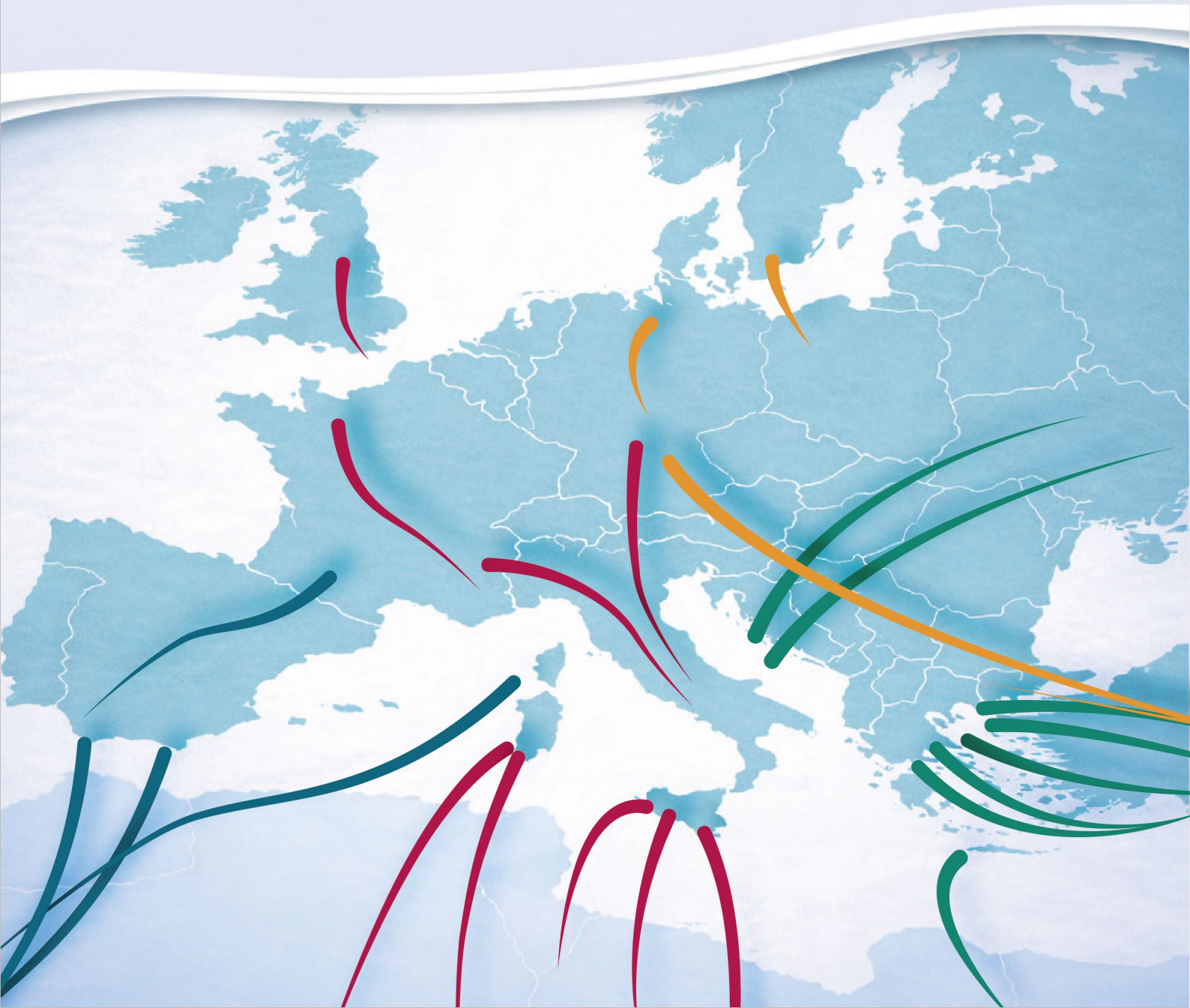
From arrival *to* settlement

Vulnerabilities of asylum seekers and refugees in Europe

Edited by
Daria Mendola



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1. Insights on the health of migrants in a reception center in Italy

Manuela Stranges, Annalisa Busetta and Daria Mendola

This study explores the health conditions of migrants hosted at the CARA Sant'Anna (a first reception center of the Italian official reception system), located in Crotone, in the south of Italy, in the period 2013 and 2018. The Sant'Anna Center has been the largest reception center in Europe for many years, with a declared capacity of 883 hosts. Using administrative data, collected during the registration at the center, and linking them with health reports filled by the center's officers, the analysis aims to describe the main characteristics of individuals who experienced health problems during their stay. Particular attention is given to the timing and reasons for exit from the center, in order to better understand how health issues intersect with the broader dynamics of the reception pathway. Descriptive analyses are used to outline patterns of morbidity and differences by gender, age, family composition and country of origin. By providing insights from one of the main Italian reception centers, the study seeks to inform broader reflection on the health of migrants in the early stages of arrival and settlement, a phase often marked by uncertainty and limited access to health services. So, the results contribute to shedding light on the specific health vulnerabilities of migrants.

1. INTRODUCTION

The health conditions of refugees and migrants in reception centers remain relatively understudied. Access to these facilities is often restricted, and most available information is collected for administrative rather than research purposes. Although substantial work examines the general health of displaced populations, much less is known about how health problems arising during stays in reception centers relate to practical outcomes such as duration of stay or reasons for departure.

This paper analyzes the health conditions of migrants (mostly refugees and asylum seekers) using data from one of the largest reception centers in Italy over a six-year period (2013-2018).

2. LITERATURE REVIEW

Numerous studies demonstrate that refugees and asylum seekers experience considerable health difficulties, particularly psychological issues like anxiety, depression, and post-traumatic stress disorder (Steel et al., 2009; Hollifield et al., 2016; Keller et al., 2003; Kleinert et al., 2019; Pejušković & Marković, 2020). These conditions tend to affect those living in reception facilities or facing legal uncertainty more severely than resettled refugees. The strain of asylum procedures – interviews, hearings, and waiting without clear outcomes – heightens vulnerability (Pejušković & Marković, 2020; Khouani et al., 2022). Physical health problems like respiratory infections and other preventable illnesses stem from overcrowded facilities, inadequate sanitation, and insufficient privacy (Müller et al., 2021; Kleinert et al., 2019; Tourneur et al., 2015). While public discussions sometimes emphasize "imported" diseases, evidence shows these cases are uncommon, with everyday health issues and chronic conditions being far more relevant (Kleinert et al., 2019).

Living conditions characterized by constrained autonomy and difficult access to services can worsen mental and physical well-being and may affect desires to leave reception facilities (Bradby & Humphris, 2017; Pejušković & Marković, 2020; Khalil & Tjaden, 2025). Extended stays combined with administrative limbo tend to intensify psychological strain (Pejušković & Marković, 2020). Existing research points to widespread health difficulties among asylum seekers and suggests these problems might indirectly influence decisions to leave reception centers, although precise causal connections need further investigation.

3. DATA

Our analysis draws on administrative records from the Sant'Anna CDA-CARA center, a major reception facility for refugees and asylum seekers in southern Italy. When data were collected, Sant'Anna was regarded as Europe's largest reception center of its kind (Stranges and Wolff, 2025; 2018). Situated roughly fifteen kilometers from Crotone, the facility occupies a former military airbase along important migration routes across the Ionian Sea.

The center has operated since 1998 and officially accommodates 883 people, though this capacity is regularly surpassed. Upon arrival, residents are registered by police, assigned to shared accommodation, and meet with social workers. Since Sant'Anna is not a detention center, residents

can leave and return freely between 8 a.m. and 8 p.m., and many opt to leave shortly after arriving, sometimes to circumvent Dublin Regulation constraints (Stranges and Wolff, 2025; 2018).

Staff keep detailed logs of every entry and exit, forming the foundation of our dataset. The logs capture precise dates of arrival and departure, stated reasons for leaving when recorded, and basic demographic details including gender, date of birth, and country of origin. Records also show whether people arrived alone or with relatives.

We connected administrative records to individual health files created by medical staff when residents required care outside the center, such as at hospitals or specialist clinics. Health records were only generated for cases deemed serious enough to warrant external medical attention, covering conditions ranging from significant injuries to cardiovascular issues. Minor complaints – colds, headaches, small cuts – were not documented. Consequently, the health variable indicates having accessed external healthcare and almost certainly underestimates actual illness prevalence.

While the complete archive runs from 2008 to 2018, we restrict analysis to entries from January 1, 2013 onward, when health information becomes available. The final dataset encompasses 24,120 entries between 2013 and 2018, of which 22,252 are non-censored observations. Among these, 777 individuals accessed external healthcare services.

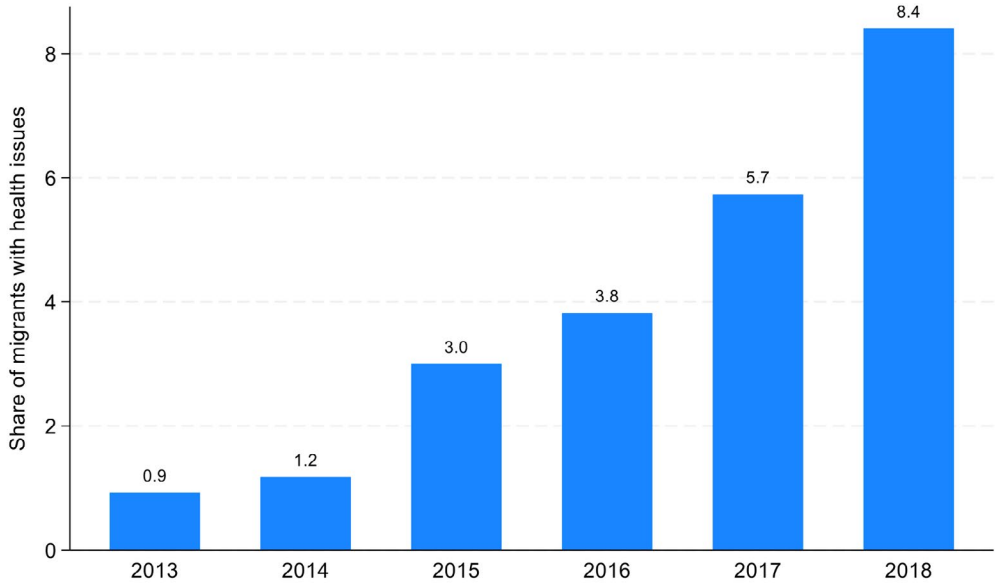
4. FINDINGS

An overview of health issues over time

Figure 1 illustrates an upward trend in the share of migrants with health issues from 2013 to 2018. In 2013, only 0.9% of residents (30 of 3,242) accessed external healthcare. This remained low in 2014 at 1.2% (52 of 4,422), then rose to 3.0% in 2015 (154 of 5,137), 3.8% in 2016 (292 of 7,641), 5.7% in 2017 (129 of 2,250), and 8.4% in 2018 (120 of 1,428).

While absolute numbers fluctuated – peaking at 292 in 2016 when arrivals were highest – the proportion accessing external healthcare steadily increased, suggesting growing incidence of serious health problems requiring attention outside the center, even as total arrivals declined in later years.

Figure 1 - Share of migrants with health problems over total migrants entering the center over time



Source: Authors' elaboration on data from Sant'Anna Cara, 2013-2018

Characteristics of migrants with health problems

Table 1 shows the distribution of health issues. Men constitute 77% of those with documented health problems, though women show higher incidence rates (4.81% versus 2.93%). While most people with health issues are men (reflecting overall population composition), women arriving at the center are more likely to develop health problems requiring external care.

Older residents (35+ years) have the highest incidence at 4.63% compared to around 3% for other age groups, though they represent only 14.54% of all those with health problems due to their smaller population share. Those arriving with family show slightly higher incidence (3.83%) compared to those arriving alone (3.11%), possibly reflecting vulnerable family members like children or elderly relatives requiring medical attention.

Country of origin reveals the most substantial differences. Pakistanis have the highest incidence at 6.57%, followed by Bangladeshis at 5.27% and Nigerians at 4.88%. Syrians show remarkably low rates (0.28%). Pakistan accounts for over one-fifth (22.14%) of those with documented health issues, making it the single largest nationality group requiring external medical care despite representing only about 11% of total arrivals.

Table 1 - Characteristics of migrants with health issues

(1) Characteristic	(2) Category	(3) Share among those with health issues	(4) Incidence of those with health issues within each category
Gender	Male	77.09%	2.93%
	Female	22.91%	4.81%
Age Class	0-17	10.94%	3.41%
	18-24	39.12%	2.64%
	25-34	35.39%	3.58%
	35+	14.54%	4.63%
Family	Alone	81.34%	3.11%
	With the family	18.66%	3.83%
Country of Origin	Eritrea	14.16%	2.82%
	Pakistan	22.14%	6.57%
	Nigeria	13.77%	4.88%
	Syria	0.77%	0.28%
	Iraq	3.22%	1.73%
	Bangladesh	8.75%	5.27%
	Gambia	5.02%	3.05%
	All other countries	32.18%	2.70%

Duration of stay

Understanding the relationship between health status and length of stay requires careful interpretation due to potential reverse causality. We cannot determine whether health problems cause longer stays or whether longer stays increase likelihood of developing health problems. Individuals who fall ill may remain longer due to medical needs or administrative delays; conversely, those staying longer simply have more time for health issues to emerge. Additionally, common underlying factors like administrative processing times or legal status uncertainties could influence both health and duration. Despite these challenges, descriptive patterns are striking. Table 2 shows substantial differences in length of stay between residents with and without documented health issues across all characteristics.

Men with health issues had median stays of 332 days compared to 12 days without health problems – a 320-day difference. Women showed similar patterns (206 versus 5 days, a 201-day difference). Women without

health issues leave more quickly overall, but both genders experience substantial delays when health problems arise.

Table 2 - Duration of stay by health problems

Characteristic	Category	Median Duration -days- (Without health issues)	Median Duration -days- (With health issues)	Difference* -days-
Gender	Male	12	332	+320
	Female	5	206	+201
Age Class	0-17	5	96	+91
	18-24	11	302	+291
	25-34	17	331	+314
	35+	8	320	+312
Family	Alone	12	330.5	+318.5
	With the family	6	146	+140
Country of Origin	Eritrea	16	141	+125
	Pakistan	187	381	+194
	Nigeria	8	326	+318
	Syria	5	119.5	+114.5
	Iraq	6	347	+341
	Bangladesh	6	369.5	+363.5
	Gambia	116.5	252	+135.5
	All other countries	7	278	+271
Overall		9	308	+299

* Difference between those with health problems and those without health problems

Older migrants with health issues stayed 312 days longer than healthy counterparts (320 versus 8 days). The youngest group had short baseline stays (median 5 days) increasing to 96 days with health problems – a nearly 20-fold increase. Middle age groups showed consistent patterns, with median differences of 291-314 days.

Those arriving alone experienced dramatic shifts from 2 without health issues to 330.5 days (+318.5 days) with health issues. Those arriving with family had shorter baseline stays (6 days) increasing to 146 days

with health problems (+140 days). While the absolute increase is smaller for families, both patterns suggest health problems substantially impede departure.

Country patterns vary substantially. Iraqis and Bangladeshis showed the largest increases – Iraqis from 6 to 347 days (+341 days), Bangladeshis from 6 to 369.5 days (+363.5 days). Nigerians shifted from 8 to 326 days (+318 days). Pakistanis and Gambians showed long baseline stays even without health issues. Pakistanis stayed 187 days at baseline, rising to 381 days with health problems (+194 days). Gambians stayed 116.5 days at baseline, rising to 252 days (+135.5 days). These groups appear to face substantial obstacles to onward movement regardless of health status. Eritreans showed moderate patterns (16 to 141 days, +125 days). Syrians maintained the shortest stays (5 to 119.5 days, +114.5 days), possibly reflecting different migration strategies or faster administrative processing.

5. BRIEF CONCLUDING REMARKS

This descriptive analysis documents notable patterns regarding health status and length of stay among asylum seekers and refugees at Sant'Anna between 2013 and 2018. The share of residents accessing external healthcare increased from under 1% in 2013 to over 8% by 2018. Women, older residents, and individuals from Pakistan, Bangladesh, and Nigeria showed higher rates of documented health problems. Syrians had particularly low rates.

Across all groups and nationalities, those accessing external healthcare due to health issues had had considerably longer stays – typically 200-350 days longer at the median – compared to those without documented health issues. These patterns should be interpreted descriptively rather than causally. We cannot determine whether health problems lead to longer stays, whether longer stays increase health risks, or whether both are influenced by common underlying factors. The timing of health events during stays remains unknown, limiting conclusions about causal direction.

Nonetheless, the data suggest a strong association between health status and duration at Sant'Anna. Whether reflecting medical needs affecting mobility, administrative processes, or other mechanisms, the patterns indicate health considerations may play a meaningful role in reception center experiences. These observations may be useful for those managing reception facilities or considering policies affecting both health services and length of stay.

REFERENCES

Bradby, H., Humphris, R., Newall, D. & Phillimore, J. (2017). *Health Status of Refugees and Asylum Seekers*. In Oxford Research Encyclopedia of Global Public Health. Oxford University Press.

Hollifield, M., Toolson, E. C., Verbillis-Kolp, S., Farmer, B., Yamazaki, J., Woldehaimanot, T. & Holland, A. (2016). Effective Screening for Emotional Distress in Refugees: The Refugee Health Screener. *Journal of Nervous and Mental Disease*, 204(4), 247–253.

Keller, A. S., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., Sachs, E., Leviss, J. A., Singer, E., Smith, H., Wilkinson, J., Kim, G., Allden, K. & Ford, D. (2003). Mental health of detained asylum seekers. *The Lancet*, 362, 1721–1723.

Khalil, S. & Tjaden, J. (2025). How reception centers affect the integration of asylum seekers and recognized refugees. *European Societies,* 27(4), 617-643.

Khouani, J., Blatrix, L., Tinland, A., Jego, M., Gentile, G., Fond, G., Loundou, A., Fromentin, M. & Auquier, P. (2022). Health status of recently arrived asylum seekers in their host country: results of a cross-sectional observational study. *BMC Public Health*, 22(1), 1688.

Kleinert, E., Müller, F., Furaijat, G., Hillermann, N., Jablonka, A., Happle, C. & Simmenroth, A. (2019). Does refugee status matter? Medical needs of newly arrived asylum seekers and resettlement refugees - a retrospective observational study of diagnoses in a primary care setting. *Conflict and Health*, 13(1), 39.

Müller, F., Kleinert, E., Hillermann, N., Simmenroth, A., Hummers, E., Zychlinsky Scharff, A., Dopfer, C., Happle, C. & Jablonka, A. (2021). Disease burden in a large cohort of asylum seekers and refugees in Germany. *Journal of Global Health*, 11, 04002.

Pejuskovic, B. & Marković, M.V. (2020). Mental health of refugees, asylum seekers and migrantsan overview of challenges and good practice examples. *Psychiatry Today/Psihijatrija Danas*, 52(1-2), 73-87.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A. & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA,* 302(5), 537–549.

Stranges, M. & Wolff, F. C. (2025). Time and reason of exit of minors from a refugee centre: the role of family links. *Genus* 81(1), 18.

Stranges, M. & Wolff, F. C. (2018). From hell to heaven? Evidence of migration trajectories from an Italian refugee centre. *Demographic Research*, 39, 963-990.

Tourneur, A., Osterhaus, A. D. M. E. & Humphris, R. (2015). Health and asylum seekers in Europe. In Oxford Research Encyclopedia of Global Public Health. Hannover: Research Centre for Emerging Infections and Zoonoses.