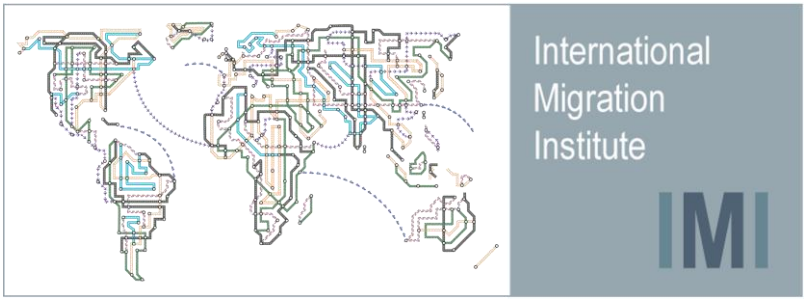

Working Papers

Paper 180, April 2024

The Impact of Covid-19 on NGOs' Provision of Primary Healthcare and Its Utilisation by Irregular Migrants in Italy

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The IMI Working Papers Series

The IMI working paper series presents current research in the field of international migration. The series was initiated by the International Migration Institute (IMI) since its founding at the University of Oxford in 2006. The papers in this series (1) analyse migration as part of broader global change, (2) contribute to new theoretical approaches and (3) advance our understanding of the multilevel forces driving migration and experiences of migration.

Abstract

This paper examines the impact of the Covid-19 pandemic on non-governmental organisations' (NGOs) provision of primary healthcare services and its utilisation by irregular migrants in Italy. Through 30 semi-structured qualitative interviews with key informants – NGO members and healthcare professionals – and migrants, the study highlights the critical role of NGOs in bridging healthcare gaps for irregular migrants, particularly during the pandemic. The study also identifies challenges irregular migrants face in accessing public healthcare in Italy, including bureaucratic barriers in obtaining special healthcare registration cards (STP and ENI codes). Policy implications include facilitating regularisation processes, increasing funding for public healthcare, and harmonising interpretations of norms governing healthcare access across regions. Networking among NGOs and associations is encouraged to enhance comprehensive support for irregular migrants. At the same time, information improvement is vital to mitigate disparities in healthcare access and utilisation among different regions and to empower migrants in seeking timely and relevant healthcare. Overall, the study contributes to understanding the dynamics between NGOs, irregular migrants, and healthcare services during crises, advocating for an inclusive healthcare system based on the human right to health.

Keywords: Covid-19; Healthcare; Irregular migration; Italy; NGOs

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Acknowledgements: This study was originally undertaken as part of the author's master's thesis at United Nations University-MERIT/Maastricht University. The author would like to thank her supervisor Lalaine Siruno (UNU-MERIT), her specialisation coordinator, Prof. Dr. Melissa Siegel (UNU-MERIT) and Prof. Hein de Haas (UvA). The author would also like to thank all the migrants, NGO members and healthcare professionals who participated in the study.

Contents

1 Introduction

The Covid-19 pandemic has triggered a discussion about fundamentally restructuring healthcare systems' functioning and financing (Assa & Calderon 2020). Italy was particularly affected by the pandemic, which revealed weaknesses in its ostensibly universal healthcare system, particularly impacting marginalised groups like irregular migrants (D'Ambrosio et al. 2020).

Access to healthcare for irregular migrants has also become a contentious political issue, intertwining human rights, national sovereignty, and policy implementation. Governments must navigate a delicate balance between immigration control and upholding human rights, constrained by international agreements and national constitutions (Ambrosini & Hajer 2023; Benhabib 2002).

Ambrosini (2013a) notes that two key factors have brought irregular migrants' healthcare access to the forefront. First, public opinion pressure has led to tightened immigration rules, while the labour market continues to absorb this workforce. Second, different interpretations of "urgent medical care" within Western countries contribute to inequalities in healthcare provision. The Italian legislation ensures emergency care, but variations exist in primary care access, influenced by regional disparities, healthcare spending controls, and the discretionary power of street-level bureaucrats (Ambrosini 2013a; Campomori 2007; Van der Leun 2006).

Italy's healthcare system is intricate and decentralised, involving a complex interplay among national, regional, and local authorities. The constitution mandates free care for indigents, with coordinated efforts between the state, Italian regions, and local authorities (Costituzione della Repubblica Italiana 1947; Ferré et al. 2014). In terms of healthcare *utilisation* by irregular migrants, the Italian legal framework recognizes their right to *urgent and essential care*. Urgent care addresses situations threatening life or health, while essential care includes services for non-immediate but potentially harmful conditions. Physicians are responsible for determining *urgency and essentiality*, introducing an element of discretionary judgment. This discretion may lead to discrimination or, conversely, an acknowledgement that untreated minor illnesses could escalate, justifying migrants' healthcare access (Gazzetta Ufficiale 2000; Perna 2018; 2019). Additionally, "regions identify the most appropriate ways to guarantee essential and continuous care" (Gazzetta Ufficiale 1999: 41), which entails further fragmentation in irregular migrants' fruition of healthcare services across different Italian regions.

According to Italian legislation, healthcare services are accessible to migrants under 18, including unaccompanied minors, through enrolment in the Regional Health Service, regardless of immigration status. However, irregular migrants over 18 are generally ineligible, except in specific cases, such as pregnant women or victims of trafficking. Other irregular migrants can access healthcare by obtaining STP (*Straniero Temporaneamente Presente*, foreigner temporarily present) or ENI[1] (*Europeo Non Iscritto*, European non-registered) codes, issued by local health authorities, hospital enterprises, university polyclinics, or scientific hospitalisation and treatment institutes. These special healthcare registration cards come with services and cost-sharing similar to those for Italian citizens, and healthcare professionals are prohibited from reporting irregular migrants to public security services (Gazzetta Ufficiale 1998).

While Italy is considered one of the most inclusive countries in providing healthcare access to migrants (MIPEX 2020), practical barriers impede irregular migrants' full utilisation of public healthcare services. Regional variations in implementing healthcare services and a complex legal framework

[1] The ENI code can be assigned to EU citizens residing outside the region (or who do not have a residence) if they do not fulfil the conditions for mandatory registration with the Regional Health System and do not receive assistance from their home countries (Gazzetta Ufficiale 2013).

dividing responsibilities between the state and regions contribute to disparities in access (Geraci et al. 2019). Obtaining STP and ENI codes poses challenges due to a lack of information on the part of migrants, civil servants, and healthcare professionals (Iaboli & Zuccaro 2009). Political resistance, influenced by factors like hostility towards migrants and the need to cut public healthcare expenditures, further restricts healthcare rights for irregular migrants, despite existing legal protections and constitutional guarantees (Ambrosini 2013a; Perna 2018).

These challenges may result in delayed healthcare-seeking behaviours among irregular migrants, leading to more severe health conditions, poorer health outcomes, and increased healthcare costs. Empirical studies highlight a considerably higher risk of avoidable hospitalisation[2] for irregular migrants compared to Italians (Allegri et al. 2022). Irregular migrants face greater vulnerability in health conditions, experiencing different burdens of non-communicable diseases (NCDs) influenced by factors like ethnicity, background, and working conditions. Excluded from national healthcare databases, they miss out on preventive measures for chronic conditions, hindering their inclusion in public health programs and epidemiological surveillance (Fiorini et al. 2023). Additionally, a lack of preventive care leads irregular migrants to rely more on emergency services, imposing a higher financial burden on countries' healthcare budgets (Portes et al. 2012).

Given the complexities and shortcomings of the Italian healthcare system, and the greater vulnerability of irregular migrants, the role of non-governmental organizations (NGOs)[3] is crucial in providing them with primary medical care (Ambrosini 2015). This has been particularly evident during the Covid-19 pandemic, with NGOs stepping in when public healthcare was insufficient, especially for marginalised populations (Alizadeh et al 2020; Johnston et al. 2020). Reports indicate that NGOs adapted their actions and collaborations with governmental and non-governmental entities to address pandemic-related needs (Sanadgol et al. 2022). Nevertheless, it remains unclear whether the pandemic has altered the dynamics of NGOs' primary healthcare provision and utilisation for irregular migrants, or if the situation has returned to pre-pandemic standards.

1.1 Research Question

This paper aims to answer the following research question: "How has Covid-19 stimulated changes in NGOs' provision of primary healthcare and its utilisation by irregular migrants in Italy?"

It will also address the following sub-questions, comparing the periods before, during, and after the Covid-19 pandemic:

- In terms of *provision*, what kinds of healthcare services do different NGOs provide to irregular migrants and how are they structured, deployed, and funded?
- In terms of *utilisation*, to what extent do irregular migrants use the healthcare services provided by different NGOs and what are the factors involved when deciding whether to use such services?
- What other factors potentially mediate the dynamics between provision on the one hand, and utilisation on the other hand, and what are the implications for Italian policies?

[2] Defined as "hospitalisations due to ambulatory care sensitive conditions (ACSC), i.e., medical conditions for which hospitalisation is not needed when primary care is timely and effective" (Allegri et al. 2022: 2).
[3] The term "non-governmental organisation" (NGO) usually refers to any non-profit, voluntary group of global citizens that operates at local, national and/or international levels to achieve various cultural, social, charitable, and professional objectives (Zahedi 2009).

1.2 Relevance of the Research

This research is relevant both from an academic and a policy perspective. First, it aims to fill a knowledge gap. Previous academic research mainly focuses on irregular migrants' barriers to accessing healthcare (Sebo et al. 2011; Biswas et al. 2012; Chavez 2012; Hacker et al. 2015; Bradby et al. 2018; Spitzer et al. 2019), on the difficulties in reaching irregular migrants' with Covid-19 vaccination (Matlin et al. 2022), or on the different impact of Covid-19 on irregular migrants, compared to the rest of the population (Fabiani et al. 2021). However, findings about possible changes in the provision and utilisation of primary healthcare for irregular migrants, with a focus on the role of NGOs, appear to be very limited. This research aims to provide a better understanding of the obstacles in the access, utilisation, and provision of primary healthcare for irregular migrants before, during, and after Covid-19. It also aims at investigating the possible lessons learned during the pandemic, both from the perspectives of providers (NGO members and healthcare professionals) and clients (irregular migrants).

Second, this research is relevant from a policy perspective, as it seeks to inform policymakers and relevant stakeholders about the challenges and strategies involved in ensuring access to and utilisation of primary healthcare for irregular migrants. By emphasising the human right to health and medical care, the research aims to inform sustainable policy solutions that can improve the provision of healthcare for irregular migrants. This is particularly important given the significant disparities in access to and utilisation of healthcare that irregular migrants face, as well as the moral and ethical imperative to ensure that all individuals, regardless of immigration status, have access to healthcare services. Ultimately, this research has the potential to inform policy decisions that can lead to better health outcomes for irregular migrants and contribute to the broader goal of achieving equitable healthcare access for all.

2 Related Literature

2.1 Irregular Migration and the Case of Italy

Migrants often face categorisation by various actors, including governments, border control agencies, human rights activists, and political parties (Talleraas 2022). State structures manage migration and construct exclusionary understandings of specific migrant groups considered "unwanted" or victimised (Anderson 2013; Schenk 2021). Understanding how migrants and migration forms are labelled is crucial, as these labels can influence perceptions, encounters, and treatment, potentially perpetuating hegemonic power relations (Erdal & Oeppen 2018; Ottonelli & Torresi 2013).

De Haas et al. (2020) provide an overview of categories used to characterise migrants' legal status and forms of migration, emphasising the need for nuanced analyses. The term "irregular" migration, while criticised, is still relevant if interpreted as migration outside state regulatory norms (ibid). International organisations like the International Organization for Migration (IOM) and the European Union (EU) officially employ the term (IOM 2023; European Commission 2023), as does Italian legislation (Gazzetta Ufficiale 1998). The term encompasses various legal statuses, reflecting the complexity of migrants' situations (Triandafyllidou & Bartolini 2020; Spencer & Triandafyllidou 2022). Such complexity is compounded by ambiguous regulations, institutional practices, and delays, leading to an "institutional production of illegality" (Ambrosini & Hajer 2023: 23). Considering ongoing debates, this paper employs the terms "irregular migration" and "irregular migrants" in alignment with Italian legislation, given its focus on Italy.

Italy, historically an emigrant country, saw a significant immigration surge from the 1970s, growing by 600 percent from 1995 to 2015, becoming a major European immigration hub (Perna 2018). Its strategic location makes it a key gateway for migrants crossing the Mediterranean (Ghio & Blangiardo 2019). In 2021, around 10 percent of Italy's migrant population (estimated at 500,000 individuals) were irregular migrants, a decrease from 1991 when half were irregular (ISMU 2022). This decline may stem from changing migration patterns, legislative shifts, and data collection challenges (IOM 2011; Vogel et al. 2011).

Italian policy responses to irregular migration have been characterised by a mix of varied and sometimes contradictory measures. While the country has exhibited increasingly strict and securitised stances towards irregular migration, it has also relied heavily on migrant labour, particularly in the agricultural, construction, and domestic sectors. Consequently, efforts to securitise irregular migration have been countered by several regularisation programmes called *Sanatorie* (Colombo & Sciortino 2003; Ambrosini 2012; 2013b). However, these have been criticised for being ineffective and occasionally detrimental (Human Rights Watch 2020; Melting Pot Europa 2022).

Several studies emphasise the exploitative conditions faced by irregular migrant workers in various sectors and the intricate relationship between the Italian underground economy and irregular migration (Perrotta 2014; Palumbo & Sciurba 2018; Latham-Sprinkle et al. 2019; Reyneri 1998; Talani 2019; Venturini 1999; Andall 2007). Scholars also analyse the social and economic marginalisation experienced by irregular migrants, including precarious living conditions and societal attitudes contributing to discrimination and stigmatisation (Busett, 2016; D'Egidio et al. 2016; Kefferputz 2004; Bello 2022). Additionally, studies have investigated the gendered dimensions of marginalisation faced by irregular migrant women (Degani & De Stefani 2020). Scholars have explored the nexus between irregular migration and asylum in Italy, revealing a strong connection, often stemming from deficiencies in the asylum procedure (Ghio & Blangiardo 2019). Researchers have analysed the limitations of Italian legislation in effectively addressing irregular migration, highlighting a disparity between restrictive policies and the growing influx of migrants (Caponio & Cappiali 2018). Structural factors contributing to policy paradoxes include external border pressure leading to restrictions and internal border pressure necessitating integration policies (Geddes & Pettrachin 2020). Additionally, scholars critically assessed the effectiveness of restrictive entry and asylum regulations, arguing that, contrary to deterring irregular migration, such measures often drive more individuals toward irregularity (Restelli 2019).

2.2 NGOs and Irregular Migration

Non-governmental organisations (NGOs) play a crucial role in migration governance, often surpassing state capabilities through moral, logistical, and expert authority, with a consistent impact on migration policy over time (Schrover et al. 2019). Their involvement in irregular migration covers various activities, with differences between international and local NGOs, each employing different strategies and networks (Hoppe-Seyler 2020).

NGOs, particularly in the Mediterranean, have faced scrutiny for their search and rescue (SAR) operations, initially praised for life-saving efforts but later publicly framed as "sea taxis" (Perkowski 2016; Ambrosini & Haje, 2023; Cusumano & Villa 2021). These shifting dynamics have altered public perception, with NGOs increasingly stigmatised and seen as facilitators of irregular border crossings (Allsopp et al. 2021).

NGOs contribute to supporting irregular migrants in various ways. They act as bridges to receiving societies, provide essential services like healthcare, address fundamental needs such as food and

clothing, exhibit tolerance towards irregular migration, and apply political pressure to influence state policies (Ambrosini 2013a). Scholars emphasise the crucial role of NGOs in offering shelter, compensating for limited access to social rights, and mediating migrants' access to public services (Van der Leun & Bouter 2015; Laubenthal 2011; Schweitzer 2022). NGOs and civil society also aid in the integration of irregular migrants by providing language classes, advocating for their rights, and lobbying for regularisation (Hamann & Karakayali 2016; Hoppe-Seyler 2020; Schweitzer, 2022). Additionally, squatting and informal settlements contribute significantly to supporting excluded migrants, with social movements and activists occupying vacant buildings to provide accommodation, legal advice, healthcare services, and language classes (Bergeon & Hoyez 2015; Belloni 2016; Molnar 2022).

NGOs' role in migration governance involves varying levels of political engagement. While some prioritise principles of neutrality, impartiality, and independence, others convey political messages and challenge exclusionary government policies, engaging in alternative solidarity forms (Barnett & Weiss 2008; Fleischmann 2020). They conduct research, expose human rights abuses, provide legal assistance, and collaborate with civil society to challenge negative narratives (Hintjens et al., 2018; Castañeda 2013; Hajer & Ambrosini 2020; Wilmes 2011; Ambrosini 2015). The dynamics between NGOs and governmental authorities are intricate. While supporting irregular migrants, NGOs may sometimes challenge state policies and practices, leading to tensions (Cuttitta 2018; Cusumano & Villa 2021). Najam (2000) identifies four NGO-government relationship types: cooperation, confrontation, complementarity, and co-optation, reflecting varying degrees of agreement on goals and means. NGOs may also actively network and collaborate to enhance effectiveness in addressing irregular migration. Formal partnerships and alliances allow collective efforts, with some NGOs embracing collaborations based on organisational goals, priorities, resources, and strategic considerations (Mommers & Van Wessel 2009; Cullen 2009).

2.3 Irregular Migrants and Healthcare

This section introduces some concepts included in the conceptual framework developed in this paper, which is built upon Levesque et al.'s comprehensive framework on access to healthcare (Levesque et al. 2013). *Approachability* addresses the provider's visibility and the client's ability to navigate the healthcare system. *Acceptability* involves cultural, social, and ethical aspects, enabling clients to choose suitable healthcare. *Availability and accommodation* concern the physical and legal accessibility of healthcare, ensuring clients can reach services. *Affordability* refers to the financial feasibility of healthcare, assessing clients' ability to pay. *Appropriateness* evaluates whether healthcare meets individual needs and if clients can engage in decision-making (Levesque et al. 2013).

In recent years, several Western countries have implemented restrictive migration policies, limiting healthcare access for irregular migrants (Magalhaes et al. 2010; Cuadra 2012; Woodward et al. 2014). These policies create a challenging landscape, impacting the *availability and accommodation* of medical services for irregular migrants (Levesque et al. 2013). Empirical studies identify barriers such as restrictive healthcare policies, legal obstacles, discrimination, lack of knowledge, economic constraints, fear of authorities, and stigma (Hacker et al. 2015; Bradby et al. 2018; Spitzer et al. 2019). Gender also plays a role, with mixed results: while certain studies suggest that women tend to utilise medical care services more than men (Bertakis et al. 2020), others indicate that female migrants may find additional obstacles, resulting in reduced access to healthcare compared to men (Richter et al. 2020).

On the *provision* side, common barriers to healthcare access for irregular migrants in Italy include restrictive policies and discriminatory behaviours by healthcare professionals. Despite Italy's

classification as one of the most inclusive countries for migrant healthcare access (MIPEX 2020), there is often a disparity between the formally universal access to emergency healthcare and its practical implementation (Perna 2018, 2019; Geraci et al. 2019). The National Health Service (Servizio Sanitario Nazionale, SSN), established in 1978, offers universal healthcare coverage to citizens, funded through taxation and health insurance contributions. However, since the 1990s, a decentralisation process began (Bandinella Martini et al. 2021; Ferré et al. 2014), creating relevant regional disparities (Bonetto et al., 2022). Privatisation, particularly in some regions, impacts healthcare access, disproportionately affecting disadvantaged groups (Franzini & Giannoni 2010). While national healthcare legislation formally includes irregular migrants, persistent issues, such as a deficit in implementation provisions, make it challenging, if not impossible, for them to access medical services, leading to a disproportionate reliance on volunteering through NGOs (Geraci et al. 2019). Frontline healthcare professionals often apply discretionary criteria when determining entitlement to *urgent or essential* medical care. Discriminatory behaviours have been observed, particularly in some regions. Street-level bureaucrats responsible for issuing healthcare registration cards (STP and ENI codes) also display discriminatory and arbitrary attitudes, possibly influenced by the criminalisation of irregular migrants and progressively restrictive migration policies in Italy (Perna 2018, 2019). However, the directionality of frontline workers may also lead to an expansion of healthcare access for irregular migrants, as healthcare professionals might exploit policy ambiguities to facilitate their access (Perna 2018). Discrimination and discretion align with Levesque et al.'s concept of *acceptability*, focusing on how healthcare systems and professionals address the diverse needs of patients, including irregular migrants, in an inclusive, equitable, and respectful manner (Levesque et al. 2013).

On the *utilisation* side, the literature primarily examines individual-level barriers to healthcare among irregular migrants, focusing on factors such as poor knowledge of healthcare systems, language barriers, lack of awareness, and financial constraints (Sebo et al. 2011; Biswas et al. 2012; Chavez 2012; Hacker et al. 2015). The concept of poor knowledge aligns with Levesque et al.'s dimension of *appropriateness*, where irregular migrants may struggle with understanding medical information, communicating with healthcare professionals, and engaging in decision-making processes due to language barriers or cultural differences. Financial constraints emerge as another significant barrier, particularly in countries where irregular migrants are excluded from healthcare services and lack access to insurance (Jensen et al. 2011; Grit et al. 2012; Hacker et al. 2015; Poduval et al. 2015). The literature highlights the impact of limited financial resources on irregular migrants, making it challenging or impossible for them to afford necessary medical services. This lack of providers' *affordability* and client's *ability to pay* (Levesque et al. 2013) perpetuates healthcare disparities. At the individual level, two additional barriers relate to discriminatory behaviours and cultural motives: the fear of being reported and deported by healthcare professionals, and the fear of stigmatisation by host countries' nationals (Biswas et al. 2011; Dang et al. 2012; Stutz et al. 2019; Goldade 2009; Chandler et al. 2012; Teunissen et al. 2014). The fear of being reported and deported is connected to Levesque et al.'s concept of *approachability*, impacting the individual's *ability to navigate* the healthcare system. The fear of stigmatisation, associated with *acceptability*, reflects concerns about being perceived as a burden, potentially leading to negative attitudes and discrimination, creating barriers to *seeking* and *accepting* healthcare (Levesque et al. 2013).

2.4 Irregular Migrants and the Covid-19 Pandemics

A key concern during the Covid-19 pandemic was safeguarding migrant workers, who were already a vulnerable group. Migrants often lack regular contracts and social protection and are susceptible to systemic exploitation. Research indicates that migrants are more likely to work longer hours without

adequate protective materials or training (Moyce & Schenker 2018; Koh 2020; Schneider et al. 2020; Askola et al. 2021). The pandemic underscored the essential nature of migrants' workers in maintaining economic stability (Berntsen & Skowronek 2021). In the pandemic context, certain countries – including Italy, Ireland, and Portugal – initiated regularisation procedures in specific economic sectors like agriculture and domestic care or service. However, these measures, driven more by economic necessities than moral values, were incomplete and temporary rather than structural interventions (Boucher et al. 2021; Ambrosini 2022).

During the pandemic, irregular migrants faced heightened risks due to suspicion towards public authorities and a lack of access to crucial information (Bhopal 2020). These barriers, associated with Levesque et al.'s concept of *approachability*, impeded migrants' ability to navigate the healthcare system (Levesque et al. 2013). In Italy, studies primarily focused on vaccination obstacles for irregular migrants, revealing discrepancies between guidelines allowing their vaccination and requirements imposed by online platforms in certain regions, creating barriers to *acceptability* (Matlin et al. 2022; Levesque et al. 2013). Empirical studies highlighted delayed Covid-19 diagnoses and increased ICU hospitalisations for irregular migrants compared to Italians, indicating a lack of *appropriateness* in healthcare services (Fabiani et al. 2021; Levesque et al. 2013).

Research also examined vulnerable groups like sex workers and agricultural migrant workers, finding that Covid-19 exacerbated existing exploitation and exclusion (Zambelli et al. 2020). In Levesque et al.'s terms, *affordability and availability* and *accommodation* played crucial roles, with limited financial resources hindering access to essential healthcare for these groups. Physical exclusion further impeded their *ability to reach* appropriate healthcare. Authors also emphasise the importance of mutual learning processes with populations heavily impacted by the pandemic, such as irregular migrants, to develop improved crisis management strategies (Sanfelici 2021).

3 Methodology

3.1 Conceptual Framework

The conceptual framework used in this research for the analysis of how Covid-19 impacted the provision and utilisation of primary healthcare services for irregular migrants in Italy was built on Levesque's "Conceptual Framework of Access to Healthcare" (Levesque et al. 2013: 5):

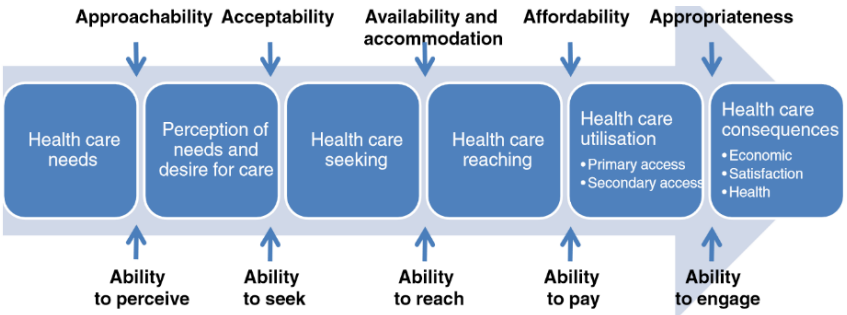

Fig. 1. Conceptual framework of access to healthcare (Levesque et al. 2013: 5).

The newly elaborated conceptual framework (**Fig. 2**) introduces two sides: *Provision* (NGO members and healthcare professionals) and *Utilisation* (irregular migrants); "healthcare" was replaced by "primary healthcare". Moreover, the framework introduced *Mediating Factors*, which were analysed at the *macro*, *meso* and *micro* levels. The macro level encompasses broader societal and structural factors;

at the meso level, the focus shifts to the organisational and community factors; while the micro level examines individual-level factors. A more exhaustive explanation of the concepts used in the framework and of the mediating factors can be found in the Appendix I (**Table 1** and **Table 2**).

The analysis followed both an inductive and a deductive approach. The inductive approach was data-driven, while the deductive approach was based on the conceptual framework and the use of sensitising concepts. The framework could be considered as 'dynamic' since it evolved throughout the analysis stage. Sensitising concepts –that "draw attention to important features of social interaction and provide guidelines for research in specific settings" (Bowen 2006: 14) – provided useful guidelines for the development of the analysis.

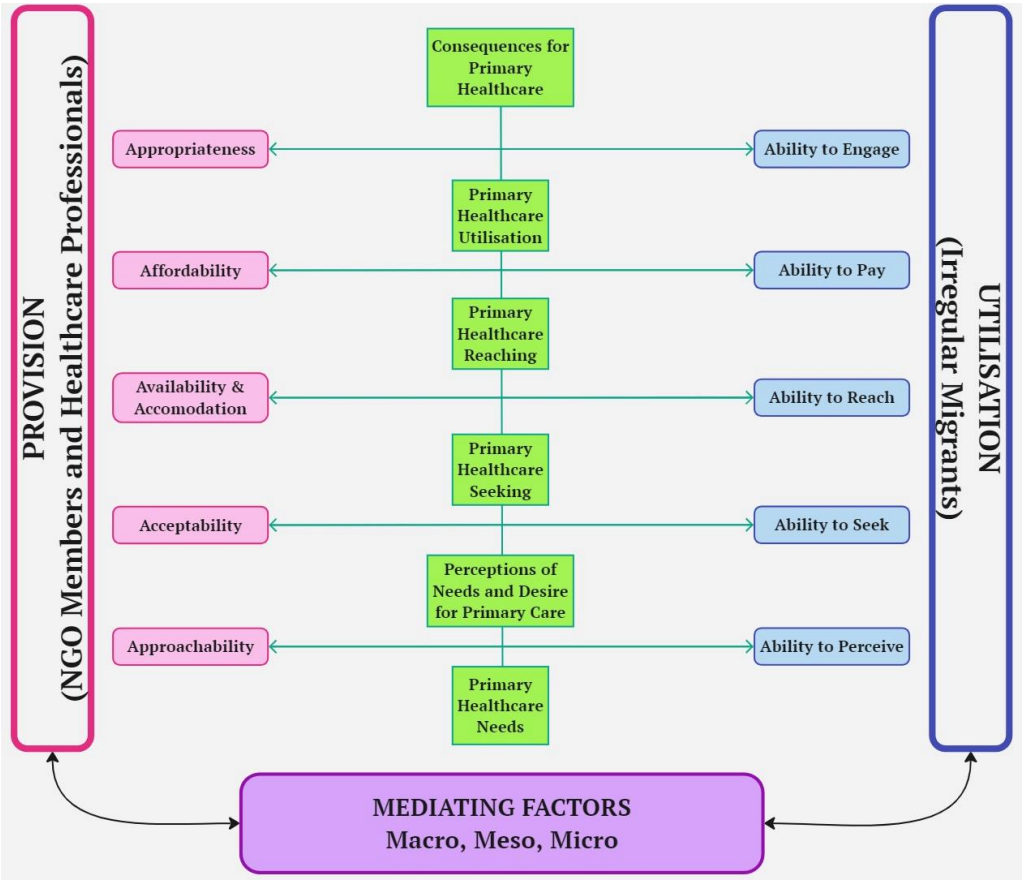

Fig. 2 Conceptual framework of primary healthcare for irregular migrants.

3.2 Sampling, Recruitment, Data Collection and Analysis

The study involved two main groups: *Providers* (healthcare professionals and NGO members) and *Clients* (irregular migrants). A purposive sampling strategy, initiated through NGOs, was used to connect with healthcare professionals and migrants. A snowball technique expanded the network. Fifteen key informants (six NGO members and nine healthcare professionals) and fifteen irregular migrants from different regions in Italy (Lombardy, Veneto, Tuscany, Latium, and Apulia) were selected for a comprehensive perspective.

Six out of fifteen contacted NGOs participated in the study. Collaborating with these NGOs, available candidates for interviews were chosen. While two NGOs declined migrant interviews, the remaining

four facilitated migrant interviews, with three agreeing on interview dates. In-person interviews during regular NGO hours ensured oral informed consent.

Data collection comprised seven individual and three group semi-structured interviews with key informants, conducted in person and online. For migrants, fourteen individual and one group semi-structured interviews were all conducted in person. Interview guides were based on the literature review and conceptual framework. Consent procedures varied based on participant vulnerability: key informants signed written consent forms, while migrants provided oral consent for recording. Interviews were recorded for precise documentation, conducted mostly in Italian, with two in English due to language barriers.

An interpretivist epistemological approach was chosen to understand diverse viewpoints. Thematic data analysis, through both inductive and deductive methods, was employed. ATLAS.ti software facilitated interview analysis, following guidelines by Matthews & Ross (2010). Preliminary themes, aligned with research questions and sensitising concepts, were identified. Transcription and careful reading established data familiarity. Key themes were compared across cases and categorised. Findings were reflected upon in relation to research questions.

3.3 Ethical Considerations

This research addressed several ethical considerations related to the sensitive themes of healthcare and irregularity among migrants. To uphold principles of compliance, integrity, and participant safety, the project underwent an ethics review and received approval from the Ethics Board of the Master of Science in Public Policy and Human Development of United Nations University – MERIT and Maastricht University.

4 Results and Analysis

4.1 Characteristics of Respondents

The study involved fifteen key informants, including healthcare professionals (doctors, nurses, and a medical director) and NGO members (coordinators, receptionist). Six NGOs, spanning Lombardy, Veneto, Tuscany, Latium, and Apulia, contributed to the study, namely Associazione Stenone, Ambulatorio Medico Popolare (AMP), Medici per la Pace, Cesaim, Naga, and Intersos. Gender distribution included eight females and seven males, with participants ranging from 30 to above 50 years old. Nine out of fifteen key informants were volunteers, predominantly retired doctors.

The study included fifteen migrants representing diverse backgrounds. The sample comprised twelve males and three females, with an average age of around forty-one years. The migrants originated from Bangladesh, Nigeria, Romania, Sri Lanka, Brazil, Moldova, Morocco, Senegal, and Tunisia. Their motivations for migration varied, with job opportunities being the primary incentive for ten migrants. The duration of their residence in Italy ranged from one to thirty-five years, with an average of fifteen years. Despite extended stays, language barriers persisted for some migrants. Educational attainment varied from middle school to higher education. Migratory statuses included eight irregular migrants, five regular migrants without residence, one with a residence but awaiting a permit, and one with a valid residence permit. Occupations in their home countries ranged from students to professionals in sectors like taxi driving, factory work, and tourism. Current occupations in Italy included roles like porter, hotel maid, kitchen assistant, waiter, maintenance technician, metal mechanic, domestic worker, and street

vendor. Migrants sought NGO services for diverse health issues including dental problems, cancer check-ups, injuries, thyroid and cardiovascular issues, otolaryngological problems, migraines, Covid-19 testing, among others. The migrants learned about the NGO's services through word of mouth, referrals from other NGOs, social workers, hospital doctors, and proximity to the clinic. A more detailed overview of interviewees' characteristics can be found in the Appendix I (**Table 3** and **Table 4**).

4.2 Sub-Question One

Sub-Question One examined how NGOs provide healthcare services to irregular migrants, focusing on service types, structures, deployment, funding, and the impact of the Covid-19 pandemic. In terms of *approachability*, NGOs commonly employed an "active approach" for outreach, using mobile clinics and targeting places frequented by marginalised populations, including irregular migrants. In contrast, public healthcare services tend to rely on a "passive outreach" approach, expecting individuals to seek services without proactive information dissemination. This distinction in *approachability* could influence migrants' initial engagement, with NGOs' active outreach potentially enhancing awareness of available healthcare resources.

The study included NGOs with varied backgrounds, ranging from large organizations with healthcare as one facet of their activities to those specifically established to address healthcare needs. Regardless of their size or focus, all participating NGOs strongly affirmed their commitment to upholding the right to health for marginalised individuals, indicating a high degree of acceptability. While some NGOs focused more on migrants, their services were accessible to anyone in need, including Italian citizens.

> *We opened clinics on the territory precisely based on an analysis of needs. We had observed that many of our beneficiaries, being migrants, did not have access to the right to health, as guaranteed by the Constitution and the various regulations.*
>
> (K.8, coordinator, Medici per la Pace)

The *acceptability* of NGOs was evident in the positive perception of their healthcare services by most migrant interviewees. NGOs were commended for their cultural sensitivity, welcoming environment, safe atmosphere, and, in some cases, the presence of cultural mediators, fostering comfort and trust among the migrant population. In contrast, participants identified deficiencies within public healthcare, especially regarding cultural and language barriers, implicitly contributing to exclusionary experiences for irregular migrants seeking medical attention.

NGOs demonstrated a high level of *availability and accommodation*, employing mobile clinics or strategically siting their facilities in locations easily accessible to migrants, such as near shelters or migrant-residing neighbourhoods. All NGOs designated specific places for clinics. Service availability varied, with some operating on weekdays (e.g., Cesaim), while others (such as Ambulatorio Medico Popolare and Medici Per la Pace) opened on specific days of the week. Despite differing schedules, all NGOs aimed to accommodate those in need, even accepting walk-ins if necessary. Conversely, the study highlighted that public healthcare services lacked such flexibility and accessible locations. NGOs also offered extensive primary healthcare services, including routine check-ups, screenings, diagnosis, and treatment of common illnesses such as infections and minor injuries. Chronic disease management was also prioritised by NGOs in supporting migrants with conditions like diabetes, hypertension, and respiratory problems. Moreover, some NGOs expanded beyond basic healthcare, providing specialist visits where migrants could access psychologists, gynaecologists, cardiologists, orthopaedists, and

other medical experts. These specialist services were either available in-house or facilitated through partnerships with private clinics or public healthcare institutions, enabling NGOs to provide comprehensive care to their beneficiaries.

In terms of *affordability*, all services provided by NGOs were offered free of charge, encompassing essential medicines like antibiotics and common pharmaceuticals. The origin of these medicines varied; some NGOs purchased them using their funds, while others received "in-kind" donations, such as those from *Banco Farmaceutico*, which collects donations from consumers and distributes them to NGOs. NGOs also explored innovative approaches, such as agreements with pharmacies, allowing migrants to obtain prescribed medicines with later reimbursement by the NGO. Financing primarily relied on private donations from citizens and private entities, with limited funding from public bodies like municipalities for specific services. *Affordability* emerged as a critical factor influencing healthcare utilisation among irregular migrants. NGOs often represented the only viable option for many migrants to access essential medicines, especially those living in marginal conditions. The financial constraints of irregular migrants made seeking continuous care, especially for chronic diseases, unfeasible within private healthcare, leading migrants to rely on NGOs for accessible and affordable healthcare options.

NGOs' *appropriateness* also played a crucial role in migrants' utilisation of healthcare services. They were noted for delivering prompt services, efficiently addressing medical concerns, and ensuring migrants received appropriate and timely care. However, NGOs faced challenges in providing certain services, like comprehensive dental care, due to financial, personnel, and other constraints.

Beyond healthcare services, some participating NGOs extended their support to address bureaucratic challenges faced by migrants. This included assistance in obtaining STP or ENI codes, residence permits, and others. Due to the complexity of obtaining such documents and the vulnerability of irregular migrants, NGOs played an indispensable role in guiding and supporting individuals through these bureaucratic processes.

> *Concerning access, it's true that we have to write a letter so that the operator at the Cup* [Local Health Unit] *issues that STP card. Why do we write the letter? Because often, that person was regular, then becomes irregular, so they used to have a tax code, but then they don't have it anymore. And for the system... everything becomes difficult, or sometimes, we even encounter Cup operators who say: 'Maybe you need to regularise your status, go to the police station first, and then come here', giving directions that are clearly improper.*
>
> (K.14, coordinator, Intersos in Rome)

The emergence of the Covid-19 pandemic significantly impacted NGOs' healthcare operations. Some NGOs temporarily closed their clinics during the initial outbreak, but their commitment to their mission drove them to swiftly reopen after adhering to stringent safety protocols, again reflecting a high degree of *acceptability*. NGOs implemented safety measures during the pandemic, such as wearing masks, conducting Covid-19 tests, maintaining social distancing within clinics, and shifting meetings to online platforms. The already challenging conditions faced by irregular migrants were further exacerbated by the pandemic, according to NGOs' assessments. Irregular migrants encountered difficulties accessing free Covid-19 tests, vaccinations, and obtaining the Green Pass, highlighting the need for additional support from NGOs to uphold their rights.

> *During that period, we still tried to be present, at least to continue adequately monitoring chronic diseases, for example, distributing medications for diabetes, hypertension, or cancer. These had to be*

ensured, so there was somehow the possibility, although not every day, to continue distributing these essential medications for the care of patients with chronic illnesses.

(K.9, medical director, Cesaim)

We had set up a system to help these individuals obtain the Green Pass, which was crucial for them because they couldn't go to work without it.

(K.12, NGO professional, Naga)

During the pandemic, patient volume at NGOs varied, with some experiencing a decline due to Covid-19 fears, restrictions, and migrants' hesitancy to seek care. Lockdown measures and movement limitations also contributed to reduced visits. Conversely, some NGOs observed an increase in patient volume as migrants sought alternative healthcare during facility closures. Significantly, chronic diseases worsened during the pandemic, as access to regular check-ups, exams, and treatments became difficult. Despite challenges, NGOs adapted, procuring safety devices and adjusting operations. Post-pandemic, patient volume generally returned to pre-pandemic levels, but trust-building posed challenges, influenced by communication difficulties caused by face masks and limitations in conveying body language, potentially impacting acceptability. Post-Covid-19, some NGOs experienced a decline in volunteer numbers, impacting their ability to sustain services for irregular migrants. This decrease, however, was noted as an ongoing trend pre-dating the pandemic.

Overall, results for Sub-Question One underscore the vital role NGOs play in providing free healthcare services and navigating bureaucratic challenges for migrants. Patient numbers fluctuated during the pandemic, and chronic illnesses worsened due to limited access to medical care. Despite challenges, NGOs demonstrated resilience, maintaining their dedication to their mission. While patient volume eventually returned to pre-pandemic levels, certain NGOs faced difficulties in establishing trust with patients due to communication barriers caused by face masks. Additionally, financial constraints and a decline in volunteer support posed operational challenges for some NGOs.

4.3 Sub-Question Two

Sub-Question Two investigated irregular migrants' utilisation of NGOs' healthcare services, exploring the extent of access and factors influencing their decision-making, considering the impact of the Covid-19 pandemic. Patient volumes in these clinics varied, from around 300 to 11,000 yearly, with predominantly male attendees, averaging 30 to 40 years old, originating from diverse countries (including Romania, Albania, Morocco, Tunisia, Bangladesh, Sri Lanka, Nigeria, Pakistan, and others). The primary motivations for migration included seeking better job opportunities, improved living conditions, and supporting families. Some individuals exhibited hesitance in discussing their migration background and reasons for coming to Italy.

In Bangladesh, working condition and payment is not good... it's a small country, there are so many people. I've always wanted to leave, not only to Italy, also to other countries France, England, Spain, to work and earn a little more, to help my family and all that.

(Male, 29, Bangladesh, Otolaryngological problem)

A significant portion of migrants reported regular attendance at NGOs' clinics, especially those with chronic conditions requiring ongoing treatment, while some visited clinics only as needed. The study revealed that migrants' *ability to perceive* NGOs' services was facilitated through active outreach efforts by NGOs, word of, referrals from other NGOs, social workers, and direct recommendations from hospital doctors. Challenges in understanding public healthcare options were linked to language barriers and limited information dissemination. A significant challenge faced by irregular migrants that emerged was knowing about the existence of STP and ENI codes, understanding how to obtain them, and finally actually obtaining them, revealing migrants' in-*ability to seek* public healthcare services. This suggests that migrants may have chosen to access NGOs' services directly, without actively comparing them with public healthcare options. Accessibility, ease of understanding, and the welcoming environment of NGOs influenced migrants' preference for these clinics, where empathetic medical staff enhanced communication and comfort.

They are very good and I mean it sincerely. I didn't know what to do, I was sick for a day, I spoke to my friend, he said to come here, they sent me straight away to take these tests and I did it. Now I come to them all the time. I am very happy; I swear to you.

(Female, 53, Romania, Thyroid problems)

Concerning the *ability to reach*, irregular migrants found NGOs' healthcare services more accessible due to strategic clinic locations, mobile clinics, and flexible operating hours, especially beneficial for those living in informal settlements. NGOs accommodated migrants with demanding work schedules, offering viable options for medical care outside regular working hours. In contrast, reaching services provided by STP and ENI doctors posed challenges with limited opening hours and sparse distribution. The lack of residence emerged as a significant legal barrier for migrants, hindering their *ability to reach* public healthcare. In this sense, NGOs' health services played a crucial role as essential alternatives, ensuring migrants could receive necessary medical attention and care.

It's very difficult to find an appointment; it's also difficult, as foreigners, to find a home... if you can't find a home you can't have a residence, you can't do anything... if you don't have a residence, you can't have a health card.

(Male, 27, Nigeria, Kidney problems)

NGOs' provision of entirely free services played a critical role for migrants' *ability to pay*. Conversely, migrants expressed an in-*ability to pay* for services from private clinics. Positive engagement with NGOs was emphasised, with migrants appreciating doctors' patience and clear explanations, fostering trust and active participation in healthcare decisions. Concerning the impact of Covid-19, only a few migrants accessed the clinics before, during, and after the pandemic. Those who did reported observable changes in patient volume, with a general increase during the pandemic. In these specific cases, migrants reported that fear and uncertainty surrounding the spread of the virus led to heightened confusion among patients.

Overall, results for Sub-Question Two revealed that migrants highly appreciate NGOs' active outreach, creating a welcoming environment; while they faced language barriers and limited information about public healthcare. The strategic locations and flexible hours of NGOs made access easier for migrants with demanding work schedules. The availability of free healthcare addressed financial barriers, and positive interactions with doctors increased trust. Results on Covid-19 impact were limited, with some migrants reporting feelings of uncertainty and confusion and an increase in patient volume.

4.4 Sub-Question Three

Sub-Question Three explored factors mediating NGOs' healthcare provision and migrants' utilisation, considering macro, meso, and micro levels. At the macro level, key informants emphasised the impact of national and regional political choices on migrants' living conditions and healthcare access. Progressive political restrictiveness and healthcare privatisation were noted, affecting both Italian citizens and migrants. Insufficient resources and investments in public healthcare at national and regional levels posed challenges. Key informants also highlighted the role of street-level bureaucrats in distributing STP and ENI codes. They noted that these bureaucrats can easily misinterpret the law – either on purpose or due to a lack of knowledge – and can act as enablers or inhibitors in granting access to healthcare. Unfortunately, they seem to act more often as inhibitors, effectively denying migrants their de facto right to health.

In Italy, beyond what is declared in the Constitution, the healthcare assistance for people without a residence permit is extremely problematic, and it's even more problematic in our region, Lombardy, where a whole range of partial support systems, which exist in other regions, are non-existent here.

(K.11, coordinator, Naga)

At the counter the staff is informed, it's just that sometimes there are directives from above that go in one direction rather than another. So, if at that moment, they tell you that maybe access to STP needs to be reduced, then… that's what it's done.

(K.7, nurse, Associazione Stenone)

Concerning Covid-19's impact on macro factors, bureaucratic procedures and the shift to online services were exacerbated during the pandemic, hindering migrants' access to healthcare. The existing challenges related to healthcare privatisation worsened, leading to increased restrictiveness. The communication system was discriminatory for non-Italian speakers, requiring translation efforts by certain NGOs. Pandemic-induced restrictions compounded difficulties in accessing STP and ENI codes, intensifying barriers to healthcare. Regional disparities were observed, with some regions being more responsive to migrants' healthcare needs during the pandemic.

We initially made the translations ourselves, and at one point, our translations were even shown on the Ministry of Health's webpage. When vaccination became possible, the entire booking system was very discriminatory for people who didn't understand Italian or had poor language skills. So, we booked the service for those who asked for it and gave instructions to those who were capable.

(K.12, doctor, Naga)

These patients, these individuals, should be entitled to a light health card called STP or ENI. However, in our area, especially during and after Covid, it became more difficult to obtain these cards. During Covid, all district offices were closed, making it physically impossible for people to access them. There was an Internet procedure that was difficult to use. It was difficult to contact the office responsible for the codes via the Internet, and we didn't have the time to assist people with the online requests. This difficulty persisted even after the end of the Covid emergency. Now, we are slowly trying to recover, but the restrictions have tightened compared to what it was just before Covid, a few years ago, regarding the issuance of these codes.

(K.9, medical director, Cesaim)

At the meso level, results showed that social support, particularly from family and friends already in Italy, influences migrants' healthcare utilisation, better equipping them to navigate the healthcare system effectively. NGOs play a vital role as mediators, collaborating with other organisations and creating networks for sustaining healthcare services. NGOs' attitudes toward external entities and their level of political engagement were also noted to shape healthcare provision. Some NGOs actively engage in activist behaviours and socio-political events, while others focus primarily on healthcare provision, influencing their style and extent of service delivery. Different NGOs exhibit contrasting approaches, yet some shared values and attitudes transcend regional boundaries, highlighting both diversity and commonality in their missions.

We have always tried to create a network of support. A network for integrating all services for people who are invisible.

(K.1, receptionist, Associazione Stenone)

At first, we were just a collective, then we formed the Association [...] *besides the healthcare aspect, we also focus on political initiatives and campaigns for the right to health.*

(K.4, doctor, Ambulatorio Medico Popolare)

Concerning Covid-19's impact on meso factors, key informants reported establishing partnerships with other NGOs, associations, and public bodies to ensure marginalised populations, including irregular migrants, were reached with healthcare services, including Covid-19 vaccines.

We were very lucky because, having the dental clinic, we already had surgical masks. We distributed masks, for example, to other centres like La Fenice [a shelter, NA], *which is located nearby*.

(K.7, nurse, Associazione Stenone)

At the micro level, key informants' empathetic attitudes, professional backgrounds, and roles in NGOs shape healthcare services' quality and accessibility. Migrants' characteristics, such as age, country of origin, gender, educational attainment, and employment status, influence their utilisation of NGO healthcare services. Younger individuals are more prevalent, and different regions face varied cultural and language barriers. While male migrants dominate service utilisation, exceptions exist, emphasising the need for further research on gender differences in accessing healthcare among migrants. Educational attainment affects health literacy, and employment conditions contribute to specific health issues, particularly for those engaged in physically demanding jobs.

Certainly, in most cases, we are dealing with pathologies related to the digestive system, followed closely by issues affecting the musculoskeletal system and connective tissue. What does this mean? It means that, for example, people working in the fields during the scorching summer in Foggia will inevitably develop health problems or conditions—perhaps the term 'diseases' isn't quite accurate, but rather pathologies, that are linked to these living conditions.

(K.13, coordinator, Intersos in Foggia)

Health conditions, particularly chronic diseases, play a significant role, with dental problems being a prevalent issue among migrants. These are also the areas where NGOs face limitations in their ability to provide comprehensive care since they often lack the necessary space, equipment, and personnel. Their interventions are mostly restricted to conservative measures aimed at minimising damage rather than addressing the root causes.

Results showed how migratory history, including traumatic experiences, affects migrants' mental and physical health. A common problem reported among this group was feet-related issues, likely stemming from the harsh conditions and prolonged walking involved in their migration.

Socioeconomic status and living conditions, including marginalisation and overcrowding, exposed migrants to various health challenges, including feet problems, breathing issues, scabies, tuberculosis, and dermatological problems.

It is clear that in these contexts [informal settlements of agricultural migrant workers, AN], the effects of so-called health determinants are much more evident. These people live in remote areas far from urban services. They lack waste collection systems, heating, access to electricity, clean drinking water. They mainly reside in these areas because they work in tomato and other vegetable harvesting during summer and winter, respectively. All these external and internal conditions significantly impact their overall health. Living in a place with no heating, working in the fields without access to clean water or a healthy diet... all this inevitably affects their physical and psychological well-being.

(K.13, coordinator, Intersos in Foggia)

Concerning Covid-19's impact on micro factors, key informants reported increasing respiratory issues among migrant patients, attributed to overcrowded living conditions hindering safety measure adherence. The emotional toll of the pandemic also complicated the healthcare needs of some migrants.

We observed a significant increase in respiratory diseases affecting the airways, which in April 2020 reached almost 15-16 per cent.

(K.10, doctor, Naga)

Overall, the study's findings on Sub-Question Three revealed macro, meso, and micro-level factors influencing healthcare provision and utilisation. Macro factors included political choices, healthcare privatisation, and bureaucratic obstacles in obtaining codes, further exacerbated by the pandemic. Meso-level factors featured social support, NGOs' networks, and their political engagement, with an increase in NGOs' partnerships for healthcare outreach during the pandemic. Micro factors encompassed migrants' age, language proficiency, health conditions, working conditions, and socio-economic conditions with "migratory status" playing a less prominent role than expected. Instead, marginalisation and the bureaucratic prerequisite for healthcare access, specifically the possession of a registered residence, emerged as more influential factors. The pandemic exacerbated bureaucratic challenges and communication barriers, and overcrowded living conditions posed challenges in safety measure adherence for migrants. A tabulated version of the results can be found in Appendix I (**Table 5**, **Table 6**, and **Table 7**).

5 Discussion and Policy Implications

Before the pandemic, NGOs were committed to providing comprehensive healthcare to marginalised populations, addressing various medical needs, and aiding in bureaucratic challenges. During the pandemic, these NGOs adapted resiliently, implementing safety measures, and experiencing

fluctuations in patient volume. Post-pandemic, patient numbers generally reverted to pre-pandemic levels, but some NGOs struggled with trust issues and declining volunteer engagement.

Before the pandemic, a subset of migrants consistently attended healthcare services, especially those dealing with chronic conditions. Social support played a crucial role, with migrant referrals contributing to awareness about accessible healthcare. Administrative barriers, like obtaining STP and ENI codes for public healthcare, posed challenges. During the pandemic, migrants occasionally sought healthcare in NGOs' inclusive environments due to limited conventional options. Challenges persisted, including difficulties obtaining STP and ENI codes. Post-pandemic, migrants expressed uncertainty, necessitating further investigation into perceptions and adaptation strategies.

Macro-level insights underscored political and privatisation influences on healthcare utilisation before the pandemic. Street-level bureaucrats played a crucial role, often inhibiting healthcare rights. The pandemic exacerbated these challenges, intensifying bureaucratic hurdles and regional disparities. *Meso*-level findings highlighted social support and NGOs as pivotal, and pandemic-induced partnerships facilitated healthcare access for marginalised populations. *Micro*-level insights revealed individual characteristics shaping utilisation, with migratory status playing a less significant role than expected. Instead, marginalisation and the bureaucratic prerequisites for healthcare access emerged as more influential factors. Over the pandemic, respiratory issues increased, intensifying healthcare complexities.

In conclusion, this study enriches our understanding of how the Covid-19 pandemic affected healthcare provision by NGOs and utilisation by irregular migrants in Italy. It emphasises the crucial role of NGOs in bridging healthcare gaps for vulnerable populations and explores macro, meso, and micro-level factors. These insights are important for present strategies and provide lessons for future crises.

5.1 Contributions to the Literature

This study's findings align with existing literature on irregular migration, emphasising the role of state structures in managing migration and constructing exclusionary perceptions of migrant groups in Italy (Anderson 2013; Schenk 2021). The importance of having a residence for accessing rights, including healthcare, resonates with previous research, highlighting the complexities of migrant status (Triandafyllidou & Bartolini 2020). The "institutional production of illegality" (Ambrosini & Hajer 2023) is reflected in bureaucratic barriers and discretionary interpretations. Efforts to securitise irregular migration and the limitations of regularisation programs are consistent with Colombo and Sciortino (2003), Ambrosini (2012, 2013b), and findings on exploited irregular migrant workers align with Perrotta (2014), Palumbo and Sciurba (2018), Latham-Sprinkle et al. (2019), and Gallotti (2020). This study also reveals migrants' socio-economic marginalisation (Busetta 2016; D'Egidio et al. 2016), depicting precarious living conditions.

The study's findings also align with existing literature on NGOs and irregular migration, highlighting their crucial role in supporting irregular migrants in Italy (Ambrosini 2013a; Van der Leun & Bouter 2015). Political activism by NGOs challenging negative narratives on irregular migration aligns with Ambrosini (2015). The study affirms the impact of networking among NGOs (Mommers & Van Wessel 2009).

The study's findings also align with existing literature on irregular migrants and healthcare, emphasising individual-level barriers such as language and knowledge gaps (Sebo et al. 2011; Biswas et al. 2012; Chavez 2012; Hacker et al. 2015). The impact of cost containment measures on the Italian healthcare system (Ferré et al. 2014), is confirmed by key informants, who signal stringent public

spending controls and declining issuance of STP and ENI codes. Decentralisation's impact on healthcare access and Covid-19's relevance (Cicchetti & Gasbarrini 2016; Bosa et al. 2021) is confirmed, exemplified by disparities in Covid-19 vaccine access. The adverse effects of privatisation on irregular migrants' healthcare access, especially in certain Italian regions, echo findings in the literature (Franzini & Giannoni 2010).

Finally, the study's findings confirm existing literature on irregular migrants and the Covid-19 pandemic, highlighting their heightened vulnerability and challenges in accessing healthcare during the crisis (Bhopal 2020). Disparities in vaccination access due to online platforms and NGO intervention align with Matlin et al. (2022). The study echoes the literature regarding delayed Covid-19 diagnosis and higher hospitalisation rates for irregular migrants (Fabiani et al. 2021). Challenges faced by irregular migrants working in the agricultural sector during the pandemic, as targeted by NGOs in the South of Italy, align with the findings of Zambelli et al. (2020).

The study also introduces several innovative contributions. Particularly, it expands Levesque's "Conceptual Framework of Access to Healthcare", by introducing and examining the mediating factors that influence the dynamics of provision and utilisation of primary healthcare services between NGOs and irregular migrants at *micro*, *meso*, and *macro* levels. One significant finding at the *micro* level pertains to language barriers, highlighting the critical role of language in accessing various services, including healthcare. Surprisingly, even long-term migrants still struggled with significant language obstacles, impeding their access to healthcare. Another pivotal finding, possibly the most significant, involves marginalisation's role as a mediating factor at the *micro* level. The study demonstrates that access to services, particularly healthcare, is not solely determined by migratory status; rather, it is an interplay of factors including marginalisation, which intersects with bureaucratic requirements and administrative barriers. The requirement for a residence to register with the Regional Health Service for accessing primary healthcare, even among regular migrants, exposes the challenge as most migrants reside in marginal conditions without registered residences. Additionally, the study strongly demonstrates NGOs' essential role in addressing structural flaws within the Italian healthcare system, effectively mitigating bureaucratic barriers for irregular migrants.

Despite the numerous challenges posed by the Covid-19 pandemic, the study shows the remarkable adaptability of NGOs in providing healthcare services to irregular migrants. While certain dynamics have managed to revert to pre-pandemic standards, others remain in the process of recovery, thereby emphasising NGOs' critical role in bridging critical healthcare gaps, particularly during times of unprecedented crises that disproportionately impact vulnerable populations, such as irregular migrants.

5.2 Limitations

In this qualitative study, the principles of *transparency*, *transferability*, *confirmability*, and *dependability* were crucial for ensuring the quality and credibility of the findings (Krefting 1991). However, certain limitations emerged.

The first limitation pertains to *transferability*, as the ability to generalise findings to a broader population was constrained by the composition and size of the sample. While the primary focus was on irregular migrants, the inclusion of migrants with residence permits but no residence inadvertently underscored the critical requirement of having a residence for accessing a personal GP through the Regional Health System. Although diverse backgrounds and perspectives were represented among migrants, which provided valuable insights, caution is needed in applying the results to other contexts due to the hidden nature of the studied population, which constrained random sampling.

The second limitation involves *confirmability*, with the possibility that participants may have responded in a socially acceptable or desirable manner, potentially compromising the neutrality of the findings. Efforts were made to mitigate social desirability bias by fostering trust and ensuring confidentiality. Preliminary results were also shared with migration studies experts to enhance the confirmability of the research findings.

The third limitation is associated with *dependability*, primarily arising from language barriers faced by many migrants. Conducting interviews in English for two participants partially addressed this issue, but the language barrier persisted with the majority of participants. The researcher remained vigilant in addressing potential language-related biases or limitations in the analysis process, although it is acknowledged that the language barrier might have influenced the dependability of information obtained from some participants.

In conclusion, while this qualitative study aimed to adhere to quality principles, limitations should be considered. Researchers and policymakers should exercise caution when generalising or applying the findings to different populations or settings, recognising the importance of ongoing efforts to uphold research rigour and validity.

5.3 Policy Implications

The Covid-19 pandemic has underscored the need for resilient and inclusive healthcare systems that can effectively address the health needs of all individuals, regardless of their legal status. Based on the study's results, the insights from key informants and migrants, and the existing literature, several policy implications aimed at improving the fruition of healthcare services for irregular migrants in Italy emerged. These recommendations span across macro, meso, and micro levels, as well as information dissemination strategies. As Italy seeks to recover from the social and economic impacts of Covid-19, integrating these recommendations will not only enhance healthcare access for irregular migrants but also contribute to a more equitable and robust healthcare infrastructure.

At the macro level, the lessons learned from the pandemic underscore the urgency of comprehensive migration policies addressing the vulnerabilities exposed by Covid-19. Migration policies should be reformed to facilitate the regularisation process for irregular migrants: simplifying and streamlining these procedures would reduce marginalisation and improve migrants' access to healthcare and other services. Additionally, it is crucial to address the issue of undeclared work and exploitation which often accompany irregular status, as these conditions are linked to a range of health issues. Combating racial discrimination is equally vital to prevent discretionary interpretations of norms that govern healthcare access for irregular migrants. Moreover, language courses tailored to the specific needs of migrants should be an integral part of the integration process, since language proficiency plays a crucial role in migrants' ability to access services, including healthcare. The pandemic revealed the necessity of a well-functioning healthcare system that can adapt to unforeseen challenges. In this sense, adopting a structural approach rather than an emergency-based one is recommended. This involves increasing funding for public healthcare, enhancing the availability of specialised physicians and general practitioners to cater to migrants' diverse healthcare needs and bolstering Italy's preparedness for future health crises. Additionally, the pandemic highlighted the differences in healthcare fruition across Italian regions, often emerging from decentralisation. In this sense, steps should be taken to harmonise the implementation of healthcare policies. Improved planning, informed by population needs rather than profit, is also essential to develop healthcare interventions that are effective and inclusive. Particularly in regions with prominent privatisation, thorough consideration should be given to safeguarding the well-being of migrants. This could involve carefully monitoring and regulating the involvement of

private entities in healthcare provision to prevent inequalities and barriers to access. Moreover, implementing a structural system of linguistic and cultural mediation in healthcare services across regions could address communication barriers and ensure that migrants receive accurate and culturally sensitive care.

A significant challenge highlighted in the study is the inconsistent interpretation of norms governing the issuance of STP and ENI codes across different regions. Harmonising these interpretations is critical to ensure equal access to healthcare services for migrants throughout the country. Furthermore, key informants consistently proposed the removal of residence as a criterion for registering with the Regional Health Service. In the context of post-pandemic recovery, ensuring equal access to healthcare services becomes essential in preventing the marginalisation of individuals without a residence, including both migrants and Italian citizens.

At the meso level, the pandemic highlighted the significance of coordination in crisis response. In particular, key informants emphasised the importance of enhancing networking between NGOs and associations that deliver similar or complementary services, which becomes an even more powerful strategy in a post-pandemic recovery phase. Concerning fostering networking with public bodies, on the other hand, some NGOs may be more reluctant and critical, since such cooperation may not completely align with their mission or principles. Therefore, while encouraging collaboration, it is essential to respect the diverse approaches and perspectives of NGOs in their interactions with public bodies.

At the micro level, post-Covid recovery underscores the importance of addressing marginalisation and improving living conditions. Adequate housing, nutrition, and hygiene are not only fundamental to migrants' well-being but also integral to preventing the spread of infectious diseases and other health conditions.

Finally, the pandemic underscored the significance of accurate information dissemination in healthcare systems. The lessons from Covid-19 highlight the need to provide reliable and up-to-date information to all stakeholders involved in healthcare provision. Effective communication strategies, including awareness campaigns and training, can counteract misinformation and biases. Particularly, providing comprehensive information for street-level bureaucrats responsible for issuing STP and ENI codes is essential in ensuring consistent and fair decisions regarding migrants' healthcare access. Regular updates and training for doctors on legislation and relevant information concerning irregular migrants and healthcare will further improve the quality of care provided to this population. Equipping migrants with information on available healthcare services, their rights, and where to access appropriate medical assistance will empower them to seek timely and relevant healthcare. Finally, launching public awareness campaigns to combat bias and misconceptions about irregular migrants' access to healthcare services is crucial in fostering a more inclusive society.

Embedding these policy recommendations within a sustainable post-Covid recovery framework positions Italy to address both immediate vulnerabilities and long-term health system resilience. By recognising the interconnectedness of migration and public health, investing in structural improvements, harmonising policies, fostering collaborations, addressing marginalisation, and improving information dissemination, Italy can not only enhance the healthcare experience for irregular migrants but also build a stronger and more equitable healthcare system for all.

6 Conclusion

This study analysed the impact of Covid-19 on the provision of primary healthcare by NGOs and its utilisation by irregular migrants in Italy. Through 30 semi-structured interviews involving 15 key informants and 15 migrant participants, the qualitative study explored changes in healthcare dynamics considering macro, meso, and micro factors.

Regarding the *provision* of healthcare services (Sub-Question One), the study highlighted the "active approach" adopted by most NGOs, strategically providing mobile clinics and reaching out to marginalised populations, including irregular migrants. All participating NGOs affirmed their commitment to safeguarding the right to health for marginalised individuals, with linguistic and cultural mediators bridging communication gaps and ensuring culturally sensitive care. The Covid-19 pandemic significantly impacted NGOs' operations, with temporary closures followed by swift reopening with stringent safety protocols. Despite these challenges, NGOs exhibited high *availability and accommodation*, with flexible opening hours and comprehensive healthcare services. Financial constraints and a decline in volunteer support were some of the challenges faced by NGOs, impacting their ability to sustain services.

In terms of healthcare *utilisation* (Sub-Question Two), the study identified various factors influencing irregular migrants' *ability to perceive*, *seek*, *reach*, *pay*, and *engage* with healthcare services. Active outreach efforts, word of mouth, and referrals facilitated migrants' perception of NGOs' services, while challenges in obtaining STP and ENI codes hindered their *ability to seek* public healthcare options actively. Migrants preferred NGOs due to the inclusive and welcoming environment provided by these clinics, with empathetic medical staff facilitating effective communication and trust. NGOs' strategic clinic locations and flexible operating hours enhanced migrants' *ability to reach* healthcare services. *Affordability* emerged as a crucial factor, with NGOs providing free services and ensuring access to essential medicines for migrants. Positive engagement and communication from medical staff fostered migrants' active participation in decision-making regarding their healthcare.

The study also identified *mediating factors* at *macro*, *meso*, and *micro* levels influencing NGOs' provision of healthcare and migrants' utilisation (Sub-Question Three). At the *macro* level, political choices and privatisation influenced healthcare access for irregular migrants, while street-level bureaucrats played a role in granting or denying access to STP and ENI codes. The Covid-19 pandemic amplified bureaucratic procedures and communication barriers. At the *meso* level, social support and collaborations with other organisations facilitated healthcare provision. NGOs' political engagement and activism varied, shaping their style of service delivery. At the *micro* level, key informants' attitudes and professional backgrounds impacted healthcare provision, while migrants' characteristics influenced their utilisation of services, with marginalisation and having a residence being the most relevant factors.

The study's findings align with existing literature on irregular migration, the role of NGOs, healthcare access, and the Covid-19 pandemic, while also presenting innovative contributions. The study is consistent with previous literature in underscoring how restrictive migration policies, coupled with exploitative working conditions and economic marginalisation, exacerbate the challenges faced by irregular migrants in accessing healthcare. Findings confirm the existing literature's concern about the heightened risks and challenges faced by vulnerable populations during times of crisis: the pandemic magnified pre-existing barriers, such as bureaucratic restrictions and language limitations. The study confirms previous research highlighting the pandemic's disproportionate impact on marginalised populations, underscoring the need for adaptive and responsive healthcare systems during such crises.

Finally, the study introduces innovative contributions by expanding Levesque's "Conceptual Framework of Access to Healthcare", examining factors mediating healthcare provision and utilisation at micro, meso, and macro levels. Notably, language barriers persist even for long-term migrants, hindering essential service access. Furthermore, the study unveils the crucial role of marginalisation as

a mediating factor, intertwining with bureaucratic and administrative barriers. It also highlights NGOs' crucial role in mitigating healthcare challenges, particularly during the Covid-19 pandemic, showcasing their adaptability and transformative impact in addressing critical healthcare gaps for vulnerable populations, including irregular migrants.

In conclusion, this study provides useful insights into the complexities of NGOs' provision of primary healthcare and its utilisation by irregular migrants in Italy, particularly within the context of the Covid-19 pandemic. The findings underscore the essential role played by NGOs in bridging healthcare gaps for vulnerable populations, especially during a crisis, filling critical gaps left by institutional barriers and restrictive policies. The study's findings contribute to the growing body of knowledge on irregular migration and NGOs, healthcare, and the impact of Covid-19 on vulnerable populations. Moreover, the study introduces innovative contributions, such as an examination of the mediating factors that influence the provision and utilisation of healthcare services between NGOs and irregular migrants, crucially highlighting the influence of marginalisation coupled with bureaucratic and administrative obstacles. The study also showed NGOs' adaptability in times of crisis and their crucial role in addressing healthcare gaps for vulnerable populations, including irregular migrants.

This study's findings provide a foundation for policy reforms centred on the human right to health of vulnerable populations, such as irregular migrants, particularly in times of crisis. Further research, particularly focusing on the *utilisation* side and on implementation gaps in the public healthcare sector, will enhance efforts to build more resilient and inclusive healthcare system.

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8 Appendix I – Tables

Table 1. Conceptual Framework: Detailed Explanation of Concepts and Definitions

PROVISION (NGOs and Healthcare Professionals)		UTILISATION (Irregular Migrants)	
Concept	**Meaning**	**Concept**	**Meaning**
APPROACHABILITY	• The provider is able to make itself known to its target clients. • The provider gives information about available treatments.	**ABILITY TO PERCEIVE**	• Irregular migrants are aware that the service exists.
ACCEPTABILITY	• The healthcare provided is appropriate in the way it is organised, so that patients feel included (i.e., gender, cultural norms etc.), and accept the treatment(s). The care "meets the needs of different cultural, socioeconomically disadvantaged and vulnerable populations" (Levesque et al. 2013: 5).	**ABILITY TO SEEK**	• Irregular migrants are autonomous in choosing to seek care. • Irregular migrants know about different healthcare options and their rights.
AVAILABILITY and ACCOMMODATION	• The provider can be reached physically and in an appropriate amount of time. • The provider disposes enough medical advice. • The provider has enough personnel, and appropriate equipment, and can dispense the required medication.	**ABILITY TO REACH**	• Irregular migrants dispose of "personal mobility and availability of transportation, occupational flexibility, and knowledge about health services that would enable one person to physically reach service providers." (Levesque et al. 2013: 6).
AFFORDABILITY	• The provider offers affordable prices for medical treatments.	**ABILITY TO PAY**	• Irregular migrants are able to pay for healthcare services.
APPROPRIATENESS	• The provider's services fit the patient's needs, i.e., "the timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the service provided" (Levesque et al. 2013: 6).	**ABILITY TO ENGAGE**	• Irregular migrants are involved in the decision-making process.

Table 2. Conceptual Framework: Detailed Explanation of Mediating Factors

Mediating Factor	Meaning

MACRO	• **National level:**
	  ○ Impact of national political choices on migrants' health
	  ○ Lack of resources in the public healthcare system
	  ○ Public opinion on migrants' access to healthcare
	• **Local level:**
	  ○ Nature or regional healthcare (i.e., degree of privatisation, presence of adequate, affordable, and accessible infrastructures, level of political pressure etc.)
	  ○ Role of street-level bureaucrats: enablers vs. inhibitors (i.e., level of discriminatory attitude, level of knowledge etc.).

MESO	• NGO's collaboration with local and national governments • NGO's collaboration with other NGOs • NGO's collaboration with other associations (i.e., *Banco Farmaceutico*) • NGO's type of political engagement (i.e., humanitarian, activist, neutral) • Migrant's social support (i.e., being part of a family, being part of a community, having friends or relatives etc.)
MICRO	• Key informant's professional background • Key informant's empathetic attitude • Migrant's age • Migrant's gender • Migrant's country of origin • Migrant's socioeconomic status • Migrant's migratory status • Migrant's employment status • Migrant's educational attainment • Migrant's language proficiency • Time spent in Italy • Migrant's health conditions

Table 3. Overview of Key Informants Interviewees.

ID	Role	Location	NGO name	Type of interview
K.1	Receptionist	Florence, Tuscany	Associazione Stenone	Individual
K.2	NGO member	Milan, Lombardy	Ambulatorio Medico Popolare (AMP)	Group
K.3	Nurse	Milan, Lombardy	Ambulatorio Medico Popolare (AMP)	Group
K.4	Doctor	Milan, Lombardy	Ambulatorio Medico Popolare (AMP)	Group
K.5	Doctor	Verona, Veneto	Medici per la Pace	Individual
K.6	Doctor	Verona, Veneto	Medici per la Pace	Individual
K.7	Nurse	Florence, Tuscany	Associazione Stenone	Individual
K.8	Coordinator	Verona, Veneto	Medici per la Pace	Individual
K.9	Medical Director	Verona, Veneto	Cesaim	Individual
K.10	Doctor	Milan, Lombardy	Naga	Group
K.11	Coordinator	Milan, Lombardy	Naga	Group
K.12	NGO member	Milan, Lombardy	Naga	Group
K.13	Coordinator	Foggia, Apulia	Intersos	Individual
K.14	Coordinator	Rome, Latium	Intersos	Group
K.15	Doctor	Rome, Latium	Intersos	Group

Table 4. Overview of Migrants Interviewees[4].

ID	Gender	Age	Country of origin	Reason for migration	Years in Italy	Language barrier	Level of education	Migratory status	Job in country of origin	Current job in Italy	Medical reason for availing of NGO's health services	How they found out about the service
M.1	M	29	Brazil	Migrated as a child	24	Medium to Low	Middle school	Regular but no residence	Was not old enough to work	Unemployed	Covid test	Redirected by other NGO
M.2	M	31	Tunisia	Job opportunity	12	Low	Middle school	Regular but waiting for a residence permit	Touristic sector	Porter	Dental problems	Word of mouth
M.3	M	43	Romania[5]	Job opportunity	20	High	Elementary school	Regular but no residence	House painter	Unemployed	Cancer (check-up visits)	Word of mouth
M.4	M	58	Senegal	Job opportunity	33	Medium to High	Middle school	Regular but no residence	Taxi driver	Unemployed (used to work in agriculture)	Leg injury	Redirected by a social worker
M.5	F	53	Romania	Job opportunity	9	Low	Professional school	Regular but no residence	Worked in a yarn factory	Hotel maid (used to be a caregiver)	Thyroid problems	Word of mouth
M.6	M	67	Sri Lanka	Job opportunity	15	High	/	Irregular	/	Factory worker	Cardiovascular pressure problems	Living nearby
M.7	M	25	Bangladesh	Job opportunity	5	Medium to Low	High school	Irregular	Student	Kitchen assistant	Otolaryngological problem	Word of mouth
M.8	M	45	Bangladesh	Job opportunity	20	Medium to High	/	Irregular	/	Street vendor (used to be a construction worker, lost job during Covid)	Heart condition and liver problems	Word of mouth
M.9	M	59	Morocco	Curiosity	35	No barrier	/	Regular	Student and worked in tourism	Maintenance technician	/	Living nearby

[4] The symbol "/" indicates that the interviewee did not answer the question.
[5] As mentioned, EU citizens can find themselves in a situation similar to irregular non-EU citizens if they do not fulfil the conditions for mandatory registration with the Regional Health Service and do not receive assistance from their home countries (Gazzetta Ufficiale 2013).

									(seasonal work)			
M.10	M	24	Bangladesh	Job opportunity	8	Very low	High school	Irregular	Student	Waiter	He was accompanying his partner	Word of mouth
M.11	F	23	Bangladesh	Family reunification	1	Very high	Middle school	Irregular	Student	Housewife	Migraine and muscular pain	Word of mouth
M.12	M	27	Nigeria	/	8	Medium to High	Middle school	Irregular	/	Metal mechanic	Kidney problems	Living nearby
M.13	M	35	Nigeria	Asylum seeking	7	High	Middle school	Irregular (rejected asylum seeker)	/	Unemployed (used to work in a factory)	Hip pain and muscular pain	Redirected by other NGO
M.14	F	44	Moldova	Job opportunity	17	No barrier	First year of university	Regular but no residence	Student	Domestic worker	Ascites (collection of fluid in the abdominal cavity, linked to cardiovascular issues)	Redirected by hospital
M.15	M	64	Sri Lanka	Job opportunity	15	High	Ordinary level (until 16 years old)	Irregular	Security firm worker	Unemployed (used to be a care giver)	Dental problems	Redirected by other NGO

Table 5. Tabulated Results – Provision

PROVISION		
Dimension	**Observed Result**	**Description**
APPROACHABILITY	NGOs' "active" outreach	Most NGOs involved in the study adopted an "active approach" for outreach operations, strategically providing mobile clinics and visiting places where marginalised populations, including irregular migrants, were likely to be found.
ACCEPTABILITY	Commitment to safeguard the right to health of marginalised individuals	All participating NGOs strongly affirmed their commitment to safeguard the right to health for marginalised individuals. While some focused more on migrants, all the NGOs were open to anyone in need, including Italian citizens.
	Presence of linguistic and cultural mediators in some NGOs	Some NGOs had linguistic and cultural mediators at their disposal to bridge communication gaps between migrants and healthcare providers, ensuring accurate and culturally sensitive care.
	Commitment to their mission even during the pandemic	The emergence of the Covid-19 pandemic significantly impacted NGOs' healthcare operations. Some NGOs temporarily closed their clinics during the initial outbreak, but their commitment to their mission drove them to swiftly reopen after adhering to stringent safety protocols
	In some cases, negative impact of pandemic on provider-client trust relationship	Some NGOs reported challenges in establishing trust relationships with patients, citing difficulties in communication caused by face masks and their inability to convey body language effectively.
AVAILABILITY & ACCOMMODATION	Adequate location and working hours	NGOs exhibited a high level of availability and accommodation, through mobile clinics or strategically situating their clinics in locations easily accessible to migrants, such as near shelters or in neighbourhoods where migrants resided. Additionally, NGOs offered flexible opening hours, accommodating the demanding schedules of migrant individuals who often work long hours. Conversely, the study emphasised that public healthcare services lacked such flexibility and accessible locations.
	Extensive provision of services	The primary healthcare services provided by these NGOs were extensive, encompassing routine check-ups, screenings, diagnosis, and treatment of common illnesses, including infections and minor injuries. Chronic disease management, an essential aspect of healthcare, was also a priority for NGOs in their mission to support migrants with conditions such as diabetes, hypertension, and respiratory problems
	Presence of specialist physicians	Some NGOs went beyond basic healthcare services and offered specialist visits, where migrants had access to psychologists, gynaecologists, cardiologists, orthopaedists, and other medical experts.
	General availability of medical and safety devices during the pandemic	While some experienced financial constraints, many NGOs managed to procure essential safety devices, like masks and gloves, without significant issues.
	Uncertain impact of pandemic on volunteers' availability	Post-Covid-19, some NGOs observed a decrease in the number of volunteers, which may impact their ability to provide comprehensive assistance to migrants. However, key informants emphasised that the decrease in the number of volunteers is not solely a direct consequence of the pandemic; rather, it has been an ongoing trend over the years.

AFFORDABILITY	Free medical consultations and medicine provision	All services provided by NGOs were free for clients. NGOs ensured access to essential medicines for migrants, such as antibiotics and common pharmaceuticals. Affordability emerged as a critical factor influencing healthcare utilisation among irregular migrants. For many migrants, NGOs represented the only viable option for obtaining essential medicines, especially for those living in marginal or impoverished conditions. The financial constraints faced by irregular migrants rendered seeking continuous care, especially for chronic diseases, unfeasible within the realm of private healthcare, leading migrants to rely on NGOs for accessible and affordable healthcare options.
APPROPRIATENESS	Timeliness in delivering (most) services	NGOs were noted for delivering services promptly, addressing medical concerns efficiently, and ensuring that migrants received appropriate and timely care. However, despite their efforts, NGOs sometimes encountered challenges in providing certain services – such as comprehensive dental care – due to financial, personnel, and other constraints.
	Provision of other services beyond healthcare	Beyond healthcare services, some of the participating NGOs extended their support to address bureaucratic challenges faced by migrants. This included assisting them with obtaining STP or ENI codes, crucial identification documents, and residence permits.

Table 6. Tabulated Results – Utilisation

UTILISATION		
Dimension	**Observed Result**	**Description**
ABILITY TO PERCEIVE	Facilitated through NGO's active outreach Most common: word of mouth and referrals from other NGOs	The study revealed that migrants' *ability to perceive* NGOs' services was facilitated through active outreach efforts by NGOs, word of mouth from relatives and friends, referrals from other NGOs, social workers, and direct recommendations from hospital doctors. However, migrants encountered challenges in perceiving the options offered by public healthcare, often due to language barriers and limited information dissemination.
ABILITY TO SEEK	Challenge in understanding access and functioning of STP and ENI codes (also due to language barriers)	A significant challenge faced by irregular migrants that emerged from the study was knowing about the existence of STP and ENI codes, understanding how to obtain them, and finally actually obtaining them, revealing migrants' in-*ability to seek* public healthcare services. This suggests that migrants may have chosen to access NGOs' services directly without actively comparing them with public healthcare options.
	Migrants appreciated NGOs' inclusive and welcoming environment as one of the main reasons why they availed of these services	Migrants expressed their preference for NGOs due to the inclusive and welcoming environment provided by these clinics. The empathetic and competent demeanour of the medical staff facilitated effective communication and further contributed to their sense of comfort and acceptance.
ABILITY TO REACH	NGOs' strategic location, mobile clinics, and opening hours facilitated migrants' ability to reach their services	Migrants found NGOs' offerings more easily accessible. Strategic clinic locations in areas where migrants reside, and the presence of mobile clinics contributed to this advantage. Another important factor easing migrants' *ability to reach* NGOs' healthcare services was the clinics' flexibility in operating hours.
	Lack of residence was one of the main obstacle for migrants' ability to reach public healthcare services in legal terms	Concerning the *ability to reach* the service in legal terms, the lack of a residence represented one of the most mentioned concerns by migrants. As a result, accessing public healthcare services presented several barriers for them.
ABILITY TO PAY	Migrants could access freely to NGOs' services and medications; they signalled their inability to pay for private clinics	NGOs played a critical role concerning migrants' *ability to pay*, as their healthcare services were entirely free for the marginalised populations they served. This ensured that migrants were able to access the care they needed. Conversely, some migrants expressed an in-*ability to pay* for services provided by private clinics, for instance, if they needed certain medical exams.
ABILITY TO ENGAGE	Migrants appreciated NGO doctors' efforts in explaining medical procedures	Migrants appreciated the patience and efforts of doctors within NGOs, who took the time to explain treatments and medical procedures clearly. This positive engagement fostered trust and comfort, contributing to the migrants' willingness to actively participate in the decision-making process regarding their healthcare.

Table 7. Tabulated Results – Mediating Factors

MEDIATING FACTORS		
Level	**Observed Factor**	**Description**
MACRO	Increased securitisation of migration policies, both at the national and regional levels	Most key informants indicated that national and regional political choices significantly influence irregular migrants' access to healthcare and on their living conditions. They mentioned that progressive political restrictiveness and the increasing privatisation of healthcare services, particularly in certain regions, have negatively impacted both Italian citizens and migrants alike.
	Increased healthcare privatisation at the regional level, particularly in some regions	
	Reduced investment in public healthcare, both at the national and regional levels	Key informants indicated that a lack of resources and investments in public healthcare at the national and regional levels has posed challenges in providing adequate healthcare services to irregular migrants.
	Street-level bureaucrats may hinder irregular migrants' access to healthcare	Street-level bureaucrats can easily misinterpret the law – either on purpose or due to a lack of knowledge – and can act as enablers or inhibitors in granting access to healthcare. Unfortunately, they seem to act more often as inhibitors, effectively denying migrants their *de facto* right to health.
	The pandemic caused an increase in bureaucratic and online procedures	Key informants highlighted the rise in bureaucratic procedures and the shift towards online services, which exacerbated the difficulties faced by irregular migrants in accessing healthcare during the pandemic.
	The pandemic exacerbated the already-existing situation	Key informants indicated how the already-existing critical situation related to the privatisation of healthcare was further amplified by the Covid-19 crisis.
	The communication system during the pandemic was discriminatory towards non-Italian speakers	The communication system during the pandemic was observed to be discriminatory towards those who did not speak Italian fluently, necessitating translation efforts by certain NGOs to disseminate safety measures effectively.
	The restrictions linked to the pandemic caused a reduction in access to STP and ENI codes	The pandemic-induced restrictions had a compounding effect on the access to STP and ENI codes for irregular migrants, contributing to further barriers to healthcare access.
	Emergence of regional disparities during the pandemic	Regional disparities were noted, as some regions displayed greater responsiveness towards addressing migrants' healthcare needs during the pandemic.
MESO	Migrants' social support plays a pivotal role in their access to healthcare	Migrants who have family, relatives, or friends already living in Italy were usually better informed and equipped to navigate the healthcare system effectively. This was evident also from the fact that the most common way migrants became aware of healthcare services provided by NGOs was through word of mouth.
	NGOs are generally supportive of networking with other NGOs and associations	Key informants stressed the importance of NGOs' collaboration with other organisations (for instance, in purchasing or retrieving medicines) and most of them supported the creation of networks to sustain and assist one another in providing healthcare services.
	NGOs showcase different levels of political engagement	Some NGOs actively engaged in activist behaviours and socio-political events, while others focused primarily on healthcare provision, influencing their style and extent of service delivery.
	Emergence of different approaches towards developing partnerships during the pandemic	Some key informants reported establishing partnerships with other NGOs, associations, and public bodies to ensure marginalised populations, including irregular migrants, were reached with healthcare services, including Covid-19

		vaccines. Some NGOs expressed the belief that certain responsibilities, such as vaccination campaigns, should primarily fall under the purview of public bodies.
MICRO	Key informants' professional background contributes to tailored healthcare services for migrants	Key informants' empathetic attitudes, professional backgrounds, and roles within NGOs may impact the quality and accessibility of healthcare services. Additionally, key informants' roles as volunteers or coordinators within NGOs can play a role in shaping the delivery of healthcare services.
	Relatively younger migrants tend to utilise NGO's services more	Migrants' age emerged as a factor, with relatively younger individuals being more prevalent in utilising NGOs' healthcare services.
	Male migrants tend to utilise NGO's services more	The majority of patients utilising NGOs' services were male, with an exception observed at Intersos' clinic in Rom (this clinic is located adjacent to a safe space for women who are victims of violence, and provides services specifically tailored to women). However, literature on the topic shows mixed results, underscoring the need for further research in this area.
	Migrants' country of origin impacts their interaction with healthcare providers	Country of origin had an impact on utilisation, as migrants from certain regions faced different cultural and language barriers when interacting with healthcare providers.
	Employment background and status, including working conditions, affect migrants' health conditions	Migrants engaged in physically demanding jobs were found to experience a higher prevalence of certain recurrent health issues, particularly orthopaedic and muscular problems: the nature of their work, which might involve working in the fields, heavy lifting, and repetitive movements, contributed to the development of these specific issues.
	Migrants with chronic conditions need consistent access to healthcare services and medications	Key informants highlighted the importance of consistent access to healthcare services and medications in the case of chronic diseases.
	Dental issues are among the most common medical problems, but NGOs provide limited dental services	One of the most prevalent health issues among migrants emerging from the interviews were dental problems. Regrettably, these are also the areas where NGOs face limitations in their ability to provide comprehensive care since they often lack the necessary space, equipment, and personnel.
	Migratory experiences affect migrants' health conditions	Some individuals faced distressing psychological and psychiatric consequences resulting from traumatic experiences, including torture and violence, during their migration journey. Additionally, physical issues were observed, particularly among migrants who endured arduous journeys, such as those coming from the Balkan route. A common problem reported among this group was feet-related issues
	Socio-economic status and living conditions affect migrants' health	Socio-economic status and living conditions emerged as crucial determinants, significantly impacting the health of irregular migrants. Poverty and marginalisation, coupled with overcrowded or unsanitary living spaces, exposed migrants to additional health challenges, including feet problems, breathing problems, dermatological problems and, more rarely, tuberculosis and scabies.
	The pandemic caused an increase in respiratory problems among migrants	Key informants reported that the pandemic resulted in an increased prevalence of respiratory problems among migrant patients.

	Emergence of difficulties in maintaining social distancing and following safety guidelines during the pandemic	Overcrowded living conditions experienced by many migrants made adherence to safety measures more challenging, heightening their susceptibility to health risks.
	Emergence of emotional distress during the pandemic	The emotional toll of the pandemic impacted some migrants, further complicating their healthcare needs during this period.

9 Appendix II – Interview Guides

9.1 Interview Guide for Key Informants

1. INTRODUCTION

1.1. Nice to meet you, my name is Giulia Mori and I am a master's student at the United Nations University in Maastricht. I am currently conducting research on how Covid-19 has changed irregular migrants' access to and use of primary healthcare provided by NGOs.

1.2. I will now hand you this consent form. Please read it carefully and ask me if you have any doubts. *The consent is signed.*

1.3. Now I will start recording our conversation.

For the first section I will ask you some basic information about you and [NGO].

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2. DEMOGRAPHIC and PROFESSIONAL INFORMATION

2.1. Could you tell me your age and gender?

2.2. Could you tell me about your professional background and when you decided to work with migrants?

2.3. Could you give me some information about [NGO], including its mission, history, staff size and how you finance your services?

2.4. Taking into account the Italian legislation on access to health, could you explain, from your point of view, why there is a need for services such as those provided by [NGO]? *Example: Can you make a link between Italian legislation and [NGO], how does your work fit into the legislative framework?*

2.5. What is [NGO]'s relationship with the National Health System?

The next section focuses on the patient population.

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3. POPULATION OF PATIENTS and COMMON MEDICAL PROBLEMS

3.1. Could you tell me about the type of patients you serve? *Example: how many patients per day/week, average age, gender, countries of origin, how many irregular migrants?*

3.2. What are the main reasons why migrant patients come to you? *Example: If they are irregular, why do they not use STP? If they are regular and have a general practitioner, why do they come to you? What is not working in the public system in this regard?*

3.3. Do you find common medical problems among irregular migrants? *Example: problems related to marginality, migration experience, etc.*

In the next sections I will ask you about your work with irregular migrants.

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4. PROVISION OF CARE

4.1. What kind of medical services do you provide to irregular migrants?

4.2. Do you use any strategies to make your services known?

5. CHALLENGES AND BARRIERS and CULTURAL COMPETENCE

5.1. In your opinion, what are the main challenges or barriers you face in providing medical services to irregular migrants? *Example: difficulties in reaching patients, language barriers, lack of resources and/or personnel, etc.*

5.2. Do you use any strategies to improve your cultural competence[6] when providing care to irregular migrants? Have you received training in this regard?

In the next sections I will ask you about the impact of Covid-19 on your work with irregular migrants.

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6. IMPACT OF COVID-19 AND STRATEGIES ADOPTED

6.1. During the Covid-19 period, how did the supply and demand for the services you provide change? *Example: frequency of visits, patient volume, etc.*

6.2. What are the main challenges you faced in providing primary health care to irregular migrants during the pandemic? *Example: lack of personal protective equipment, lack of masks, increase in patient volume, etc.*

6.3. During the Covid-19 period, did you collaborate with other organisations or associations to better respond to the needs of irregular migrants?

7. CURRENT CHALLENGES POST-COVID-19

7.1. What impact has Covid-19 had on your work? What are the main challenges you face today as a consequence of Covid-19?

7.2. Which services or dynamics, in your opinion, have returned to pre-pandemic standards and which have not?

In the next section, I will ask you possible recommendations to improve access and utilisation of primary health care services for irregular migrants.

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8. RECOMMENDATIONS FOR IMPROVING ACCESS TO HEALTH SERVICES

8.1. Do you have any recommendations that you think could have improved access to primary health care services for irregular migrants during the pandemic?

8.2. Do you have any recommendations to improve the current access to and use of primary health care services for irregular migrants?

The interview is almost over. In the next and last section, we will discuss some final topics.

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[6] If the respondent does not know the definition of cultural competence: **Cultural competence**, as traditionally understood, is the ability to understand and deal with patients and families belonging to different cultures, hinges on knowledge of the values, beliefs, and behaviours of the various ethnic, religious and national groups.

9. CONCLUSION

9.1. Do you have any other topics you would like to discuss? Would you like to add something to the conversation?
9.2. In the unlikely event that I need a further question or clarification, could I contact you again?
9.3. Finally, I would like to remind you that your participation in this interview is voluntary and confidential and that if you have any questions or concerns you can contact me or my interviewer, even if you decide not to participate in the research anymore.

9.2 Interview Guide for Migrants

1. INTRODUCTION

1.1. Nice to meet you, my name is Giulia Mori and I am a master's student at the United Nations University in Maastricht. I am currently conducting research on how COVID-19 has changed irregular migrants' access to and use of primary healthcare provided by NGOs.
1.2. I will now read you the informed consent form. Please listen carefully and ask me if you have any doubts. Consent is given.
1.3. Now I will start recording our conversation. *Recording starts.*
1.4. Can you confirm that I have informed you sufficiently and that you are taking part in this interview voluntarily**?**

For this first section of the interview, I will ask you for some basic information about yourself.

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2. DEMOGRAPHIC INFORMATION AND MIGRATION BACKGROUND

2.1. Could you tell me your age, sex and marital status (if you are married*)?
2.2. What is your country of origin and how long have you lived in Italy?
2.3. Can you tell me your educational background and what was your job before coming to Italy?
2.4. Can you tell me why you came to Italy and a bit of your story?
2.5. Could you tell me what your current job is? (ask about working conditions)

I will now ask you about your use of the primary health care services provided by [NGO].

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3. USE OF PRIMARY HEALTH CARE SERVICES

3.1. What do you think of the Italian healthcare system?
3.2. What difficulties do you encounter/have you encountered in using the Italian public healthcare system? Do you have a general practitioner? Have you ever been to an emergency room?
3.3. How long have you been using primary health care services provided by [NGOs]?
3.4. How did you learn about the services provided by [NGO]?
3.5. Until now, how would you describe your experience in using primary health care services provided by [NGO]?

3.6. Do you feel welcomed by [NGO]? Does [NGO] use language/intercultural mediation services? Do doctors explain treatments to you? Do you feel involved in decisions about your health?
3.7. Do you have specific health needs?
3.7.1. If yes, how did [NGO] address these specific needs?

I will now ask you some questions about the impact of Covid-19 on your health and utilisation of primary health care services.

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4. **IMPACT OF COVID-19 ON HEALTHCARE ACCESS AND UTILISATION**
4.1. Can you tell me what you remember about the Covid period? *Your personal experience, living conditions, if you had Covid, if you were afraid, if you had vaccine etc.*
4.2. Did you use the services provided by [NGO] during the pandemic?
4.2.1. If yes, what were the main changes in your access to services provided by [NGO] since the beginning of the COVID-19 pandemic?
4.3. What were the main challenges you faced in accessing and using health services during the pandemic? *i.e., changes in operating hours, fear of leaving home, lack of available transport.*
4.4. Have you experienced changes in your health needs since the beginning of the pandemic?

5. IMPACT OF COVID-19 ON MENTAL HEALTH
5.1. Do you think that the Covid-19 pandemic has had an impact on your mental health?
5.1.1. If yes: Did you use any resources or support systems to address your mental health needs during the pandemic?

For the next section of the interview, I will ask for your opinion on possible recommendations to improve access to and use of primary health care services for undocumented migrants.

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6. **RECOMMENDATIONS FOR IMPROVING ACCESS TO HEALTH SERVICES**
6.1. Do you have any advice or recommendations that could have improved access to primary health care services provided by [NGOs]?
6.2. Do you have any recommendations to improve access and use of primary health care services for irregular migrants in Italy?

In the next and final section, we will discuss some final topics.

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7. **CONCLUSION**
7.1. Do you have any other topics you would like to discuss? Would you like to add something to the conversation?
7.2. In the unlikely event that I need a further question or clarification, can I contact you again?
7.3. I would like to remind you that your participation in this interview is voluntary and confidential and that if you have any questions or concerns, you may contact me or my interviewer, even if you decide to leave the research.