (13.55)	14 (34.14)	
Middle East	1 (1.69)	13 (31.71)	

Table 2
Differences in CBR-Is score between migrant people with and without disability

Questions	Without disability N Mean (SD)	With disability N Mean (SD)	P	Positive outcomes
H01. In general, how would you rate your health today?	2.02 (1.14)	2.30 (0.51)	0.320	<2
H02. On your last visit to a health-care provider, to what extent were you satisfied with the level of respect you were treated with?	3.71 (1.11)°°	3.60 (1.26)°°	0.787	>4
E01. What is the highest level of education you have achieved, or are working to achieve?	3.85 (1.95)	2.40 (1.57)°°	0.035*	>4*
L02. Do you have enough money to meet your needs?	1.75 (0.81)°°	1.80 (0.78)°°	0.861	>4
S01. Do you feel that other people respect you? For example, do you feel that others value you as a person and listen to what you have to say?	3.30 (1.10)	3.80 (1.03)	0.209	>4
M01. Do you get to make the big decisions in your life? For example, deciding who to live with, where to live, or how to spend your money?	3.64 (1.32)	2.20 (1.54)°°	0.005**	>4
H03. Has your (doctor, CBR worker, or any other health professional) ever discussed with you the benefits of eating a healthy diet, engaging in regular physical exercise, or not smoking?	1.47 (0.50)	1.40 (0.52)	0.678	1
H04. When was the last time you had a regular health check-up?	1.47 (1.06)	1.00 (0.12)	0.167	1
H05. In the last 12 months, has there been a time when you needed health care but did not get that care?	2.02 (0.53)	2.00 (0.94)	0.911	2 to 3
H07. On your last visit to a health-care provider, to what extent were you involved in making decisions for your treatment?	2.97 (1.62)°°	2.61 (1.57)°°	0.524	>4
H08. In the last 12 months, has there been a time when you needed rehabilitation services, such as physical, occupational, or speech therapy, but did not get those services?	2.68 (0.63)	2.33 (1.03)	0.259	2 to 3
E04. Do you participate in learning opportunities to improve your skills for everyday life or work?	1.28 (0.46)	1.20 (0.42)	0.581	1
E05. To what extent does it fit your needs?	3.07 (1.18)°°	2.75 (0.42)°°	0.461	>4
L03. Do you get to decide how to use your money?	4.30 (1.11)	4.40 (1.27)	0.806	>4
L04. Do you know how to get financial services such as credit, insurance, grants, savings programs?	1.76 (0.40)°°	1.60 (0.51)°°	0.209	1
L05. Do you currently benefit from any social protection programme, such as loss of income through old age, sickness or disability?	1.80 (0.41)°°	1.80 (0.42)°°	0.989	1
L06. Do you know how to get social protection against loss of income resulting from old age, sickness or disability?	2.00 (0.00)	2.00 (0.00)	0.419	1
S02. Do you get to make decisions about the personal assistance that you need (who assists you, what type of assistance, when to get assistance)?	4.03 (1.17)	2.21 (1.54)°°	0.001**	>4
S03. Do you get to make your own decisions about your personal relationships, such as friends and family?	4.26 (1.17)	3.25 (1.07)°°	0.047*	>4
S04. Do you get to participate in artistic, cultural or religious activities?	3.60 (1.26)°°	3.26 (1.23)°°	0.501	>4
S05. Do you get to participate in community recreational, leisure and sports activities?	2.75 (1.31)°°	2.40 (1.42)°°	0.463	>4
S06. To what extent do you know your legal rights?	2.41 (1.35)°°	2.00 (0.94)°°	0.372	>4
S07. Do you know how to access the justice system?	1.64 (0.48)°°	1.80 (0.42)°°	0.372	1
M02. Do you think that the policies in your country provide people with disability equal rights as other people?	1.70 (1.11)°°	1.01 (0.25)°°	0.048*	>4
M03. Are you satisfied with your ability to persuade people of your views and interests?	2.90 (0.96)°°	2.05 (1.03)°°	0.178	>4
M04. Do you get to influence the way your community is run?	3.04 (1.42)°°	2.74 (1.31)°°	0.799	>4

°°Mean score below references values considered as good; * $p<0.05$; ** $p<0.01$

Regarding the "Education component", although all migrants participate in learning opportunities to improve their skills for everyday life of work, these training courses do not fit their actual needs. This can lead to feelings of frustration, already strongly challenged by occupational deprivation as well as by occupational imbalance and change [30]. Furthermore, refugees with disability have been invisible in policy and service provisions. In addition, reliable data is quite limited, and there has been little research into their experiences of educational inclusion and exclusion [31]. An international effort in this field is highly recommended.

With regard to the "Social component", migrants experience barriers that limit their participation in cultural or religious activities. These barriers are even greater when considering the opportunities for recreational, leisure and sport activities (good outcome >4, mean score for each group 2.75-2.41). Furthermore, they are not very aware on how get access to the justice system and they do not know much about their legal rights (good outcome >4, mean score for each group 2.41-2.00). Regarding the 'Livelihood component', all migrants of both groups are not aware of legal issues, especially aspects regarding how to obtain financial services or social protection. Research has highlighted the multiple barriers that migrants with health impairments face in accessing formal support [32]. These barriers may be structural, social or cultural, or may relate to the challenges facing refugee and minority ethnic community organizations, which often become the key source of support in the absence of, or restrictions in, statutory provision [33].

With reference to the "Empowerment component", both groups are not very satisfied with their ability to persuade people of their interests and points of view. Moreover, they feel that they are not able to influence the community where they live (good outcome >4, mean score for each group 3.04-2.74). Indeed, increasing refugee and migrant participation in the design and implementation of integration policies is crucial for developing effective policies that are tailored to the needs of the main beneficiaries. Actively involving migrants, asylum seekers and refugees, while also promoting their participation in consultative and decision-making processes that concern them, can contribute to their empowerment and long-term integration into society. This is the direction of the European Commission Action Plan [34] on the integration of third-country nationals from 2016, stressing that the involvement of third-country nationals in the design and implementation of integration policies is essential to improve their participation and their integration outcomes.

Limitations

Despite these encouraging results, the present investigation has some limits. These results may not generalize broadly to other samples, because participant sample was relatively small and restricted. Considering the explorative nature of the study, the research group did not conduct a statistical power analysis, and this does not allow to generalize findings. Secondly, we did not have normative data on the Italian population to compare outcomes of migrants with and without disability, as well as similar data that refer to migrants in other countries. Furthermore, to identify people with disability the research group asked if the subject considered himself as person living with a condition of disability, instead to use specific tool. Lastly, in this investigation children or non-accompanied minors are not included. Further research should investigate global needs of children and young migrants, in order to focus more in depth on the services and inclusion strategy within the community they live in.

CONCLUSIONS

The differences between migrants with and without disabilities have some distinctive features. However, both groups are influenced by the social determinants of health. In addition to health issues, challenges in social life, livelihood and empowerment also clearly emerge. Governments and different stakeholders are urgently called to intervene with multi-sectoral and cross-cutting strategies. Only by acting as a European Community will it be possible to overturn and change a discriminatory system and guarantee the respect of human rights, regardless of one's legal status, disability or sexual orientation, or the country to which one is forced to migrate.

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Conflict of interest statement

No potential conflict of interest was reported by the Authors.

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