

# Inequalities and health: analysis of a model for the management of Latin American users of an emergency department

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## Key words

Health inequalities • Emergency department • Public health

## Summary

**Background and objectives.** *The number of foreigners using emergency departments has risen in recent years. The aim of this study was to assess the management of Latin American users, above all Ecuadorian, of an emergency departments by analysing the main reasons for access to the emergency departments, the triage codes assigned and the attitudes and behaviours of healthcare personnel towards foreign nationals, particularly those classifiable as foreigners temporarily present.*

**Methods.** *The management model was examined through the analysis of medical data, field observation and semi-structured interviews conducted in Spanish regarding sociodemographic, socioanthropological and healthcare issues.*

**Results.** *Latin Americans accounted for 7.51% of the total number of users of the emergency departments; 50.91% were classifiable as foreigners temporarily present. The triage codes*

*assigned to these patients have a high percentages of white (19.75%) and green (69.81%) codes. Patients with foreigners temporarily present status showed high rates of requests for prescriptions and examinations (85.19%), gynaecological problems (69.90%), fever (64.04%), abortion/pregnancy-related requests (56.77%) and leave without being seen (63.91%).*

**Conclusions.** *The study revealed that foreigners temporarily present look to the emergency departments for non-urgent services, as this is the only facility to which they are entitled to refer for medical treatment. This fact underlines the need to reform healthcare legislation in such a way as to entitle every foreigner to be treated by a Family Physician; this would reduce both waiting times in the emergency departments and the irritation of medical personnel who are called upon to deal with non-urgent cases.*

## Introduction

### BACKGROUND

The influx of immigrants into Italy, and also into the Liguria Region, has increased markedly in recent years. In the municipality of Genoa alone, 3,415 legal immigrants were registered in 2005, and at least as many illegal immigrants are estimated to have arrived. Of these, 45.24% come from the Caribbean, Central America and South America (1.84%; 0.52% and 43.16%, respectively) [1, 2]. Clearly, such a high level of immigration places demands on public health authorities with regard both to the state of health of these people and to the management of foreigners within healthcare facilities. In 2000, the Parliamentary Assembly of the Council of Europe expressed concern over the healthcare provided for refugees and immigrants into the EU [2], and pointed out that some countries did not guarantee healthcare or social assistance for certain categories of immigrants.

In Italy, the right of foreign immigrants, whether legal or illegal, to receive healthcare was formalised in 1998 by Law N. 286 "Provision related to immigration and foreign condition" [3] of 25th July, which established that healthcare must be provided for foreigners, including those not in possession of a valid stay permit, with regard to "... urgent, essential and ongoing hospital and

outpatient treatment for illness and injury ..." [3] and that "... preventive medicine programmes to safeguard the health of the individual and the community..." [3] should be extended. The subsequent ministerial circular of 24th March, 2000 gave illegal immigrants the right to receive urgent and essential hospital and outpatient treatment, services for preventive medicine, pregnancy, maternity and child health, international prophylaxis measures and vaccinations, the treatment of infectious diseases and environmental sanitation, penitentiary healthcare and services for drug addiction [4]. These benefits are provided free of charge, in that the beneficiaries are bereft of financial resources. To register with the Italian National Health Service (NHS), the immigrant must present a valid stay permit (or a receipt attesting its renewal) and self-certification of residence and tax code number. On registration, the legal immigrant enjoys the same rights as an Italian citizen with regard to healthcare.

Foreigners without a stay permit may request an FTP (Foreigner Temporarily Present) card on arrival in hospital or other regional health service facility; the card is valid for 6 months, renewable and recognized nationwide. This enables foreigners without a stay permit to obtain urgent medical treatment and prescriptions for medicines or specialist examinations, but not the services of the Family Physician or paediatrician.

This solution does not adequately address the question of healthcare for immigrants without a stay permit. Indeed, the only source of treatment and prevention available to this type of immigrant is the emergency department, which consequently becomes overburdened with requests for services that are normally provided by the Family Physician. This contributes to overcrowding and lengthens waiting times [5-7].

#### AIM OF THE INVESTIGATION

The present investigation was carried out in the Emergency Department (ED) of Genoa's Ente Ospedaliero Ospedali "Galliera", which is located in proximity to the largest "historical centre" in Europe, and which is the main healthcare facility in the city used by non-EU citizens without a stay permit. A model for *cultural competency in health care* [8] is not used in Liguria. Nevertheless, specific attention to the access of foreign users to healthcare facilities can be discerned within the ED.

The aim of the present study was to analyse a model for the management of non-EU citizens entering an emergency department. The investigation focused on the main reasons for access to the facility, the triage codes assigned, and the attitudes and behaviours adopted with regard to disease prevention and treatment for foreign nationals.

## Materials and methods

#### STUDY DESIGN, SETTING AND PARTICIPANTS

The facility examined is a level-1 ED which treats approximately 51,000 patients per year. The ED is equipped with a computerised data-collection system called PIESSE (designed by the Consortium of Bioengineering and Medical Informatic, located in Pavia, Italy). This programme records the entire pathway followed by ED users, from their arrival at triage until they leave the facility, and whether the patient is an FTP or non-FTP. The data gathered from 1<sup>st</sup> January, 2005 to 31<sup>st</sup> December, 2005 were processed by means of the Stata SE® 9 statistical programme (Stata Corporation, USA). As Genoa has a large Latin American community (16,069 residents as of 30th April, 2006) the investigation focused on these users.

The investigation also involved a medical-anthropological study, which was conducted by a medical anthropologist in the triage and examination rooms of the ED. Observation was always carried out within the ED facility: in the triage room, physicians' rooms and another area, which was used exclusively for the questionnaire-based in-depth interviews.

The ethnographic observation was subdivided into three periods: morning (8:01/14:00), afternoon (14:01/20:00) and night (20:01/8:00), and was carried out for 9 months. During each medical examination of a "Latino" patient, a preliminary interview contact was initiated if the patient's medical condition permitted. Conducted in Spanish, the preliminary interview concerned the patient's country and locality (city or village, rural, coastal, etc.) of origin, length of stay in Italy, plans for future migration, previous

immigration, and the presence of any family members in Italy. At the end of the medical examination, persons who had shown a willingness to co-operate were asked to undergo a second interview with a medical anthropologist in an adjacent room. A total of 30 complete, open and semi-structured interviews with a mean duration of 30 (15-45) minutes were conducted. The interview included: *demographic aspects*, marital status, children, relatives, studies/courses undertaken in the country of origin and in Italy, occupation in the country of origin and in Italy, and work contract (legal or illegal); *anthropological aspects*, migratory expectations, self-appraisal of the subject's social status before and after migration, social relationships, and religion; and *medical aspects*, reason for going to the emergency department, knowledge of the medical system in their native country and in Italy, use of traditional remedies (and also visits to *healers*), health status, relation between drug use and health status, and so on, as shown in the attached questionnaire.

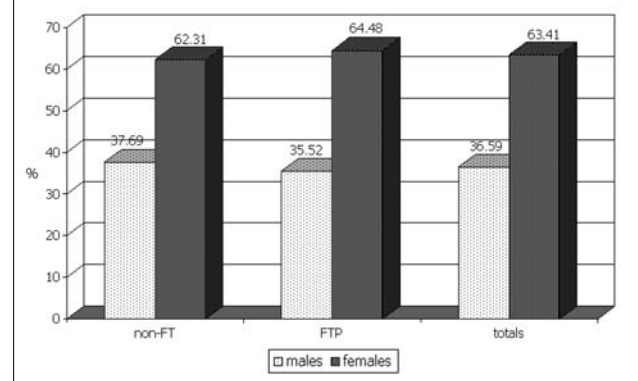
## Results and discussion

#### ED DATA RECORDED

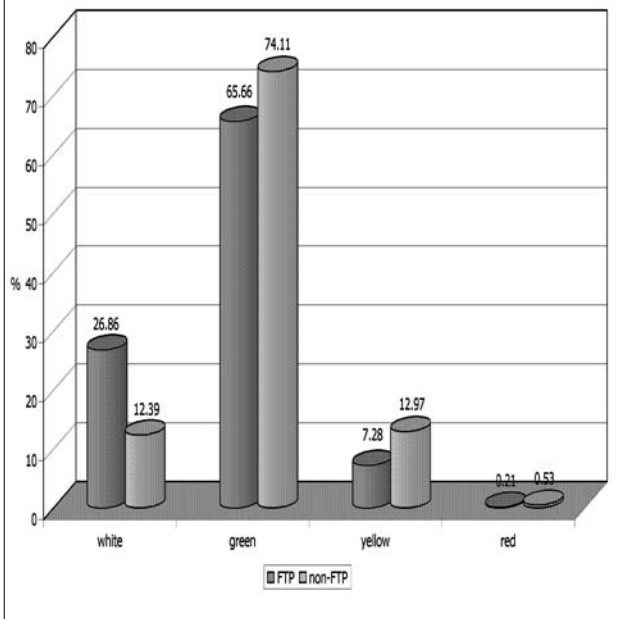
As the ED is located close to Genoa's historical centre, where many of the city's immigrants live, it handles a large number of foreign nationals. In 2005, the facility treated 51,000 patients, 3,832 of whom were Latin American. Our study considered the largest groups of foreign immigrants living within the municipal boundaries. Ecuadorians are the most numerous, accounting for 72.34% of all Latin American patients entering the ED, followed by Peruvians (9.45%), Chileans (5.43%), Colombians (2.82%), Brazilians (2.35%), Dominicans (2.32%), Argentines (1.98%), Bolivians (1.72%), Venezuelans (0.97%), Salvadorans (0.39%), Mexicans (0.16%) and Hondurans (0.08%). Of the Latin American patients entering the ED, 1,951 (50.91%) (35.52% males and 64.48% females) had no stay permit, while only 1,881 (49.09%) (37.69% males and 62.31% females) were in possession of a valid stay permit (Fig. 1).

With regard to the triage codes assigned on entry, the results show that 19.75% of Latin American patients were

**Fig. 1.** Percentage frequency of Latin American users with or without FTP status, as a function of sex.



**Fig. 2.** Percentage frequency of triage codes as a function of stay permit status for Latin American patients.



assigned a white code (non-urgent: indeterminate wait), 69.81% a green code (non-urgent: not serious patients; examination within 2 hours), 10.07% a yellow code (urgent: serious patient, but life not in danger; examination within 20 minutes) and 0.37% a red code (life-threatening: immediate attention) (Fig. 2). These figures differ from those recorded in the same year for Italian nationals: 7.74% white codes, 72.90% green codes, 17.64% yellow codes and 1.71% red codes. They also differ from the figures recorded for Italian nationals in a nationwide study, which reported the assignment of white codes in 25.74% of cases, green codes in 58.54%, yellow codes in 14.40% and red codes in only 1.32% [9].

In addition to these differences in the assignment of triage codes, differences also emerged between foreign ED users and their Italian counterparts in terms of exit from the facility. Indeed, 7.23% of the foreigners walked out without waiting for their medical report to be filled in; the corresponding figure for the overall patient population was 5.14%. Similarly, only 4.46% of the foreigners were hospitalised, as opposed to 16.26% of the overall patient population. The discharge rate was also higher among foreigners (88.31%) than in the overall patient population (77.80%). These patterns indicate that the ED tends to be used by foreigners as a source of generic, rather than emergency, medical treatment.

Given that Ecuadorians form the largest group of non-EU citizens, both in the municipality (10,169 persons) [2] and in the ED (2,772 patients), we conducted a detailed analysis of the data on this community. It emerged that 57.11% of the city's Ecuadorians are classifiable as FTP (foreigners temporarily present), while only 42.89% have a valid stay permit and can therefore utilise the National Health Service.

With regard to the times of day when Ecuadorian users enter the ED (Tab. I), it was found that most (49.06%)

**Tab. I.** Percentage frequency of Ecuadorians using the Emergency Department at different times of day.

Times	Percentage frequency
Morning (08:00-13:59)	49.06
Afternoon (14:00-19:59)	30.05
Night (20:00-07:59)	20.89

arrive during the morning hours. Moreover, analysis of the diagnoses made by medical personnel at the different times of day reveals that, during the morning hours, the most frequent complaints concern *abdominal pains* (45.03%), followed by *gynaecological problems* (19.20%) and *requests for prescriptions* (17.55%). Little difference is seen during the afternoon, when the main problems are *abdominal pains* (31.27%), followed by *gynaecological/obstetrical problems* (28.19%) and *fever* (15.41%). During the night, however, in addition to the above-mentioned *abdominal pains* (36.87%), *gynaecological/obstetrical problems* (20.62%) and *fever* (13.75%), a large number of cases concern *alcoholism* (16.25%).

Analysis of the data revealed that treatment is sought for various non-urgent problems which should not be dealt with by an emergency department. Given that the only healthcare services to which foreigners without a valid stay permit are entitled are provided by the ED, particular attention was paid to analysing these non-urgent complaints as a function of the absence of a stay permit. From this analysis it emerged that subjects with FTP status displayed far higher rates than non-FTP subjects with regard to *requests for prescriptions* (85.19% FTP vs. 14.81% non-FTP), *gynaecological problems* (69.90% vs. 31.10%), *fever* (64.04% vs. 35.96%) and *leaving without waiting for attention* (63.91% vs. 36.09%). With regard to alcoholism, however, the situation was reversed. Indeed, 65% of alcohol-related problems among Ecuadorians were dealt with at night, and in 57.50% of these cases the person had a valid stay permit, suggesting that there could be a link between alcohol-related problems and the fear of being reported as an illegal immigrant. With regard to requests for examinations concerning *pregnancy/abortion*, non-FTP subjects accounted for 56.77% and FTP subjects for 43.23%; it should be noted that abortion requests involved 45 out of 88 (51.14%) non-FTP subjects and 40 out of 67 (59.70%) FTP subjects. In the category *anxiety and psychomotor agitation*, 58.67% of Latin American patients were legal immigrants, while 41.33% were FTP. Only in the case of Ecuadorians is the situation different; 39.53% had a valid stay permit, while 60.47% did not. This unexpected finding does not seem to confirm the results of studies on the stress and anxiety caused by being an illegal immigrant [10]; rather, it suggests that anxiety syndromes are subjective and are shared to a similar degree by Italian nationals and immigrants, whether they have a stay permit or not.

#### DATA FROM QUESTIONNAIRES

Medical-anthropological interviews (Appendix) were conducted with 30 respondents: 25 Ecuadorians, 2 Peruvians, 1 Bolivian, 1 Salvadoran and 1 Brazilian. Their mean

age was 34 years (57% women). The higher percentage of women can be explained by the fact that 63.63% of all Latin American citizens resident in the municipality of Genoa are female [11]; this is in line with the findings of other studies published in Europe [12]. Two of the respondents were minors (interviewed with the consent of their guardians). In this regard, it should be noted that immigrant children account for a fairly large portion of the ED users, even though the ED under examination is not a paediatric facility.

With regard to the other socio-anthropological data collected from Ecuadorian users, the main reason for immigration [item 18] is reported to be the economic hardship of the 1990s; indeed, following the crisis caused by the adoption of the dollar in Ecuador, many were prompted to emigrate in search of employment. Although these immigrants recognize that in Italy they have greater possibilities (of employment, saving, study, etc.) [items 8, 10] and a higher standard of living, they nevertheless maintain that their social status has markedly deteriorated since they arrived (loneliness, homesickness, difficulty in finding housing or a job, health problems) [item 20]; this is especially true of those who formerly had a good job in their own country [items 9, 10]. Five of the respondents reported having bought a house, while the remaining 25 live in rented accommodation in two neighbourhoods of the historical centre of the city [items 29, 30].

With regard to diagnoses, no particular differences emerged in comparison with the overall sample observed in the emergency department [item 62]. Ten respondents, mostly women, stated that they made use of traditional remedies from their home country in addition to conventional medicines [items 44, 45, 46]; though available in some shops in the historical centre, these traditional medicines (*chancha piedra*, *sangre de drago*, etc.) are often sent directly from the country of origin. Moreover, it is noteworthy that such traditional healthcare practices are carried out almost exclusively by the women. A high percentage of respondents, both men and women, report that traditional remedies are reinforced by prayer and *fatalism*, especially in the phase of coming to terms with illness.

Among those who were interviewed, 76.70% claimed to be familiar with the National Health Service [item 41], though they were unable to provide accurate answers to specific questions regarding its workings. Those who were registered with the National Health Service (46.60% of respondents) reported having difficulty with their Family Physicians (FPs) on account of inflexible surgery hours and numerous absences of FPs. This is also a commonly expressed complaint among Italian nationals who arrive at the emergency department. FTP subjects accounted for 53.40% of respondents; most of these had already renewed their cards two or three times.

Almost all interviewees claimed to have a good knowledge of the National Health Service in their country of origin, and pointed to financial difficulties as the main obstacle to access to emergency care. Many expressed mistrust in and disappointment with their own National Health Service [items 38, 39]. By contrast, they praised the Italian National Health Service and did not mention any form

of racial discrimination. At the same time, however, they complained of long waiting times. Only with regard to this aspect did a small number of respondents voice their suspicion that ethnic considerations might be involved.

## Limitations

The main limitation of this study lies in the fact that it is the first observational study to be conducted on the foreign users of an ED; little such research has been conducted in Italy [11-13]. In view of the lack of bibliographic and comparative sources in Italy, our analysis had to be limited to a few variables.

## Conclusion

The present study shows that the FTP card, on account of its legal status, enables persons without a stay permit to have access to emergency facilities in order to obtain *medical prescriptions*, *specialist examinations* or general consultations. While the right of every person to receive medical treatment is guaranteed, it clearly emerges that legislative reform is needed in order to provide FTP subjects with a Family Physician available for consultation in facilities independent from the ED or, at least, in dedicated areas within each hospital. This would cut waiting times for users and reduce the irritation of medical personnel who, in addition to dealing with urgent cases, are called upon to play the role of the Family Physician [7].

No racial discrimination was noted in the ED with regard to waiting times; indeed, the fact that the system is computerised means that patients are called in accordance with a list that can be consulted in the waiting room. It also emerges, however, that patients, whether foreign or Italian nationals, are not fully aware of the procedure whereby triage codes are assigned, and that the explanatory notices do not appear to be completely clear. Another feature shared by foreign and Italian users is the conviction that "emergency" is synonymous with speed. For this reason, a three-hour wait becomes intolerable [5].

Staff attitudes towards Latin American patients were investigated in a previous study (in press), which revealed no differences with regard to either patient reception or the medical approach. However, in spite of the large number of Latin American patients handled by this ED, the situation is not yet comparable to that seen in other countries [14-21]. We cannot, therefore, exclude the possibility that the cultural prejudices already manifested by a small part of the staff may become consolidated in the future. Indeed, it emerged that medical and healthcare personnel had little knowledge of the laws governing healthcare services for unauthorised foreign nationals. In addition, it should be noted that a few practical difficulties in triage code assignment arose from the frequency of some complaints (such as headache, pelvic pains or pregnancy pains) reported by Latin American patients, which might, in the long run, be underestimated by staff. This may explain the tendency to assign a white code more frequently to FTP subjects (26.86%) than to

non-FTP subjects (12.39%) or to Italian nationals (7.74%). The paradox here is that, as the FTP subjects do not have a Family Physician, they are obliged to turn to the emergency services, while the ED personnel are often obliged to assign them a white code.

In the case of Latin Americans, language is not a barrier to obtaining healthcare, since Spanish and Portuguese are both very similar to Italian. At the same time, however, the common tendency to lump all Latin cultures together carries the risk of creating a simplistic vision of these societies on the basis of an Italian model; this may give rise to incomprehension and, hence, to difficulty in treating the patient. No cases were recorded of children having to act as interpreters between parents and medical personnel, though a tendency for Latin American patients to be accompanied by various family members on arrival at the ED was noted. Moreover, no cases were recorded of Latin American patients immigrating specifically to seek healthcare.

In conclusion, steps need to be taken to protect the public health of immigrants. These should include providing information on risks at home and in the workplace, on the effects of drug and alcohol abuse and on infectious and sexually transmitted diseases. In addition, investments should be made in both preventing and safeguarding pregnancy [22]. Finally, dietary education should be provided for diabetic foreigners, as diabetes is likely to become a major public health problem in Italy in the next few years.

## Key points

- This study aimed to analyze a model for the management of the foreign users of an emergency department

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ment called upon to provide healthcare services for immigrants with a temporary stay permit.

- Although a small number of staff manifested some cultural prejudices, no discrimination against Latin American users, in terms of patient reception and medical treatment, was observed.
- The study brings to light a nationwide public health problem, in that it underlines the need for legal reform aimed at ensuring that foreigners with a temporary stay permit have access to a Family Physician in facilities independent from EDs.

## List of abbreviations

ED: emergency department  
FTP: foreigners temporarily present  
FPs: Family Physicians

## Author contribution statement

The study was conceived by Dr. M. Sartini and Dr. P. Cremonesi, and organized by Dr. S. Brigidi; Dr. M. Sartini, Dr. C. Costaguta and Dr. S. Brigidi supervised the data collection; Dr. M. Sartini processed and analyzed the data; Dr. S. Brigidi, Dr. M. Sartini, Dr. C. Costaguta and Prof. ML Cristina drafted the manuscript. Dr. M. Sartini was the scientific supervisor and coordinator of the study. All Authors contributed substantially to its revision.

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Appendix: Questionnaire administered to the studied subjects.

<b>Questionnaire</b>
Date
First name and family name
Place
<b>Socio-demographic data</b>
Country of origin
City/district
Date of birth/age
Parents
Marital status/cohabitation
Children
Studies/courses taken in country of origin
Studies/courses taken in Italy
Occupation in country of origin
Occupation in Italy
Type of contract
Stay permit
Various
<b>Socio-anthropological data</b>
Length of time in Italy
Was Italy your first destination as an immigrant?
If not, where, how long and why?
How did you arrive in Italy?
Main reason for immigrating
Future plans for migration
Has your situation worsened?
What do you miss most about your country?
What are the main differences?
Would you like to go back?
Religion
Do you practise your religion?

Has your religious practice changed since you arrived?  
 Who do you mostly spend your free time with?  
 Do you frequent Italian people?  
 Home/accommodation  
 Neighbourhood  
 Did you have problems finding accommodation?  
 Who do you live with?  
 Are you satisfied with your present accommodation?  
 How many homes have you had in Genoa?

#### Background medical data

Why did you decide to seek medical treatment?  
 How long ago did your symptoms begin?  
 Why did you wait?  
 What health problems did you have in your country?  
 How does the health service work in your country?  
 Where would you go for medical treatment in your country?  
 Are you familiar with the Italian health service?  
 Who do you turn to in an emergency?  
 Are you satisfied with the health service in Italy?  
 Do you use other forms of assistance ?  
 Do you consider yourself to be healthy?  
 Do you take any medicines?  
 Do you have any contact with social services?  
 Or with other services: NGOs, associations?  
 Do you know what the FTP card is?  
 When members of your family came to visit you, did you make them get an FTP card?  
 Do you habitually drink alcohol?  
 What do you drink?  
 Did you have the same drinking habits in your own country?  
 In your opinion, why do so many of your fellow citizens drink, and what do you think of them?  
 Have you ever had one or more of these symptoms: tremors; palpitations; a feeling of heat in the heart area; torpidity of the hands, feet or limbs; compulsive movements of the body?  
 Do you know what **ATAQUES DE NERVIOS** [fits of nerves/epileptic fits?] are?  
 Has anyone in your family ever had them?  
 What do you think they look like?  
 How were they treated?

#### Medical data

Interview language  
 Reason for consultation  
 What do you think is the cause of your illness?  
 What symptoms have you got?  
 What do you expect from the treatment?  
 How many examinations have you had?  
 Type of treatment  
 Final diagnosis  
 Triage