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Disability, Rehabilitation, and Assistive Technologies for Refugees and Asylum Seekers in Italy: Policies and Challenges

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Abstract: Good health and well-being for all, including those with disabilities, is one of the main sustainable development goals. Data on refugees and asylum seekers with disabilities are limited. Refugees have poor access to rehabilitation and assistive technologies, although laws and policies in Italy guarantee this type of healthcare. However, there are several limitations to the successful implementation of these services. First, the national health system is regionally based, and therefore healthcare facilities and services vary in terms of quality in different regions. A link between reception centers and the healthcare system is therefore highly recommended, because only 10 out of 20 regions have specific services for refugees and asylum seekers with disabilities. Second, only 2% of the total available posts for hosting refugees are reserved for people with disabilities. The lack of a standardized vulnerability assessment represents the main barrier to the organization of specific services for migrants within the community. National stakeholders urgently need to collaborate in order to remove barriers to rehabilitation and assistive technology for refugees with disabilities. Initiatives should focus on health literacy and the empowerment of migrants, data collection on health, disability, and assistive technology, and the organization of community-based rehabilitation programs.

Keywords: disability; refugees; migrants; rehabilitation; assistive technologies; policies; reception centers; data

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1. Introduction

At the end of 2020, the United Nations High Commissioner for Refugees (UNHCR) reported that there were 26.4 million refugees and 48 million internally displaced persons worldwide due to conflict [1]. Results of the World Health Survey indicate that the prevalence of disability in this population is 15% [2]. However, various international organizations and the European Union have critically highlighted the lack of data on disability in the migrant population.

Refugees with disabilities represent an underserved group of individuals who are forced to leave their countries due to particularly disadvantaged situations [3]. Refugees and asylum seekers with disabilities face multiple and intersecting forms of discrimination, have worse health outcomes, and experience greater difficulties accessing higher levels of education, as well as the labor market [4]. Moreover, with specific regard to health, they do not receive the healthcare services they need, and about half of people with disabilities

cannot afford healthcare [5]. However, addressing the needs of migrants with disabilities is fundamental for the achievement of the global Sustainable Development Agenda [6], specifically goal # 3, which calls for the development of good practices that guarantee good health and well-being for everyone. Data on migration and disability must be uniformly collected since they are needed to inform the health policy actions of individual countries. In order to monitor progress on the 2030 Agenda, the international community unfortunately relies on disaggregated data on both disability and migration status. The statistical inclusion of data on migrants with disabilities is crucial to allow migrants full and equal participation in society. Statistical data on migrants can enable inclusive disability policies and practices, as well as programs that result in better accommodation and access to critical services and reduce marginalization and discrimination.

In recent years, the Global Compact on Refugees (GCR) [7] was approved. Building on the predicament of global sustainability and the 2030 Agenda for Sustainable Development, the GCR is a framework based on four strategic objectives: to (1) ease pressures on host countries, (2) enhance refugee self-reliance, (3) expand access to third-country solutions, and (4) support conditions in countries of origin to allow refugees to return in safety and dignity. The GCR urges the international community to respond comprehensively and innovatively to the plight of refugees, and to make a paradigm shift in global humanitarian aid to emphasize refugee self-reliance and livelihoods. Solutions should be country-specific to avoid tensions between displaced populations and host communities, and should enhance refugees' self-reliance, particularly in situations of protracted displacement. The GCR's success will also depend on a comprehensive response that involves a multiplicity of actors, states, and organizations at the regional level [8].

The GCR addresses the topic of persons with disabilities explicitly, mentioning issues related to human rights, discrimination, and abuse; fostering the participation of Disabled Persons Organizations (DPOs); contributing to community development and the design of inclusive and accessible societies; fostering inclusive sports and cultural activities; collecting, analyzing, and sharing disaggregated data on disability; addressing the specific needs of persons with disabilities including education, employment, and health [7,8].

The GCR seems to privilege and promote a community-based inclusive development framework. However, the approach of the EU, whose Parliament approved the Global Compact of Refugees, which Italy has not ratified, is different from the UN approach, due to the resistance of several EU countries [9]. In fact, rather than reception, European policies are oriented toward reducing the flows of migrant people. Under the current migration governance of the EU, state sovereignty is manifested in migrant interdiction, interception, and detention policies. While reinforcement of the Schengen region's external borders is a key aim of the EU's internal migration politics, in the last decade, collaboration with third world countries regarding migration control has become a key feature of its external migration policy [10]. Finally, the EU has pledged to build a common European asylum system based on the full and complete application of the 1951 Geneva Refugee Convention. At present, this project has reached a deadlock and even the call for a balanced redistribution of migrants still finds much resistance in some member countries. The Valletta Agreement [11] between some countries for the equitable redistribution of migrants is a timid step forward, but the Dublin Convention that binds countries of entry to host migrants still remains in place. A common EU response based on equal solidarity and clear legally binding commitments for all EU member states in line with Treaty decision-making procedures should be prioritized instead; this is the key to strengthening the Union's legitimacy and credibility in asylum and migration policies, both internally and with regard to relations with third world countries [11].

The attention paid to migrants with disabilities has certainly grown in recent years. International debate has produced a series of tools and policy guidelines to implement appropriate protection of human rights. The UNHCR provides key recommendations for providing adequate support for refugees with disabilities: (1) map out the national government health services; (2) assess the availability of rehabilitation services and access

to assistive technology for persons with disabilities in the national and local context; (3) integrate disability data collection methods into agency-specific or sector-wide information management systems and processes that link identification, needs assessment, and response; (4) advocate for disability-specific (e.g., rehabilitation, assistive technology, respite care) and inclusive indicators [12].

In light of these recommendations, the present work aims to critically analyze Italian policies targeting refugees and asylum seekers with disabilities, explore approaches to disability identification, and propose strategies to ensure refugees' and asylum seekers' access to rehabilitation services and assistive technology (AT).

2. Healthcare Policies for Refugees and Asylum Seekers

2.1. Principles of the Italian National Health Service

On 23 December 1978, Law n. 833 established the Italian National Health Service (NHS) based on the principles of universality of healthcare, solidarity of financing through general taxation, and equitable access to services. Subsequent milestones included the establishment of a system of local health authorities to promote efficient and effective management and the establishment of the core benefits package (i.e., the LEAs (essential levels of care)) to ensure uniformity of service delivery across the country. Universality, equity, and solidarity are the three guiding principles of the Italian NHS, which aims to achieve uniform levels of care throughout the territory, equitable access to services for all citizens, and fiscal solidarity as the fundamental way of financing the health system. This means that all services included in the benefits package must be equally accessible in all Italian regions. However, the NHS is a regionally based health service and therefore regional governments are responsible for delivering a benefits package to the population. Healthcare facilities and services vary in terms of quality in different regions of Italy.

2.2. Healthcare Service and Policies for Refugees and Asylum Seekers

In 1995, the Dini decree contained norms that guaranteed health assistance to even non-regular immigrants. However, the decree was not converted into law, and in the end guaranteed assistance to only 200,000 regularized persons.

In 1998, the "Napolitano–Turco" law attempted to regulate immigration by encouraging regular immigration. The regular immigrant is characterized by a series of steps towards the acquisition of the rights of the "pleno iure" citizen, including rights to family reunification, health, and education. The illegal immigrant, in contrast, is subject to expulsion from the State.

In 2002, the Bossi–Fini Law n. 189/2002 determined a more restrictive policy. The residence permit was linked with a work contract and became more difficult to obtain. Expulsion was made easier and detention in centers of temporary stay was extended from 30 to 60 days.

In April 2008, a national survey to ascertain the types of services provided in order to guarantee healthcare revealed considerable differences among regions and limited access to healthcare by the immigrant population despite the legal apparatus recognizing the right of refugees and asylum seekers to healthcare access. Moreover, within the same regional territory and between regions, there were different interpretations of the rules regarding healthcare access for migrant populations that undermined the principles of universal and equitable care. In December 2012, to guarantee immigrant populations on the national territory adequate access to treatment and healthcare, as provided for by the LEAs, the permanent conference for relations between the State, regions, and the autonomous provinces of Trento and Bolzano stipulated guidelines for the correct application of healthcare regulations for the foreign population by Italian regions and autonomous provinces. Table 1 summarizes laws on healthcare services and policies for refugees and asylum seekers.

Table 1. Summary of laws on healthcare services and policies.

1995	Dini decree
1998	Napolitano–Turco Law
2002	Bossi–Fini law
2012	Guidelines for the correct application of legislation on healthcare to the foreign population from the regions and autonomous provinces

2.3. Reception Centers for Refugees and Asylum Seekers

National policies for hosting refugees and asylum seekers in Italy have changed rapidly [13]. In 2001, the National Association of Italian Municipalities (ANCI—Associazione Nazionale Comuni Italiani), UNHCR, and the Italian Ministry of the Interior signed a memorandum of understanding to establish the National Asylum Program (PNA—Programma Nazionale Asilo). The PNA was the first public system established for the reception of asylum seekers and refugees throughout the Italian territory. The PNA instituted shared responsibilities between the Ministry of the Interior and local authorities.

Law n. 189 of 30 July 2002 institutionalized the PNA by establishing the Protection System for Asylum Seekers and Refugees (SPRAR—Sistema Protezione Richiedenti Asilo e Rifugiati). Subsequently, the Ministry of the Interior established a central co-ordination office and appointed the ANCI to manage it.

In 2018, the SPRAR was renamed the Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors (SIPROIMI—Sistema di protezione per titolari di protezione internazionale e per minori stranieri non accompagnati) (Legal Decree n. 113 of 4 October 2018, enacted as Law n. 132 of 1 December 2018). The new legislation provided access to SIPROIMI's integrated reception services to holders of a residence permit for special reasons, including victims of violence, trafficking, domestic violence, labor exploitation, calamities, poor health, or for acts of particular civic value.

In 2020, the SIPROIMI was renamed the Reception and Integration System (SAI—Sistema Accoglienza e Integrazione) (Legal Decree n. 130 of 21 October 2020, enacted as Law n. 173 of 18 December 2020). The new legislation set out that access to SAI's integrated reception services should be provided to refugees, asylum seekers, unaccompanied foreign minors, and foreigners entrusted to the social services upon reaching the age of majority. Moreover, the 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 the SAI is to provide support to each individual in the reception system through an individual program designed to enable that person to regain a sense of independence and thus enjoy active participation in life in Italy in terms of employment, housing, access to local services, social interaction, and scholastic integration for minors. Table 2 summarizes the development of laws for hosting refugees and asylum seekers in reception centers.

Table 2. Summary of laws for reception centers hosting refugees and asylum seekers.

2001	Start National Asylum Program (PNA—Programma Nazionale Asilo)
2022 Law n. 189 of 30 July 2002	Protection System for Asylum Seekers and Refugees (SPRAR—Sistema Protezione Richiedenti Asilo e Rifugiati)
2018 Law n. 132 of 1 December 2018	Protection System for Beneficiaries of International Protection and for Unaccompanied Foreign Minors (SIPROIMI—Sistema di protezione per titolari di protezione internazionale e per minori stranieri non accompagnati)
2020 Law n. 173 of 18 December 2020	Reception and Integration System (SAI—Sistema Accoglienza e Integrazione)

3. Refugees and Asylum Seekers with Disabilities

3.1. Availability for Hosting Refugees and Asylum Seekers with Disabilities

Concerning SAI reception centers, the latest available data from the SAI data portal in 2021 revealed large disparities in services for refugees with disabilities between Italian regions. First, it is important to point out that compared to 2020, more ordinary places were funded (from 32,456 to 39,418), but this increase did not include availability for refugees and asylum seekers with disabilities (excepted for the Apulia region). Only 10 regions have specific services for people with disabilities. The center area has the best distribution of services, with all four regions providing services dedicated to people with disabilities. The region with the most capacity to assist refugees with disabilities is the Apulia region: 5.06% of total availability is dedicated to people with disabilities. Overall, the SAI can accommodate a total of 39,418 people, but only 2.03% of available posts are reserved for people with disabilities. Table 3 reports the total available posts for hosting refugees and asylum seekers and the posts reserved for people with disabilities.

Table 3. Availability for hosting refugees with and without disabilities in Italy.

Map	Macroregion	Region	Total Availability for Hosting Refugees	Availability for People with a Disability N (%)
	North-West	Aosta Valley	37	0 (0)
		Liguria	1148	0 (0)
		Lombardy	3388	40 (1.18)
		Piedmont	2454	46 (1.87)
	North-East	Emilia-Romagna	3683	123 (3.33)
		Friuli Venezia Giulia	324	0 (0)
		Trentino-South Tyrol	237	0 (0)
		Veneto	654	0 (0)
	Center	Lazio	3080	38 (1.23)
		Marche	1571	13 (0.82)
		Tuscany	1862	43 (2.30)
		Umbria	459	6 (1.30)
	South	Abruzzo	832	0 (0)
		Apulia	4004	203 (5.06)
		Basilicata	751	0 (0)
		Calabria	3502	63 (1.79)
		Campania	3809	0 (0)
		Molise	948	0 (0)
	Islands	Sardinia	288	0 (0)
		Sicily	6221	228 (3.66)
Total		20	39,418	803 (2.03)

3.2. The Need for Systematic Evaluation of Disability

In September 2020, the European Commission launched the New Pact on Migration and Asylum to much debate. The New Pact [14] does not fully consider the diversity of migrants and asylum seekers with disabilities. The EU proposal for a vulnerability assessment should be performed during the pre-entry screening process. Authorities should pay "particular attention (. . .) to vulnerable persons, such as (. . .) persons with an immediately identifiable physical or mental disability". Asking authorities to carry out examinations based on the observation of "immediately identifiable disability" ignores the complex needs related to disability and discriminates de facto people with disabilities. The proposed approach reintroduces a medical vision of disability and health, which conflicts with the bio-psycho-social and human right approaches promoted by the United

Nations Convention on the Rights of Persons with Disabilities (UNCRPD) [15] and with the standards currently used at the international level.

In recent years, many organizations have proposed different approaches to measure disability among the migrant population. In 2017, the UNHCR, together with the non-governmental organization (NGO) Humanity & Inclusion (formerly Handicap International), proposed the Vulnerability Assessment Framework (VAF) [16], which includes a short set of questions from the Washington Group on Disability Statistics (WG). In 2020, the Access for Migrants with Disabilities (AMID) project funded by the European Union proposed the Needs Assessment Tool (NAT). The NAT allows both qualitative and quantitative analyses, thus reconciling the need to measure and obtain comparable data in different countries with the need to record the different experiences of migrants in a narrative dimension [17]. The NAT includes the Extended Set on Functioning developed by the WG. In 2021, the NGO Relief International, together with the International Centre for Evidence in Disability of the London School of Hygiene & Tropical Medicine, investigated disability among refugees in Turkey using the WG's short set enhanced tool, together with the child module of the WG and UNICEF [18]. In 2021, a group of Italian researchers at Sapienza University of Rome, together with the Italian Society of Migration Medicine and the Rehabilitation & Outcome Measures Assessment (ROMA) association, investigated disability within migrant populations using the WG short set enhanced tool, revealing a proportion of 21.7% (95% CI 15.6–28.9) of people with disabilities [19]. The working group also used the community-based rehabilitation (CBR) indicators developed by the World Health Organization (WHO) to explore access to healthcare, social, and employment services [20]. Preliminary results highlight that refugees with disabilities faced challenges in each domain of the CBR matrix, namely health, education, social, employment, and empowerment domains [21].

3.3. Perspectives for Rehabilitation and Assistive Technology (AT) Services

There are no data on access to rehabilitation and AT for refugees and asylum seekers in Italy. At the international level, limited evidence exists regarding the prevalence of disability (estimated rate 3–10%) [22]. The most common diseases are related to mental health, while one in six migrants experience physical health problems [23]. A recent study in Turkey revealed that the overall prevalence of disability in refugees was 24.7% (95% confidence interval (CI): 22.1–27.4), when including people who self-reported difficulties in at least one functional domain using the WG tool (15%, 95% CI: 13.1–17.2), moderate/severe musculoskeletal impairments (8.7%, 95% CI 7.6–9.9), and/or symptomatic anxiety, depression, and post-traumatic stress disorder among children 8–17 (21.0%, 95% CI 18.2–23.9) [18]. Therefore, among refugees and asylum seekers hosted at an SAI network in Italy, the needs of people with disabilities are likely underestimated. The lack of a standardized disability evaluation tool is the main barrier to providing quality of care and comprehensive support for refugees and asylum seekers. A methodological study to identify the best tool to measure disability in the target population is highly recommended [24].

To provide comprehensive rehabilitation and health services for refugees with disabilities, different experiences with a community-based approach were used at an international level. Community-based inclusive development (CBID), formerly known as community-based rehabilitation (CBR), is a multi-sectorial community strategy to guarantee that people with disabilities enjoy the same rights and opportunities as all other community members [25]. CBID/CBR was proposed by the World Health Organization and is organized in five domains: health, education, social, livelihood, and empowerment. CBID/CBR for refugees can lead to both occupational and social justice for persons with disabilities [26], and its principles can also help children overcome difficulties associated with forced migration [27]. CBID/CBR was found to be an effective strategy to increase access to healthcare services [23,28], though education and training for both healthcare professionals and community workers are recommended [29,30]. In the Italian setting, there is an opportunity to organize adequate services with a CBID/CBR perspective. A task force involving the

SAI network, academics, and governmental and non-governmental organizations could provide specific rehabilitation services by organizing appropriate identification pathways, planning targeted rehabilitation projects, training health professionals and community workers, and involving refugees in treatment and supervision within the SAI network. In addition to health issues, social life, employment, and empowerment challenges also clearly emerge [21], and national stakeholders should provide adequate support to refugees and asylum seekers in Italy.

Regarding AT, there is very little evidence of AT provision for refugees. However, AT provision is an implicit requirement of Article 11 of the UNCRPD and the World Health Assembly resolution [31]. AT provision is an unmet need. For example, 19% of people with musculoskeletal impairments at a refugee camp in Turkey did not receive an AT product, not even basic equipment [32]. In 2021, the Italian non-profit organization Federazione Italiana Superamento Handicap (FISH) produced a qualitative research report on migrants with disabilities [33], which highlighted the AT needs of migrants and their barriers to access. Many migrants are not aware of available healthcare services, especially services such as rehabilitation or AT (e.g., wheelchairs, prosthetics, or communicators) [34–36]. However, the Italian Minister of Health Notice n. 5 of 24 March 2000 guarantees refugees and asylum seekers access to AT and rehabilitation. In some cases, regional governments have extended this norm to non-regular migrants, but differences between different Italian regions continue to appear, both in interpretations of laws and in a lack of awareness among social workers, healthcare workers, and migrant peoples. A massive rights literacy initiative targeting migrant communities should be undertaken at a local and national level [4,37], as well as a specific information campaign for different stakeholders working on this topic.

4. Conclusions

There are no consistent and systematic national initiatives in Italy to organize or improve rehabilitation and AT services for refugees and asylum seekers. Italy, together with Greece and Spain, is the first gateway to Europe, and therefore a specific vulnerability assessment should be considered in reception centers and during the identification process. In this perspective, it would be important to highlight the role of information technologies in cross-sectoral data exchange, to better address the health and global needs of refugees and asylum seekers. For instance, a first attempt to create a European database on the needs of migrants with disability was created throughout the AMID Project in 2020 [17], but the sharing of information on laws and policies may vary across European countries. In fact, although there are national policies guaranteeing access to rehabilitation and AT, people are not aware of these possibilities, and regional differences in services for refugees and asylum seekers with disabilities are evident. Training healthcare professionals and social and community workers on migration and disability is recommended. CBID/CBR should be considered an effective strategy. Funding models and arguments for international cooperation and transparency in accommodating migrants with disabilities internationally are urgently required [38]. Therefore, national stakeholders, together with regional governments, should collaborate to remove barriers to these persons' access to rehabilitation and AT, as well as to guarantee equity in healthcare and a good quality of life for all.

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