

**CONTRADICTIONS AND EXCLUSIONS: AN ETHNOGRAPHIC STUDY
OF AFRICAN IM/MIGRANTS' RIGHT TO HEALTH IN ITALY**

by

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

The Faculty of Graduate and Postdoctoral Studies
(Anthropology)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

August 2014

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Abstract

This thesis examines the complex and “messy” nature of the right to health and its intersections with race, gender, and migration in the Italian context. The laws in Italy purportedly outline a framework that includes “illegal” im/migrants in the healthcare system. The diverse ways in which the “right to health” have been understood theoretically are based on a commitment to universal and legal rights or the right to health from a moral and humanitarian perspective. Drawing on participant observation in medical clinics, and semi-structured formal and informal interviews with medical staff, practitioners and patients in two cities of Italy, this thesis provides insights into “the right to health” in theory and in practice. Two key concepts in the study of the right to health are moral economies and biolegitimacy. On the basis of my research I argue that currently, the moral economy of health in Italy regarding “illegal” im/migrants is one of reluctant compassion. While im/migrants’ social legitimacy stems from their biological state, or biolegitimacy, within the setting of the clinics it does not necessarily extend further. In Italy, “illegal” im/migrants enjoy legitimacy via their biolegitimacy, but they are yet to be fully accepted into the social and moral community. While “illegal” im/migrants are recognized as having a right to health they are simultaneously excluded politically, economically, and discursively from the social community. Even in the “humanitarian” version of healthcare in Italy which provides a legal framework where, in principal, everyone can access healthcare, there is still a lack of comprehensive treatment (*cura totale*). Ultimately, this thesis demonstrates the ways in which the right to health in Italy is complex, messy and often contradictory with respect to other aspects of social life even in a context where there is a legal framework outlining a provision of healthcare for all. Additional research is necessary to understand how the right to health is interpreted in other regions of Italy and particularly in

detention centers, such as Lampedusa, which have received a lot of media attention recently for their treatment of African detainees and im/migrants.

Preface

The author conducted all the research included in the thesis. The UBC Behavioral Research Ethics Boards approval number is H13-00710. The author had affiliation with the University of Modena-Reggio Emilia for this study.

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Acknowledgements

As with any worthwhile project, a number of people were crucial to the completion of this thesis. The clinics, medical personnel, and health authority offices in Modena and Reggio Emilia opened their doors to me and allowed me to spend time observing and responding to all my questions. I am truly grateful for their openness and interest in my project including the doctors, staff and all the patients I met throughout the process. Furthermore, this research would not have been possible without the constant support of the University of Modena and Reggio Emilia and especially Dr. Giovanni Guaraldi and Francesco Guaraldi. I am particularly appreciative for the many insightful conversations I had with Dr. Giovanni Guaraldi. The careful guidance and countless coffees at the vending machine and the café close by with Francesco Guaraldi provided me with both intellectual and physical sustenance. I am also indebted to Dr. Paola Bertolini and Dr. Enrico Giovannetti for their inspiration, enthusiasm and assistance at the inception of the project when it was still just an idea. There is an additional person I would like to thank although I will not name her here for privacy reasons. She provided me with valuable information about the clinics and we had many thought-provoking, informal conversations over various dinners and appetizers served for *aperitivo*. She became a very good friend with whom I hope to keep in contact.

My long-time friends were unfailingly supportive throughout the process and spending any time with them is pure joy for me. Thank you to Daniele Ferraguti and his family for all their hospitality and making me feel at home in Modena. Also, many thanks to Francesca Piacentini, Riccardo Righi, Tiziana Ventre and Elisabetta Niedda for their friendship, reassurance and continued peer support and inspiration. I will always remember and draw strength from our journeys and conversations.

Of course, I owe a debt of thanks to the faculty, staff and fellow students at the University of British Columbia. In particular, I am grateful to Dr. Leslie Robertson for her thorough comments and patient reading and re-reading of my research. I am also grateful to Dr. Carole Blackburn for her excellent comments and encouragement. I would also like to thank my supervisor, Dr. Vinay Kamat for his advice, instruction, and cups of chai while discussing my project.

Finally, I reserve my warmest appreciation to my parents, Dr. Pat Lauderdale and Dr. Annamaria Oliverio for their lifelong commitment to education and influence in my pursuit of justice and love of learning. To my siblings, Patricia and Tommie, may we continue to encourage each other in all our lifelong endeavors.

1. INTRODUCTION

“I love animals -- bears and wolves, as everyone knows -- but when I see the pictures of Kyenge, I cannot but think of, even if I'm not saying she is one, the features of an orangutan”

“It is all very well that she be a minister but in her own country. Given that this government needs to govern Italy, I hope that it is done by Italians”

(Italian Sen. Roberto Calderoli quoted by Yan, Russell and Milanova. “Bananas Thrown at Italy's First Black Minister Dr. Cecile Kyenge”. *CNN*, July 29, 2013)

In 2013, with the new appointment of the Minister of Integration, Dr. Cecile Kyenge, concerns about im/migration¹, rights and race were once again at the forefront of Italian politics and in the mindsets of the general Italian public. Dr. Kyenge is a Congolese-born Italian citizen with a medical degree from the University of Modena and Reggio Emilia. She is Italy's first racially “black” minister. She is also an Italian citizen, a doctor and a political figure; yet, she was met with comments from a fellow minister that had strong racist overtones, indicating a less than positive understanding of her inclusion in the government of the Italian nation-state. These recent political events heighten and make more transparent the racial and nationalistic tensions that have arguably existed previously in Italy (Angel-Ajani 2000). In many of her efforts and political campaigns, Dr. Kyenge has promoted awareness and cooperation and she has been a strong advocate of rights for im/migrants.

My research falls within the general context of ethnographic studies of human rights. Human rights are typically understood as stemming from a natural rights interpretation or a positivist interpretation. With the former, an individual has rights based on the fact that they are a human being; the latter suggests they have rights because the state recognizes their rights. Two

¹ This thesis will use the convention of “im/migrant”/“im/migration” set out by Willen et al. (2011) to indicate the boundary between migrant and immigrant as flexible.

questions arise here: do “illegal” im/migrants have human rights and if so under what circumstances? Should they have rights at all? In his examination and recapitulation of international law, Cole (2009) suggests that nation-states privy to the UN regime have discretion over whether noncitizens within their territory are owed healthcare. Quoting UN Special Rapporteur, Gabriela Rodriguez-Pizarro, Cole (2009: 73) states that the purpose of international laws and instruments such as the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights is to protect every person, which includes migrants, within the jurisdiction of a state. With the enlargement and solidification of the European Union, member states have increasingly signed on to international agreements, such as the Geneva Convention and the International Covenant on Economic, Social and Cultural Rights that have their fundamental bases in liberal values such as respect for human rights. As a member of the EU, Italy has declared itself to be part of this international human rights paradigm. Respect for human rights has stood as representative of “modern” liberal civic-oriented democratic countries. However, characterized by what Triandafilopoulos (2011) has termed a “new civic aggressive integrationism,” the desire for nation-states to protect and uphold certain liberal values often results in illiberal policies.

In anthropology, Goodale (2009) identifies three ways anthropologists approach human rights. The first is through a contribution to “emancipatory cultural politics.” The second is by converting the practice of human rights into a topic for ethnographic research. Third, through critical scholarship that synthesizes the first two approaches. Writing about ethnographic research, Goodale (2009: 37) states:

This research and analysis, which were made possible by the rapid rise in human rights talk and institutional development since the early 1990s, both documented the contradictions and contingencies that surround the practice of human rights and led to the creation of a cross-cultural database on the meaning of human rights.

The right to health and the provision of healthcare is particularly intriguing in the Italian context. Certain rights are outlined in the Italian constitution pertaining to all people residing within Italian borders, regardless of legal status and without discrimination. Under Article 32 of the Italian Constitution it is stated that health is a fundamental right.² This legislation ostensibly indicates that all people are provided care and are seen as equally deserving of healthcare services. However, “deservingness” is fundamentally based in notions concerning morality and morals that are rarely straightforward (Willen 2012). Although provision of healthcare is outlined in both the federal constitution and in the Legislative Decree (No. 286 of 25 July 1998), health services are regionally based establishments. Given this situation, there is a certain degree of arbitrariness in the ways the laws are translated into practice in each region, province, and city by local health units or by authorities (Azienda Unita Sanitaria Locale, AUSL). While the right to health is arguably a positive liberal concept and value it has emerged in a time when many liberal values are being used to defend illiberal policies that promote aggressive integrationism.

This thesis seeks to examine the intersections of race, gender, migration and health in the Italian context. I argue that despite the legal framework that outlines a provision of healthcare for all people residing in Italy, healthcare is in fact inconsistent and not egalitarian for im/migrants when compared with the care and moral understandings of deservingness the “native” Italian population receives. There is a lack of comprehensive treatment (*cura totale*) where medical services apply to all people regardless of race, gender or legal status. Although this could be a utopian standard to achieve in practice, on paper this is how the legal healthcare framework in Italy reads. The right to health is often confronted by seemingly contradictory ideas and rhetorics of exclusion. These rhetorics of exclusion extend to exclusionary policies that create what has

² Art. 32 The Republic safeguards right to health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent (The Constitution of the Italian Republic)

been termed “new aggressive civic integrationism” (Triadafilopoulos 2011). While a commitment to the right to health represents a positive liberal value, this new integrationism based on a commitment to liberal values may in fact undo this positive step toward integration and erasure of inequality. In Italy, while illegal im/migrants enjoy legitimacy via their biological life they have yet to be fully accepted into the Italian moral and social community.

The legal framework for providing healthcare in Italy has previously been described as “humanitarian” as opposed to the “utilitarian” approaches of countries such as the Netherlands, Belgium and Germany (Willen, Mulligan and Castaneda 2011).³ Scholars have debated whether healthcare should be a right, what this means and whether healthcare should be provided to all people regardless of their legal status or insurance coverage in countries ranging from within Europe to Israel (Willen et al. 2011; Romero-Ortuno 2004). Fieldwork was undertaken in various medical clinics in two cities of northern Italy and interviews were conducted with many medical staff and practitioners including two doctors, one health authority and one mediator. It may seem that the right to health, and by extension healthcare, stands to combat large disparities in the general health of the whole population residing in Italy; however, this is not always the outcome. In the setting of the clinic, the suffering body of the im/migrant is recognized and legitimized. But outside of this setting, apart from their biolegitimacy, illegal im/migrants are often socially illegitimate subjects via their racialized bodies.⁴ This dichotomy illuminates the complex and sometimes paradoxical nature of right to health in the Italian context where better coverage and

³ “Utilitarian” refers to the social health insurance systems found in countries such as the Netherlands, Belgium and Germany where medical services are provided on a fee-for-service basis and proof of insurance is needed to access services. “Humanitarian” refers to the tax-based health care systems in countries such as Spain, Italy and the United Kingdom that provide medical services to a wider range of people residing in the country.

⁴ The power *of* life is “biolegitimacy,” which Fassin suggests characterizes contemporary societies more than the power *over* life, “biopower” in the Foucauldian sense, although the concept derives from an examination of Foucault’s work (Fassin 2009).

accessibility to healthcare has been described as “humanitarian” compared to many countries in the world (Romero-Ortuno 2004).

In this thesis, I draw on theories about race, moral economies and biolegitimacy, “Fortress Europe” and “illegality.” Subsequently, I review how the right to health, which seems straightforward and clear is often “messy” and complex both discursively and also in practice (Willen et al. 2011). After providing a theoretical background, I then elaborate on my methods and fieldwork followed by a background of im/migration and integration policies in Italy.⁵ Finally, I provide perspectives from four medical personnel.

While this thesis critically analyzes dynamics of race and inequality that exist in Italy, I do not wish to erase the good intentions of many of the people I worked with and met during my research. These medical staff and practitioners are hard-working and committed individuals, working often as volunteers. My analysis is intended to foreground the complexity of the situation surrounding healthcare as it pertains to various groups of people in order to hopefully inform understandings about the quality of care. Additionally, my hope is that the analysis provided in this thesis will further clarify some of the complex issues about the right to health in a broader context.

1.2 Emilia Romagna: Gastronomic Treasures and High Im/migration

According to the Italian Constitution, as previously noted, certain rights pertain to all people residing within Italian borders, regardless of legal status. However, although provision of healthcare is outlined in both the federal constitution and in the Legislative Decree No. 286 of 25 July 1998, health services are regionally based establishments. Although the legal framework for the provision of healthcare to all persons living in Italy exists, the manner in which it is implemented and whether it is implemented at all varies from region to region and even city to

⁵ Fieldwork and methods will be discussed in greater detail in chapter three.

city. This variation was apparent between the cities of Modena and Reggio Emilia. I was told that although geographically close, there are some substantive differences, including the variety of healthcare services and even the behavior and local attitudes of the Italian populations.

The region of Emilia Romagna, in which Modena and Reggio Emilia are located, has over four million inhabitants and is located in the northern part of Italy. The capital city of the region is Bologna. The region is widely known for automotive industries such as Ferrari and gastronomic treasures such as prosciutto and parmigiano reggiano. The University of Bologna as well as the University of Modena- Reggio Emilia are two of the oldest universities in the world. Demographically residents in Modena number about 184,000 and in Reggio Emilia 169,000. Im/migrants comprise about 12.7% of the population of Modena and 13% of Reggio Emilia (Fanfani and Pieri 2010). However, these estimates do not include “illegal” im/migrants for which estimates tend to be quite speculative. Given that the numbers of im/migrants are generally higher in these two cities than compared to the national average of 7.5% and that many im/migrants often move via social networks creating chain migrations, it can be inferred that the number of “illegal” im/migrants is similar to their im/migrant counterpart number in these two cities (Freeman 1995). Immigration is quite high in this region due to the successful industrial economy, specifically the mechanical industry, which provides many jobs, at least initially, for many im/migrants. However, this may not represent all “illegal” im/migrant populations who migrate for economically independent purposes or who flee countries looking for asylum in Italy. Aside from these demographic data, both cities provide healthcare to im/migrants, including “illegal” im/migrants; yet, they serve their diverse populations in different ways.

“Illegal” is one of many terms such as “undocumented”, “unauthorized”, or “irregular” used as a label for people who occupy a particular legal status with respect to immigration laws.

Since in Italy often physicians used the term *irregolare* I will use the term irregular along with others. However, I also use illegal in scare quotes as this has been used by other authors to denaturalize and designate “illegality” as a construction for analysis (De Genova 2002; Willen 2007). *Clandestino* is also often used meaning clandestine but it has more negative connotations. These terms are often found in the media, used by authority figures such as physicians as well as by the general public. The official term used in the legislation of the recent law (94/09) is “cittadini di Paesi non appartenenti all’Unione europea e gli apolidi” and “straniero” which translates to “citizens of countries that are not part of the European Union and stateless peoples” and “foreigner”. On official websites such as the European Commission, terms such as “third-country nationals” are used.

“Illegal” im/migrants are a diverse population coming from various places, to a “host” country for various reasons. With them they also bring their diverse languages and sociocultural beliefs and practices. In Italy, a minimum standard of care is outlined at the national level but policy is enforced at the local and regional levels creating diversity and disparity between different regions of Italy. I will examine some of these differences and disparities with respect to the kinds of services each city provides. While it is clear that some regions, such as Emilia Romagna provide care to “illegal” im/migrants, this might not be the case in other regions. Within Emilia Romagna there are differences between clinics such as general visibility of the clinics in each city, number of staff and hours of operation. The following section will provide a theoretical framework for the thesis.

2. THEORETICAL FRAMEWORK: RACE, THE BODY AND MORALS

2.1 Fortress Europe, Race and “Illegality”

With the creation of the European Union, researchers have identified what they call the formation of “Fortress Europe,” sometimes also referred to simply as “New Europe.” Fortress Europe refers to those legal policies recognizing certain people as within and included in Europe but additionally it is a concept that refers to ideological constructions of inclusion and exclusion allegedly based on difference: cultural and racial (King, Lazaridis and Tsardanidēs 2000; Stolke 1995; Shore 2000). Via a market driven analysis, Favell and Hansen (2002) argue that Fortress Europe is an insufficient metaphor for understanding the control of borders in the EU and migration in Europe generally. The authors suggest that the Fortress is in fact breachable because of market labor needs, but they also note that: “for asylum, the image and argument of fortress Europe are correct about the aims but wrong about the outcomes” (Favell and Hansen 2002: 582). These aims have crucial impacts which Favell and Hansen do not address. While these authors argue that EU countries are now pro-im/migration and have moved away from their years of zero-im/migration, they do not precisely define what a pro-im/migration policy is, nor do they consider whether there is a type of im/migrant that is preferred, namely either one from an approved country of origin or a silent, non-disruptive economic laborer. Keeping in mind that Favell and Hansen use a market-focused analysis and that their examination is pre-September 11, 2001, it seems their conclusions overlook certain crucial considerations. Fortress Europe is a metaphor for more than the permeability of the border for all types of im/migrants, including economic and asylum seekers. It is an ideological platform of exclusion for those who become the scapegoats for the socioeconomic problems of Europe. “Illegal” im/migrants are legally excluded via progressively more restrictive laws leading to more policing of the borders and within borders that contain Fortress Europe. Paradoxically, with the creation of the European

Union, boundaries have become more porous among EU countries. Through national Italian laws and international EU laws, “illegal” im/migrants are more and more excluded from and pushed out of Fortress Europe and are thus politically not recognized as belonging to the social community.

“Illegal” im/migrants are often discursively excluded from the social community. Ideologies of cultural difference justify what has been called a “cultural politics of race” (Angel-Ajani 2000). Recently, scholars have identified a “new racism” variously called a “cultural politics of race” or even simply “cultural racism” that is based less on biology, yet produces similar discriminatory effects (Barker 1981; Angel-Ajani 2000; Pojmann 2006). Stolcke (1995) astutely points out some of the differences between biological racism and what she identified as “cultural fundamentalism.” While these differences are important, cultural fundamentalism and biological racism also share similar outcomes such as exclusion and inequality that can be derived from what I and past authors have called cultural racism. Angel-Ajani (2000) suggests that the increase in policing of borders and restrictive laws about im/migration in Italy creates state-sanctioned discourses that criminalize certain im/migrant groups, especially those from Africa. She explains how certain im/migrant groups, especially those people from Morocco, Nigeria, Ghana, Senegal, and Tunisia, face perceptions of criminality from the Italian community despite the fact that only two percent of the im/migrant population is incarcerated, typically for improper documentation. In her article, Angel-Ajani (2000) further examines how anti-im/migration sentiments, racist brutality and violence towards im/migrants have resulted in constructing more controls on im/migration and limiting the rights of im/migrants. Racist attitudes are now justified and “naturalized” as cultural difference. While discursively, terms directly relating to skin color such as *nero/neri*, (meaning black or black people), are not often

used, other terms exist in the social lexicon and popular culture implying generalizations about im/migrant groups and exclusionary attitudes based on difference. *Extracomunitari*, a term literally meaning “outside the community,” is often used in reference to Eastern Europeans, Asians, Africans and Latin Americans but is not typically used for people of North American or Western European origin. Another popular term is *marocchini*, literally meaning a Moroccan person. But this term may also be used to signify all persons of color. “*Vu’ cumpra,*” is a derogatory term for African street vendors that mocks their mispronunciation of the standard Italian way to say “do you want to buy?” or *vuoi/vuole comprare?* (Merrill 2006; Angel-Ajani 2000). These terms contribute to the way im/migrants are discursively excluded from the social community under the façade of cultural difference masking racist attitudes.

A rich literature exists examining the social construction of “illegality,” including “illegal” im/migrants’ position in a hierarchical structure of inequality. Willen, Mulligan and Castaneda (2011) suggest that “illegality” becomes embodied contributing to notions of exclusion and “undeservingness” that exacerbate to im/migrants’ adverse health risks. “Illegality” is a politically and legally constructed term applied to groups of people signifying their relationship to the law and ideologically signifying boundaries of inclusion and exclusion. There is nothing natural or biological about “illegality,” yet, subjectively it can interact syndemically with race and gender to exacerbate exposure to illness and violence (Singer 2009).⁶ “Illegal” im/migrants are characterized as economic im/migrants whose “choices” to im/migrate for economic reasons are often entrenched in global political-economic imbalances. They often

⁶ Defined in the field of public health, syndemics is an approach to thinking about disease that goes beyond the biomedical. This approach examines the interactions of the sociopolitical structures and the surrounding physical and social environment that contribute to the health of a community. “Illegality” can interact with other socioeconomic, structural inequalities producing low health outcomes (Singer 2009).

work in dangerous and demeaning sites within local labor markets (Willen et al 2011; Quesada, Hart and Bourgois 2011).

Many im/migrants who came to the clinic in Modena had sustained work-related injuries. Since they are not “officially” or legally workers for a company, they are not covered by any insurance and cannot choose a primary physician. Thus, one of their first recourses is to come to the NGO clinic. Larchanche (2012) examines how “illegal” im/migrants’ access to healthcare may minimize their sense of entitlements to rights, influencing how they think about their own moral assessment of “deservingness.” While there is research examining the embodiment of health risks associated with “illegality” from an epidemiological perspective, there are few studies regarding embodied “illegality” as lived experience, an approach which usually defines much work in medical anthropology. Similar to other subjective dimensions such as race, “illegality” works to exclude im/migrants from the social community and contributes to human rights violations by exacerbating vulnerabilities to adverse health risks.

2.2 Right to Health and “Deservingness”

“Deservingness” has been debated and theorized in the realms of bioethics and by physicians in various medical fields but has been given relatively little attention by social scientists. Willen (2012) qualifies “deservingness” as relating to vernacular assessments of moral worth that are distinct from assertions of entitlements which are anchored in formal legal rights or policy commitments. As Sargent (2012) points out, “popular and political understandings of immigrant ‘deservingness’ shape and reflect formal policies and legal ‘entitlements’.” Imbedded in this analysis of health, healthcare and “deservingness” is the idea of healthcare as a human right versus healthcare as a commodity (Castro and Singer 2004). In a compelling article about healthcare in France -- which has been praised for being inclusive and progressive, Larchanche (2012) identifies the intangible factors of social stigmatization and a climate of fear and

suspicion as having powerful “subjectivation” effects which influences how both “illegal” im/migrants and health providers think about “deservingness.” Similar to France, the legal framework for providing healthcare in Italy has been described as “humanitarian” in contrast to the “utilitarian” approach to healthcare systems evidenced in countries such as the Netherlands, Belgium and Germany (Romero-Ortuno 2004). In Italy, as with France, certain intangible factors amounting to social exclusion legally, economically and discursively may also result in “subjectivation” effects. In her study of an NGO in Tel Aviv, Willen (2011) identifies multiple understandings of right to health, including a rights-based interpretation and a humanitarian interpretation. Interestingly, while physicians in Modena and Reggio Emilia proudly pointed out to me the inclusion of “illegal” immigrants in the legal framework they were fairly ambiguous as to their personal stance regarding right to health. While they were less likely to commit themselves to a rights-based political and legal interpretation, physicians were more willing to subscribe to a humanitarian stance which allowed them to remain in the “Hippocratic bubble” separate from politics and law (Portes, Light and Fernandez-Kelly 2009: 495).

2.3 Moral Economies and “Biolegitimacy”

An ethnographic inquiry into the right to health invariably invokes difficult questions. Whether or not a certain population is included and seen as part of the moral community, questions about “deservingness” and which rights are protected, are all moral issues. Whether human rights have a moral basis and are universal or not, is also a moral question. For as much as human rights might be intended to be universal and inalienable, indivisible, interdependent and interrelated, they are in fact only recognized in some ways and in some places. Many countries do not prescribe to the international human rights paradigm. This thesis is thus a contribution to medical anthropology as well as to what Fassin has called a “moral anthropology” (Fassin 2008). Moral anthropology does not define the moral obligations of the

anthropologist but rather attends to a ‘science of morals;’ an anthropology whose object of study and investigation is morals (Fassin 2008).⁷ This inquiry into the right to health is culturally, temporally and historically specific. Theoretically, I ground my discussion within the concept of moral economies. Fassin (2004) maps out the history of the concept of moral economy starting with its inception by E.P. Thompson (1971) who explains it as the social norms and obligations understood by a particular community, for the proper economic functions of various parties in the community.⁸ More recently anthropologists have expanded on this definition to refer to “the economy of the moral values and norms of a given group in a given moment” (Fassin 2005: 265). Designating moral economies in the plural recognizes that norms and values are contested and dynamic, and that the moral economy may change over time as it is context dependent. In my examination of the moral economy surrounding healthcare in Italy, I discuss: the rationale behind the provision of healthcare, values and moral assumptions which guide ideas about health; who is seen as deserving; and how health and the right to health is socially understood from the perspective of health practitioners in Italy. Laws such as Turco-Napolitano (recognizing healthcare for “illegal” im/migrants and provision of care for certain life-threatening diseases), can be understood as the “compassionate” side of the moral economy of im/migration policies and health. Conversely, the increased detention times implemented through the Security Set (125/08, 94/09) from a maximum of 60 to 180 days may be understood, in Fassin’s terms (2005), as the “repressive” side of the moral economy of im/migration policies.

According to Fassin (2004), in contrast to claims made on the basis of political oppression or in response to a demand for labor, illness has now become the basis of claims for “illegal” im/migrants whose rights are legitimized in the name of the suffering body.

⁷ Nietzsche, Friedrich (1989 [1886]) *Beyond Good and Evil: Prelude to a Philosophy of the Future* (trans. Helen Zimmern). New York: Prometheus Books.

⁸ In Thompson’s example it was the British poor.

Referencing the economic boom in Europe, Fassin (2005: 372) writes, “A few decades ago, this body was legitimate for economic reasons and disease would be suspect. I suggest that the situation is reversed now.” His compelling examination of the moral economy of im/migration policies in France show how legal definitions are socially reckoned and how individuals become legitimate under the scope of the state depending on the historical time period, economic activity and the political position of the host country. Similar to France, Italy has an “illness clause” whereby a person can obtain legal status, remain in the country and receive care if they have a life-threatening illness for which they likely cannot obtain care in their country of origin. This process of legitimization based on life as such is called “biolegitimacy”.

Whereas Foucault theorized “biopower” as an expression of the state, as power over life, Fassin uses “biolegitimacy” to refer to the power of life and the unequal politics associated with the sanction of valid life. He qualifies life not as bound by its biological definition but in its multiple senses including social, moral and political life. Biolegitimacy becomes crucial in understanding moral economies because life is now not just about the governmentality of populations or biopower, but is also imbued with meaning and value. For example Fassin (2009) argues that Augusto Pinochet, Maurice Papon and Heina Barth were not seriously punished because they claimed to be too ill to sustain punishment. For these dictators and war criminals their supposedly threatened legitimacy of life overruled the assessment of their political life. This withholding of punishment was accepted on “humanitarian grounds.” A further example of these politics is visible in the shift away from the legitimacy of the “refugee,” (now often seen as suspect), in contrast to the legitimacy of the “sick,” who gain legitimacy and legal status for having a life-threatening disease for which they cannot receive medical care in their country of origin. More recently, Bessire (2012) has examined the politics of voluntary isolation wherein

“isolated” peoples are seen as a new “valid” category of indigeneity following the renewed or recent biolegitimacy of certain indigenous groups. Castaneda (2013) also utilizes biolegitimacy in her discussion about medical aid as a form of protest in Germany where she identified a “hierarchy of aid work.” In her study, refugees and victims of torture were recognized by physicians as more legitimate migrants, as more deserving compared to rejected asylum seekers and economic migrants. This hierarchy of aid stands as an example of differentiated biolegitimacy.

As previously stated, moral economies have the capacity to change. Fassin (2004) describes the moral economy of immigration policies in France as alternating between repression and compassion. In Italy, “illegal” im/migrants are generally recognized within the healthcare system, albeit in a limited fashion that is indicative of the moral economy surrounding health in Italy. “Illegal” im/migrants can access care in hospitals and specialized clinics but the Caritas clinics are the only official medical facility for primary care. The Caritas clinics are humanitarian aid organizations created by the Roman Catholic Church and are located in various places across Europe. At this historical moment in Italy, the moral economy of health regarding “illegal” im/migrants, seems to be one of reluctant compassion. I say ‘reluctant’ because the general approaches concerning “illegal,” foreign im/migrants are characterized by restrictive legislation and less tolerance for these groups. Physicians I spoke with often offered humanitarian reasons for providing healthcare and concern for the general Italian public. I maintain that the moral economy is compassionate in that “illegal” im/migrants are not turned away by physicians. They legally retain a right to health. But this legal right to health becomes contested as Larchanche (2012: 859) states, “legitimate access to healthcare on the basis of universal rights, however, has been put to the test by the socially constructed illegitimacy of undocumented migrants as a

group.” Once again, it is within the social context that im/migrants endure arbitrary interpretations of “humanness,” this affects their right to health and subjects them to perceptions that determine whether they deserve to be treated or not. Fassin (2004) explains this in reference to the French context, where, in times of economic depression when im/migrant labor is no longer needed they also become socially undesirable. Their loss of residence permits and legal status logically lead to a loss of legitimacy. Im/migrants often partially internalize their social position and feel they have no right to complain or make demands. Fassin also criticizes healthcare as only a small remedy to the generally poor health experienced by “illegal” im/migrants. Health disparities exist due to poor living conditions. Access to healthcare has only a limited effect on overall health and is not “constructed as a tool at the service of social justice” (Fassin 2004: 212). Because of their social illegitimacy, “illegal” im/migrants’ right to health is often contested and so, the moral economy is both compassionate and reluctantly compassionate. In the following chapter I outline my methodology and discuss my fieldwork for this study. Ethnographic descriptions of context for the interviews and details about the clinics will be addressed in chapter five.

3. RESEARCH CONTEXT, SETTINGS AND METHODS: FROM CLINIC TO CLINIC

My family is from the southern region of Calabria, Italy. I hold both American and Italian citizenship and have also been back and forth to Italy for the past ten years, mostly during the summer. Although not a researcher during this time, I was able to grasp the Italian language and attain some understanding of the culture, economy and politics. I already knew a few professors from the University of Modena-Reggio Emilia and I had spent some time in the region of Emilia Romagna. I also knew that im/migration, and likely “illegal” im/migration, tended to be higher in this region. For these reasons, I located my research here.

I conducted my fieldwork with support from the University of Modena-Reggio Emilia (UNIMORE). The university provided me with office space and I worked closely with a researcher and project manager from the Centro Universitario di Servizi Per la Cooperazione allo Sviluppo (CUSCOS). The director of the center, a professor of the university in the faculty of medicine helped me to gain access to the community and initial contact with physicians. I was in Modena and Reggio Emilia doing fieldwork during the summer, between the months of June and August 2013.

Recently, Willen (2012) has called for anthropologists to not simply rally behind the right to health, but to take the right to health as a subject of ethnographic study. Ethnographic studies of right to health often involve conducting research in a manner described by Laura Nader (1972) as “studying up.” I conducted my research with medical personnel and im/migrants in the waiting rooms and examination rooms of various clinics in both the cities of Modena and Reggio Emilia as well as the offices of the local health authorities in Reggio Emilia. I visited clinics that were staffed mainly by volunteers and supported often in part by Caritas. In studying right to health, it is important to examine both the perceptions and perspectives of those who are in

positions of power as well as those more commonly defined and understood, especially by the state, as “powerless.”⁹

Because of the ways their experiences are racialized in Italy, I focused my research on the problems surrounding healthcare for people im/migrating from Africa. I consciously chose to converse with im/migrants from central or West African countries such as Cameroon, Nigeria, and Ghana as these participants were also more likely to speak English. Many African im/migrants speak either English or French. Other languages I encountered included French, Romanian, Russian, and Chinese as well as local languages of origin. Many of the im/migrants I met spoke a local language from their country of origin first, then English and then Italian. For logistical reasons I was not able to interview people who spoke these other languages or had minimal working knowledge of Italian.

I have not included any im/migrants’ perspectives directly for ethical purposes and to maintain their privacy. Additionally, I did not feel I had collected a broad enough sample to accurately portray of their situations. I had a few informal conversations with im/migrants and I was unsure whether or not they understood clearly the implications of the research I was conducting. To include their perspectives, I needed more time to form solid research relationships with them. “Illegal” im/migrants’ voices are an undeniable component of research on right to health in Italy, but to understand the broader societal systems and institutional attitudes about health and im/migrants, it was imperative to also speak with and interview health authorities and physicians.

Although I had initially wanted to conduct interviews with “illegal” immigrants, I did not manage to do so, as previously mentioned. I had brief conversations but no formal interviews. I

⁹ When I say powerless it is not to say that “illegal” im/migrants have no agency just that they occupy a position that from the state’s point of view is one of subordination.

found “illegal” immigrants were understandably hesitant to spend any more time at a clinic talking to doctors or me than necessary. I needed more time to foster relationships if I was going to have a chance at a more complete interview. Formal interviews probably would not have happened regardless, as I found out quickly I did not feel comfortable recording interviews with people classified as “illegal” im/migrants due to their vulnerable legal status. Im/migrants whom I did interview were working at the clinics and held regular status at the time. I spoke with these people during off work hours, in quiet offices or private areas with no one else around. I found that privacy was needed given that im/migrants often shared their feelings about living in Italy and about the Italian population.

I engaged in participant observation in waiting rooms, observed doctor-patient interactions, conversed with various individuals of the general public and conducted semi-structured interviews with various medical professionals and personnel. I conducted most of my interviews with medical staff, practitioners and im/migrants in English, although I did one interview in Italian with the aid of an interpreter and one where the questions were in English and my respondent used Italian. Although the interviews were mainly in English, I was open to responses in Italian when there was a word or phrase that they did not feel they could relate accurately in English. All translations are my own, but most quotes were spoken in English by the respondent. I have made minor adjustments to grammar but have also tried to retain as much of the integrity and meaning of the original words as possible. I was flexible as to where to conduct the interviews although most doctors chose to do them during work hours in their office and just before or after work hours in the clinic.

I presented myself as an anthropology student coming from Canada who wished to conduct interviews for the purpose of her MA thesis work. Maybe the fact that I was from a

Canadian institution helped me gain access, but I also had approval from a well-known and respected doctor within the fairly small city of Modena. Methodologically, Laura Nader highlights the need for flexibility and eclecticism when “studying up.” She recommends using various forms of interviewing (formal/informal, face to face or telephone), and analyzing a variety of documents instead of participation when becoming a member of large-scale institutions would not truly apply. However, I did to engage in informal conversations with people in waiting rooms and I was allowed to sit-in on discussions between doctors and patients.

In situations where doctors conversed with patients there was often a weak standard of ethical consent to collect data about those discussions. I fear sometimes there was confusion from some patients who I later found out thought that I was a medical doctor. I did clarify this in further conversations. I seek to maintain the privacy of all patients and so I do not include any specific information where I was not given voluntary consent. As I am not a trained physician, I do not comment on the care given to patients directly but I do note the general environment within which discussions took place between doctor and patients and when I participated in conversations with doctors. I also attended some events that were geared toward multi-ethnic audiences and noted the general attendance and content provided to the public at these events. To inform my research beyond what I was able to collect firsthand, I also examined documents including media news reports, popular representations, brochures produced by clinics or the city, and legal materials.

Some of my original research questions included: How is right to health understood in the Italian context? What types of services support the notion of a right to health in Italy? In Italy, where healthcare is largely accessible to “illegal” im/migrants (or at least there exists a framework allowing this access), do medical practitioners and health authorities feel im/migrants

“deserve” healthcare services and have a right to health? My data include fieldnotes which I usually hand wrote during the day as I was at clinics and then typed up on my computer every night. I conducted eight recorded interviews and approximately ten informal interviews that I did not record. I transcribed the interviews with medical personnel and I also collected photographs of the clinics. I adopted a snowball approach to navigate my way through the medical terrain of Modena, proceeding from one doctor to another via recommendations by doctors, scholars and health authorities. This led me to Reggio Emilia, located approximately 35 kilometers away, as a scholar from the UNIMORE had informed me that the health officials there were very happy and willing to have researchers. I understood why when I arrived at their clinics -- they had impressive facilities that included several doctors with different specialties and often mediators as well.¹⁰

In this thesis, all names of physicians and health authorities are pseudonyms. Although medical practitioners are in positions of power and authority some of them in fact, did relate controversial opinions to me. I informed them that all information would be kept confidential and to the best of my abilities, their identities are anonymous. Before providing perspectives from medical personnel in chapter five, I provide some general information about Italy’s im/migration and integration history.

¹⁰ Mediators are organized by social service cooperatives in the cities and act as intermediaries between doctors and patients. They are by definition, cultural mediators, and not solely translators. This will be explained further in the next section.

4. GENERAL BACKGROUND

4.1 *Im/migration and Integration in Italy*

Italy became known as a receiving country in the 1980s, and the first comprehensive legislation about im/migration was established in 1990 with Martelli Law. Previously, Italy was characterized as a country of emigration. It is estimated that millions of Italians were leaving shortly after unification of the country, between 1876 and 1976, and after World War II to North and South America (Pojmann 2006: 20). Furthermore, during the 1960s with the economic boom, the term “im/migrant” was used even to define southern Italians who migrated north (Merrill 2011; Angel-Ajani 2000).

Rather than being created out of consolidation and simplification, Italian im/migration legislation builds upon previous laws resulting in rather wordy, complex laws. In 1998 with the Turco-Napolitano Law, legislation regarding im/migrants became even more restrictive.¹¹ This law also set up the first detention centers in Italy originally called *centri di permanenza temporanea* (Temporary Detention Centers-CPT), and now known as *centro di identificazione ed espulsione* (Center for Identification and Deportation-CIE).¹² These centers have received national and international criticism from organizations and some politicians for the way they treat detainees, some of whom are asylum seekers. Andrijasevic (2009) has criticized the Italian state and the EU for lack of transparency, accountability and legitimacy regarding policies and available data about the detention and deportations of irregular migrants. In her article she also notes that NGOs that have taken legal action asserting the Italian Government is in violation of

¹¹ Following the general migration stop of 1973-74 of European states, Italy's Martelli law, although a bit late as it came into law in 1990, was an attempt to terminate immigration yet also recognize those working in the informal economy by regularizing their status (Favell and Hansen 2002, Merrill 2006). It also set quotas and established different types of entry visas. Turco-Napolitano Law aimed at making “illegal” entry more difficult and repatriations more effective by establishing complex detention and deportation policies.

¹² CPT became known as CIE with the onset of the Security Set (125/08, 94/09)

the right of defense and of all parties to be heard as well as violations prohibiting torture and inhumane or degrading treatment. Despite the Italian Government's official denial of any human rights violations taking place on the island of Lampedusa, a main entry point for many im/migrants, the European Parliament and United Nations' Human Rights Committee have conveyed disapproval about the conditions of detention there (Andrijasevic 2009).

While restrictive, the Turco-Napolitano Law extended access to services such as emergency healthcare for both documented and undocumented im/migrants. Im/migrants may also obtain regular status for life-threatening illnesses for which they cannot receive treatment in their country of origin. By 2002, the most restrictive law pertaining to im/migration called Bossi-Fini Law was passed. Established under the right-wing government of Berlusconi, this law directly ties legal status to employment, such that if an im/migrant's work is terminated they become "irregular" and "illegal," lose their access to certain services, and may consequently be deported or detained in the CIE. Given that the current system of employment in Italy makes it difficult for even Italian citizens to find permanent work, it is exponentially difficult for im/migrants. Furthermore, the possible loss of work shifts their legal status to the precarious boundary between "legal" and "illegal." Bossi-Fini Law focused primarily on "illegal" im/migrants, restricted legal entry, further restricted family reunification and reduced the budget for integration.¹³ By 2009, the Security Set (125/08, 94/09) *pacchetto sicurezza* formally established "illegal" im/migration as a crime. The set also included a clause about the responsibility of medical personnel to report instances where "illegal" im/migrants access healthcare. Although this amendment passed, due to high opposition, the part establishing who it refers to and when the law had to be enforced was not agreed upon. Physicians vehemently protested the law, and indeed during my fieldwork, I never encountered an instance nor did I

¹³ Only spouses and children under 18 are able to join family members in Italy

hear of medical personnel ever denouncing any “illegal” im/migrants. While physicians were well aware of the Security Set -- and in practice they did not denounce any “illegal” im/migrants -- they also often gave me conflicting information about its exact nature and contents.

Integration often refers to either the economic or sociopolitical inclusion of im/migrants. Integration also has to be analyzed at both the nation-state level and broader EU level given that being a member state implies that competency and jurisdiction about certain issues alternates between these two levels. Guild (2006: 631) states that “at the heart of the EU there is and has always been an ambition and duty to reconfigure the territory of the Member States in order to achieve economic aims.” This economic, market-based logic for integration implies that the European labor market dictates supply and demand for labor and can draw upon labor from within the EU and beyond (Favell and Hansen 2002). While at the EU level integration is understood through economic principles, there is also the sociopolitical integration in Italy to consider and this has often been understood via conceptions of citizenship and juridical status.

It would seem that even if economic integration is more or less achieved, sociopolitical integration may lag behind substantially.¹⁴ Similar to countries such as Greece, Italy’s reaction to the integration of “illegal” im/migrants already in the country involved the implementation of regularization schemes in the years of 1986, 1990, and 1996.¹⁵ However, Triandafyllidou (2000) identifies these regularization schemes as only temporary solutions to the problem of integration in Italy. It is unclear whether Italy’s national identity, which is closely connected to ideas of inclusion and integration, is derived more from a civic tradition or an ethnic, nationhood

¹⁴ Implying that market needs for labor are met and integration of im/migrants from an economic and labor perspective are achieved including outlining and enforcing labor rights and regulations for non-European laborers. These stipulations are for the legal economy and legal im/migrants, leaving out an entire discussion about the informal, underground economy and im/migrants that work in that system.

¹⁵ Regularization schemes or amnesties are for those “illegal”/irregular im/migrants already working and living in Italy who meet certain requirements in order to gain a residency permit and regularize their status.

tradition. Civic traditions of Italy highlight the particular political and legal structures that define the territory that emerged shortly after, and in relation to the unification of the country (Triandafyllidou 2000). The ethnic, nationhood tradition is characteristic of countries where citizenship is based on descent (*jus sanguinis*), which is the case for Italy today, as opposed to being based on birthplace (*jus soli*) which has been interpreted as a more “liberal” and civic oriented tradition (Stolcke 1995; Brubaker 1992). In terms of funding allocated to integration, according to the European Commission (EC) Italy received approximately 78 million euros dedicated to the integration fund and 22 million euros to the refugee fund. These two funds are overseen by the Ministero dell’Interno (Italian Ministry of Interior). According to the EC both funds include programs and goals regarding integration of third-country nationals or non-European nationals. In Italy for example, programs such as “Beyond Vulnerability 2” exist for vulnerable asylum seekers to receive help with social and economic integration in Italy. In other countries, programs which introduce intercultural mediators into hospitals are considered worthy of receiving funding from the EC. However, from a funding perspective, it is not clear what “integration” specifically refers to and how funds are allocated to which programs.¹⁶ According to MIPEX (Migration Integration Policy Index), integration is measured through data points such as family reunion eligibility, anti-discrimination laws, long-term residence and education. This broader conception of integration includes legislation concerning legal status and extends to social issues such as education.

Aside from the criteria of citizenship, human rights (which often form another basis for inclusion of im/migrants at various levels from political to medical arenas), were not part of the original schema of the EU. In the wake of EU enlargement, member states are grappling with

¹⁶ All information was taken from the European Commission website and Ministero dell’Interno government website of Italy.

how to manage issues such as asylum and refugee policies (Guild 2006). Respect for human rights has become a liberal value, a pillar of liberal-democratic states. Other “liberal values” include upholding women’s rights and minimizing religious attire. But it has been argued that policies aimed at protecting these liberal values in fact conceal the exclusion of certain groups, specifically, Muslim peoples. While many European countries have renounced multiculturalism as an approach, in taking a more aggressive civic approach to integration, Italy is caught between the French approach of republican assimilation and British communitarian multiculturalism (Triandafyllidou 2006). However, Triandafyllidou states that policies supporting liberal multiculturalism have been in decline since 2001 and the onset of the Berlusconi government. Triadafilopoulos (2011) further argues that the new aggressive, civic integrationism which is based on respect for liberal values and is characteristic of many European countries is likely to aggravate the problems it desires to alleviate. Thus, the goal for societal homogeneity of this new integrationism, while ostensibly based on liberal values, is a poor approach to integration. While the right to health is likely one of the less controversial liberal values that states such as Italy uphold, other values associated with aggressive civic integrationism stand to reverse this positive step with more exclusionary policies.

5. TREATMENT OF IM/MIGRANTS AND “DESERVINGNESS”:

ACCOUNTS BY MEDICAL STAFF AND PRACTITIONERS

This section is comprised of various accounts from medical practitioners and staff working in the healthcare system and clinics of Modena and Reggio Emilia. I present diverse perspectives and themes that emerge from each narrative, revealing the different understandings of right to health. The provision of healthcare for “illegal” im/migrants in Italy positions it legally amongst the liberal and progressive nations of Europe. However, the manner in which this legal framework translates into practice is controlled by each province’s local health offices and thus the translation into practice is variable by province and region. Accordingly, between the cities of Modena and Reggio Emilia I found a diverse range of offered services, means of promotion and visibility of the clinics. All the clinics in these two cities offer services to the culturally and linguistically diverse populations of “illegal” im/migrants who live and work there.

5.1 Reggio Emilia: Local Health Authority - “gatekeeper”

Below I sketch an outline of the clinics in Reggio Emilia that I visited and provide accounts concerning right to health from the perspectives of a local health authority, Dr. Columbo, and a “mediator”, Chiara.¹⁷ A professor at the University of Modena and Reggio Emilia invited me to interview Dr. Columbo in Reggio Emilia. The interview was held in the offices of the local authorities, a setting that was quieter than my subsequent interviews with medical personnel which often took place during the hours of operation of the clinics and in various doctor’s offices. Dr. Columbo was able to set me up with observation sessions at the clinics and this led to interviews with various staff members. The whole system from the doctors to the health authority administrators in Reggio Emilia were very helpful in regards to my work

¹⁷ These are pseudonyms as are all other names in the thesis

and this leads me to suspect the situation is quite good, maybe more comprehensive, in relation to possible situations I could encounter in other regions of Italy. Everyone seemed very proud of the services they provide to “illegal” im/migrants.

When asked about the differences in approach between clinics and cities, Dr. Columbo from Reggio Emilia responded that:

...last year [2012] we had the first regional you know training programs or stuff on these issues. So there is an attempt to address this sort of variety and disparities between the provinces... Well it's [the differences] even more evident at national level. Because the state sets sort of minimum standards of care and then it's up to the regions to do more... But the actual comparative policy is developed and enforced at the local level, regional level. So you have advantages and disadvantages. So you have very advanced regions and very, what is the opposite of advanced, very backwards...?¹⁸

Dr. Columbo was very clear that there are differences between regions concerning what and how medical services are provided to people. While there is a minimum standard set at the national level it is left to the regional authority offices to control and manage medical services and clinics. Concerning the legal framework for healthcare and the inclusion of im/migrants in the social and moral community, he further stated:

Since the beginning...we focused on the issue of providing care for undocumented migrants and since then we continue to do that. I mean it's not ideal, I mean it is a separate service but for us it's a sort of a gatekeeper to the whole system. So you enter there but your care doesn't finish there because you have the connection to Caritas, and also with the hospitals with the mainstream services.

Question by interviewer: Do you think it's important to provide care to irregular migrants?

Their long-term target is to become regular, and become regular citizens, in a host country, in this case Italy. So I think it's convenient because if you don't provide healthcare for them you will just move forward the problem... So it's better to, in our

¹⁸ Interview with health authority, Dr. Columbo, Reggio Emilia, June 17th, 2013

experience, just accept that they are here and provide for the most efficient way of providing healthcare for them.¹⁹

When asked what the reasons were and why it was important to provide care to “illegal” im/migrants, Dr. Columbo provided a number of justifications including a natural rights based justification, but also a humanitarian explanation and a public health explanation. He also interpreted im/migrants not as just temporary residents in Italy, but as possibly additional permanent residents of Italian society. His personal opinions indicate that he believes right to health is based on a natural rights justification for “illegal” im/migrants whom he already sees as potential citizens and integral participants in Italian society. Citizens in this case refer both to the legal definition granted by the nation-state and also to their participation in socioeconomic life regardless of legal status. Asserting that these “illegal” im/migrants may very likely become permanent members of the society is tantamount to asserting they are, or should be integrated in to Italian society. This stated level of inclusion was unique among all my discussions with other medical personnel. He was the only person to make such a statement. Dr. Columbo, being at the level of the health authority, this inclusivity of “illegal” im/migrants suggests their right to health based on entitlement. However, at the level of the health authority that oversees the management of the clinics, these statements are more theoretical and it is crucial to see how these notions filter down to the on the ground work in clinics. While right to health based on entitlement may be Dr. Columbo’s personal opinion and even that of the management at the higher levels, in fact he states that Italy, including its general public, some politicians and probably some medical practitioners, is far from seeing im/migrants as included in the social community. He represented this idea as follows:

¹⁹ As mentioned previously, minor adjustments to grammar have been made to quotes spoken in English by interviewees, but the content of the quote remains intact. Interview with health authority, Dr. Columbo, Reggio Emilia, June 17th, 2013.

Because migration -- immigration in Italy is quite a recent phenomenon so people are not used to living in a multicultural societies so they see the diverse, different people in a suspicious way. So they are prejudiced, they build stereotypes. This is why it is very important for what we can do in the healthcare service is to provide for training for health staff... explaining what it means to have very different population to take care of in the healthcare services.

Question by interviewer: Does the healthcare sector or the general public see irregular immigrants as part of the community, that it is important to include them?

Well no, I think we are very far from that [social inclusion of irregular migrants in the community] sill. Migrants in general- also regular ones and irregulars create an image, the general public has [an image] of irregular migrants as people connected to you know, crime or... they see irregular migrants as a problem for the city or for the society.²⁰

In these statements Dr. Columbo provides a more generalized version and understanding by the larger Italian community of “illegal” im/migrants position in society. He attributes suspicion and discrimination of “illegal” and legal im/migrants to Italy’s recent transition into a receiving country of im/migration. It is the novelty of having im/migrants present in the country that produces these negative projections. Whether this is the entire explanation, it would seem that regardless of why there is suspicion or discrimination it does indeed exist. This discrimination produces a lack of integration of im/migrants into the social community. These statements from a local health authority, Dr. Columbo, in Reggio Emilia exemplify the complex and sometimes contradictory nature of right to health and its social implications from a theoretical and legal level to practical everyday interactions.

5.2 Reggio Emilia: Mediator – “suppress and control”

In Reggio Emilia there are two clinics that cater specifically to “illegal” im/migrants and that “speak to each other”.²¹ They share records between the clinics and try to coordinate training and best practices. In the brochure for these two clinics in Reggio Emilia there is information

²⁰ Interview with health authority, Dr. Columbo, in Reggio Emilia, June 17th, 2013

²¹ Interview with local health authority, Reggio Emilia, July 17th, 2013

about the location of both clinics and hours of operation. This includes maps, telephone numbers and local buses for easy-access. The brochure is in eight different languages including English, Spanish, French and Arabic. One clinic is called Health Centre for Foreign Families (Centro per La Salute Della Famiglia Straniera) which is located quite centrally in the city, near the train station. The offices of the doctors are located in a basement area of a hospital. The waiting room seats about thirty-six people, although most of the time when it was busy at this clinic there could be up to around fifty people in the waiting room, many standing. Upon entering the waiting room, you are surrounded by doors with blue and yellow splotches and numbers on them, each door is the entrance to an examination room or hallway that leads to an examination room. General physicians as well as specialized physicians such as pediatricians, midwives and gynecologists work in the clinic. Other workers include volunteers and a few regular staff that are paid by the local health authority offices as well as cultural mediators paid by a social service cooperative.

The other clinic is called *Querce di Mamre*. Although *Querce di Mamre* was not as centrally located, it was in a fairly new building with a large waiting room that provided ample natural light and housed multiple offices for doctors of various specialties. In these offices you could also find cultural mediators however, apart from the mediators the rest of the staff were volunteers.

Researchers examining the interactions amongst patients, physicians and cultural mediators find that mediators are not only important for translation and coordination of the patient-physician dialogue but also as responders. Although not always the case, cultural mediators tend to be im/migrants themselves. As responders, cultural mediators are able to access the emotions of patients and provide understanding, support and confirmation of their

emotions. Baraldi and Gavoli (2007) suggest that cultural mediators have the capacity to promote and enhance patient involvement. As an example, the mediator, Chiara, I interviewed said:

I could translate to the doctor- “she says she has a toilet disease”- in Italian. But for a Nigerian who comes and tells you or an African or Sub-Saharan tells you she has a toilet disease she means she has *candidaitis*²². Do you understand? So she says “toilet disease.” And I will tell the doctor she says she has *candidita*. And the doctor will be like, “But I didn’t hear that, I didn’t hear her say I that.” That’s how they call candida. So in this case it is not *interpretato*. I didn’t interpret. I mediated.²³

Examples such as the one above demonstrate how useful and possibly enhancing a mediator can be in a situation between an Italian doctor and a foreign im/migrant. The facilitation, clarity and simple language communication that the mediator provides can aid in providing better care overall and reducing the disparity in *cura totale* between the native Italian population and im/migrants. Considering there are working staff paid by the social service cooperative as well as support from the state for these services (as noted by Dr. Columbo), a compassionate or humanitarian component of the moral economy of health can be discerned, recognizing “illegal” im/migrants as having a right to healthcare. However, this clinic in particular seemed to be more indicative of a commitment at the primary level of care -- not just at specialized clinics or the hospital, to the right to health as a formal assertion of entitlement based on natural, universal human rights. Perhaps this is because of the presence of cultural mediators whose salary is paid for by the state. This clinic seemed to provide a variety of health services, had the most staff available, staffed mediators during hours of operation and organized their patients by appointment, avoiding the situation where patients are turned away. Not all the Caritas clinics I visited were as organized as this. The presence and importance placed on cultural mediators whose salary is paid for by the state, represented a sensitivity to diversity.

²² She is referring to a fungal/yeast infection

²³ Interview with mediator, Chiara, in Reggio Emilia, June 15th, 2013

While there seems to be a spectrum of commitment to the right to health based on the legislation and application by the clinics, when asked about general legislation regarding im/migrants Chiara responded:

Number one, citizenship. I think it has to be looked into. It has to improve. There are many laws against immigrants here. Every day there is a new law against immigrants. It's too much. What makes it difficult is that when Italians leave this country and go to African countries, they don't encounter these kinds of laws. And they [Italians] forgot that they migrated to a lot of places but the immigrants in their country they don't regard them much... But no, the laws related to healthcare are still ok. Because illegal immigrants have these clinics where they go and obtain health, where they can obtain a cure. It's ok.²⁴

Chiara connects legitimacy and belonging to citizenship and juridical status. While language barriers or employment can be seen as contributing to the integration of im/migrants, Chiara only mentioned legal status as a problem. She says there are “new laws against im/migrants” but unfortunately never clarified what kinds of laws; however, the implication is that these laws are discriminatory. This was often a topic of discussion during the interview and was related to the difficulty in gaining legal status. However, in regards to right to health she finds that the laws are sufficient because im/migrants are able to access care. Of course working in the clinic might influence the kinds of people she encounters, namely those who have sought out healthcare and therefore excludes encounters with people who might have difficulty accessing or feeling they can access care. She had very few negative words about her interactions with medical staff previous to her employment at the clinic or during. She might have felt constrained by professional employment to freely comment about the current clinic she worked in, but any negative words she had about past interactions with doctors she attributed to a lack of knowledge or ignorance on the part of the native Italians. She gave the example of chicken pox which an Italian doctor was unable to identify because she explained, it was on darkly pigmented skin and

²⁴ Interview with mediator in Reggio Emilia, June 15th, 2013

the doctor had not ever seen chicken pox on darkly pigmented skin. Within the setting of the clinic, im/migrants' biolegitimacy validates their right to health and the law in this case also appears to support this legitimacy.

To understand more about the job of a mediator, I asked Chiara to tell me more about her training and also how she obtained the position. She was recommended by her son's teacher to apply for the job. The job required applicants to have ample knowledge of the Italian language and although Chiara had not formally learned Italian in school she was able to learn teaching herself. I asked her if she could tell me some of the things her employers asked before she received the job and about her initial experiences working as a mediator. She responded:

They asked me how long I've been in Italy. And then I believe that they more or less judged me by the way I was speaking Italian. Because you know, for this job you really need to know how to speak Italian very well. Then she asked me how I came to Italy. She wanted to know if I was a prostitute... if I came through prostitution. I said, "No, my husband brought me." I don't know if this is why she asked the question but this is what I think.²⁵

Concerning her initial experiences but during a longer discussion about race and discrimination the mediator also told me:

When I came here initially, you know, it did affect their way of thinking. But I had to start teaching them. Well, if you see a black girl out there it doesn't mean I am the same thing as that girl out there. Okay, that girl is that girl, and I am who I am. But then sometimes, you know, there is a part of them that has to, you know, you need to suppress all the time, but sometimes it comes out. I'm sorry. I'm sorry but it comes out. But then you have to continue to control it.²⁶

The second quote had been after I relayed to her a conversation I had with a patient coming out of a different clinic the day before who was from Africa. In Chiara's interpretation, racism stems from overly simplistic generalizations and ignorance on behalf of the native Italian population.

²⁵ Interview with Chiara in Reggio Emilia, June 15th, 2013

²⁶ Interview with Chiara in Reggio Emilia, June 15th, 2013

The general Italian public's imaginary of foreigners is constructed in generalizations and typologies that are not representative of the complexity of people coming from all over the world. She expressed desires to be seen as an individual beyond a preconceived notion of a woman from Africa, or even more so as a black woman who is associated with prostitution. Whether her definition of racism is valid or not, some form of discrimination or exclusion based on skin color or instead, perhaps, what has been called "cultural racism," exists and produces real effects in everyday social life. Additionally, racist attitudes and discrimination can produce negative consequences in terms of integration of im/migrants. Chiara expresses her experiences of discrimination and misrepresentation based upon unfounded generalizations. She says that these notions of discrimination need "to be suppressed all the time but sometimes they come out and you have to continue to control it." Such feelings of discrimination, even after living in Italy for over twenty years, are an indication of a lack of successful integration of im/migrants, at least on a sociopolitical level. However, her comment about laws and citizenship indicate that she might also feel there is additionally a lack of integration based on legal status. While their biolegitimacy validates right to health in Italy, simultaneously there is a lack of integration of im/migrants. With this lack of integration it would seem that human rights are only partially accepted as universal and pertaining to all people.

5.3 Modena: General Practitioner – "dignity"

The first clinic dedicated specifically to "illegal" im/migrants in Modena is located off the main roads and next to two cemeteries. I would bike about fifteen minutes from my apartment to arrive there, and often would pass people who I would later see coming into the clinic, walking along the pavement, following the train tracks. This clinic is strictly a Caritas establishment. The medical office is attached to a church and another building where short-term housing is provided as well as meals. All the staff, including the six physicians, receptionist and

one nurse, are volunteers. There is no formal waiting room but chairs are placed in the hall for patients waiting to be seen in the single examination room available. All the doctors are general physicians. There are no cultural mediators and no specialists at this clinic, so general physicians write out referrals for specialists. In Modena, this is the only clinic that provides primary level care to “illegal” im/migrants. On several occasions when I was present, not only was a lack of cultural understanding evident to me, but also a lack of language translation that caused delays in care-giving and general confusion. Although there is a provision for healthcare in the legislation in Modena, primary care is covered by the Caritas NGO. This implies a lack of commitment by local state authorities to the right to health as a natural, universal, rights based interpretation. Instead, the reliance on Caritas indicates a more humanitarian understanding of right to health and provision of health based on humanitarian justifications rather than formal entitlements.

In Modena, once a general physician writes a referral, the “illegal” im/migrant can go to a regular clinic to access care. As noted earlier in the interview with Dr. Columbo, these Caritas clinics act like a “gatekeeper to the whole system.” The diverse services that are provided in each city, especially at the primary level of care, exemplify the diverse ways that the laws about right to health are subjectively interpreted and put into practice by local health authority offices.

I had been to this Caritas clinic in Modena quite a few times while I was in Italy doing fieldwork and it was not the first time I had a conversation with Dr. Rittoni about irregular im/migrants and healthcare. The morning of the interview Dr. Rittoni, the translator and I arrived early, before the working hours and set ourselves up in the office where consultations and examinations are usually done. Most of my interviews were in English either because -- in the case of immigrants -- English was more dominant than Italian, or with doctors and professionals for purposes of consistency. However, I stipulated that if someone wanted to do an interview in

Italian or if at any time there was something a person would have rather related to me in Italian rather than English I was very willing to proceed on these terms. I realized as I proceeded with my data collection that sometimes it was beneficial to have the interview done in the person's native language and I would later translate it, keeping as much of the content and essence of the meaning as possible. Dr. Rittoni spoke to me in Italian and I had a translator present. However, the direct quotes that follow are my own translation of his words. Dr. Rittoni was well prepared and when we sat down. He gave me a few photocopies of information he thought was important and that I could refer to in the future. My first question was about the mission or goal of the clinic which he responded to by saying:

I copied the mission of the national Caritas which should be the mission of all the Caritas clinics. The mission should be to relate to each person, by recognizing each person's self-esteem, the value of each human life from all cultures, all stories and backgrounds, to learn and understand their health needs, and to promote the need for health of all those especially those who are more disadvantaged until they are recognized, reaffirmed and are able to access all levels of the community and institutions providing rights and dignity to all without any exclusions...In the last twenty years that I've been working here, the goal has always been the same in that we don't just provide healthcare. Someone who is ill might come here, we see the person, and provide medicine but also we relate to the person as someone with dignity, with fundamental rights, so that we let them know about all their rights, not just their right to healthcare. Health is just one of the problems we address.²⁷

Although he responded to the question by relaying the goals and mission of Caritas as an organization, he also supported and defended this mission. Dr. Rittoni was one of the few doctors I met at a Caritas clinic who was not retired, yet also volunteered his time at the clinic. During the entire interview Dr. Rittoni was giving me not only his opinion but also teaching me about the things he had learned being at the clinic and standing as an advocate for Caritas and the rights of all humans, including im/migrants. While Dr. Rittoni maintained a defense of human rights because of humanitarian reasons, because all humans are endowed with and should be treated

²⁷ My translation of the interview with the general practitioner, Dr. Rittoni, in Modena, June 21th, 2013.

with dignity, he also prescribed to a commitment to right to health based on the universal, internationally recognizable human rights paradigm derived from a natural rights perspective. He found Emilia-Romagna to be moderate in the kinds and amounts of medical services provided in relation to other regions and described himself as possibly too optimistic in believing that there is more that can be done and done better. However, he thought the system whereby Caritas is the first point of entry for irregular im/migrants was sufficient. The main deficiency and critique he provided was that the laws need to be recognized and followed. He mentioned that there was a “double ignorance” on behalf of both irregular im/migrants and health professionals:

...there is also a double ignorance—not only of the irregular immigrant who isn’t aware of the laws, their rights, but also ignorance on the part of the employees –so we need to be advocates for the people as well as promote these rules/laws at the institutional level so that the laws are being applied.²⁸

He again asserted that part of his position working with the clinic was to teach others about the rights of irregular im/migrants. He described the legislation in Italy regarding healthcare to be “ample” and even “beautiful,” but not always put into effect for lack of knowledge. In this way he was not just a doctor but also an advocate who helped ensure the laws would be applied correctly. Dr. Rittoni alluded to a comparison between the United States’ healthcare system and understanding of im/migrants in relation to right to health. Dr. Rittoni promoted Italy’s health system as exemplary and one that the United States should take heed of. He saw me as the messenger of crucial information such as a duty to uphold the right to health, especially from a public health perspective.

²⁸ Interview with Dr. Rittoni in Modena, June 21th, 2013

5.4 Modena: Women's Clinic Doctor – “cura totale”

The other clinic I visited in Modena was the *Consultorio Familiare Centro Salute Donne Straniere*, the Center for Health of Foreign Women, which is centrally located off a main road and is open two days a week. This clinic is funded by the state and functions under the jurisdiction of the local health unit of Modena (AUSL- Azienda Unita Sanitarie Locale). Once a week they have special hours dedicated to providing services to Arab populations and another day with hours dedicated to women from Sub-Saharan Africa. During these special hours mediators are hired by the local social services organization to help with translation of language and possible cultural misunderstandings between patients and doctors. The building where the clinic is located utilizes the second floor of the complex and has two waiting rooms with about ten examination rooms. On the days I visited it was either fairly populated with patients waiting or overflowing with people waiting in the halls as well as the waiting rooms. The number of people seemed to vary daily. Just like many other health facilities in Italy this clinic is frequented by citizens, and by both regular and irregular migrants. The doctors at the Center for the Health of Foreign Women will perform medical exams of women's reproductive system, looking out for abnormalities and possible problems. They also provide care for pregnant women before and after birth.

Upon arriving at the Center, I walked up a smooth set of stairs, following a yellow handrail, and proceeded to wait for the director. I had previously asked to conduct interviews with two or three physicians from the Center, but I was not permitted to observe interactions between physicians and patients at this clinic as I was previously at other clinics. I was told that this request could not be accommodated as they had other researchers present and could not

accommodate too many people in the examination rooms at one time.²⁹ Indeed, a room with a physician, two researchers, a patient, possibly a mediator, as well as a nurse who comes in and out, is overwhelming -- not to mention uncomfortable for the patient.

I had little interaction with the physicians prior to interviewing them. Instead, when it was my turn, I was ushered into a room and expected to conduct my interview during the physician's busy working hours. Thus, multiple times during the interview, we were interrupted and I felt a frustrating sense of urgency to finish the interview. I sat in a corner with my blue notebook, a pen and my phone which doubled as my recording device. The physician sat at a desk with a computer. We were not facing each other directly; instead, we were positioned in diagonal proximity to each other. Although she obviously understood English she was clear that she preferred to answer my questions in Italian.

Dr. Mariani expressed the idea that Italy lacks a *cura totale* or as I translate it, comprehensive treatment, whereby all people are treated equally by healthcare practitioners and able to access equal care to that of Italians. In her understanding of right to health she invokes both the Hippocratic stance that it is a personal obligation of a physician to help and also a right to health as a human right given on the basis of being human. I began the interview by asking her if she thought providing healthcare to irregular im/migrants was important. She responded, "It's normal. Whoever is human has the right." She initiated using the term "right" in this instance. Throughout our interview she anticipated concepts that I often had to directly ask of other physicians. She later stated that she believed not all Italian physicians possibly thought of right to health in the same terms she did. She suggested that there are inconsistencies amongst physicians as to how patients were treated and how physicians approached patients. She stated that," the

²⁹ These researchers were conducting surveys about general health and well-being of patients that visit the clinic including diet and exercise routines.

mentality, unfortunately, of all the doctors to see the essence of all humans with the same dignity/equality, doesn't exist... The mentality [perspective] of the Italian doctors to see all their patients with the same equality [rights] doesn't exist."³⁰ Dr. Mariani gave a gender specific example of this disparity. Sometimes an im/migrant woman may be trying to get pregnant and going to many clinics and not succeeding. But this woman has not been told that there is a service provided by the hospital that will conduct the appropriate examinations to determine the problem and assist with resolving the issues. Whereas for a native Italian woman with the same problem the assumption is that either she would know of these specific services or be told in advance by a doctor about them. When she gave this example it was not clear whether she was speaking about illegal im/migrants or im/migrants in general but regardless, she was gave this example to highlight disparities in healthcare based on race. This was her example of a lack of *cura totale*.

Dr. Mariani also brought up the topic of racism without my prompting. While I asked about issues regarding right to health in a variety of ways, until she initiated the topic of race, I had yet to allude to it. She stated that racism exists in Italy and she thought im/migrants were not always open enough to Italians and remain closed. She described it as, "Two walls, one against the other, doesn't arrive anywhere." She also made reference to the dichotomy of the "traditional" women from developing countries and the "modern" Italian women, described by many researchers within feminist discourses. She stated that people looked at her with greater respect once she became a physician in contrast to when she was a housewife. Her own occupational choices were framed by her gender as well as her nationality.

When I asked Dr. Mariani about the Minister of Integration, Dr. Cecile Kyenge, she spoke clearly about rights and citizenship. Dr. Kyenge has been an advocate for introducing

³⁰ Interview with Dr. Mariani, June 19th, 2013

citizenship based on birth in a country's territory (*ius solis*) rather than the current designation in Italy where citizenship is based only on blood and inherited through parents (*ius sanguinis*). Dr. Mariani's conception of rights is not necessarily tied to citizenship. In her opinion, the importance of recognizing rights surpasses citizenship and if people truly have their rights they will be considered valuable contributors, exercising their abilities to the fullest, thus giving them full legitimacy, assisting in their integration. Instead, she sees the granting of citizenship as cathartic and secondary. Interestingly, female im/migrants have been lobbying labor rights and settlement rights (among others) for many years (Pojmann 2006; Zontini 2008). Although there has been some success, it still proves to be an upward battle; whereas, with Dr. Mariani's conception of rights and citizenship, im/migrants would enjoy more rights regardless of citizenship.

This doctor expressed a certain set of ideas concerning ethical commitments and understandings of rights and obligations that differed from many of the other doctors I interviewed or conversed with. Notions of belonging can directly affect ideas about inclusion or exclusion in "host" communities and possibly even extend to doctors' approaches to healthcare and to ideas held by im/migrants. In her responses, Dr. Mariani gave her personal perspective on right to health, the perspective she felt other doctors had while also recognizing her position as a non-Western, im/migrant woman. She expressed ideas pertaining to inclusion and exclusion based on rights, race, gender, and status as either an im/migrant or an Italian. Despite the theoretical right to health as outlined in the legislation, given the diversity among female im/migrants it is perhaps understandable - that there is a lack of *cura totale*, comprehensive treatment, even for women coming to a female specific clinic in Italy.

In my informal conversations with patients some of them expressed feelings of discrimination or differentiated treatment towards them based on race. Others attributed feelings of discrimination based on what they described as “ignorance” on behalf of Italian medical practitioners and the general public but had a generally positive impression of the Italian population. There were also a few instances where patients seemed unclear about the diagnosis a doctor gave or did not want to answer the doctor’s questions completely. It was unclear exactly why this behavior happened and was often situation-specific. However, I was informed by medical personnel that they felt it was because of a lack of trust or possibly embarrassment that led to this behavior. While it is expected or at least reasonable that I heard accounts of racism and discrimination from im/migrants, it is of particular note that many doctors also attested to this fact and recognized this aspect of social life that exists in Italy.

Aside from this negative aspect of social life which has a tendency to have an influence even in medical setting, medical personnel and the mediator interviewed identified some positive characteristics of the right to health in Italy. Particularly in Reggio Emilia there was an overtly strong commitment to the right to health. This was exemplified in Dr. Columbo’s interview as he gave a natural rights based, humanitarian and public health justification for providing care to illegal immigrants. The mediator, Chiara, was generally positive about the services provided and the mediators’ involvement at the primary level in the Caritas clinics was an important part of this commitment to the right to health. However, in Modena the general practitioner, Dr. Rittoni, that I interviewed not only maintained that the right to health for all people should be recognized out of the dignity attributed to all humans but he also was a strong advocate for the mission of Caritas to provide services even beyond those regarding healthcare. Dr. Mariani, from the other clinic in Modena, also provided an even-handed analysis of the relations between native Italians

and im/migrant populations. Additionally she also believed in the advocacy of rights above even that of formal citizenship. While many of the doctors I interviewed felt a personal commitment to the right to health they indicated that not all doctors likely felt this way nor the general public. In the next section I address the more theoretical implications of the comments given by medical personnel and staff as well as some of the general media attention surrounding im/migration in Italy.

6. DISCUSSION

Referring to the 1999 Declaration on Anthropology and Human Rights, Goodale (2009: 126) states that, “ it [the declaration] makes two related assertions: first, that ‘human rights is not a static concept’; and second, that ‘our understanding of human rights is constantly evolving as we come to know more about the human condition’.” In the wake of anthropologists’ current interest about right to health it seems crucial to understand that human rights are dependent on context and time and that they have the ability to change. The question of whether “illegal” im/migrants have a right to health is an example of the potential expression and dynamic possibility of the concept of human rights. As of now, Italy has a legal framework that provides healthcare to “illegal” im/migrants. But as the laws stand it is up to the regions and local health authorities to provide the facilities and infrastructure for healthcare and as such there is a diverse range of services provided specifically at the primary care level, even in cities as physically close as Modena and Reggio Emilia. Physicians seem to understand the right to health in Italy as stemming from a universal rights foundation, a humanitarian assertion, or a public health basis but either way “illegal” im/migrants are included in healthcare, an indication of the moral economy of health in Italy. The moral economy of health in Italy seems to be one of, what I call, reluctant compassion, where “illegal” im/migrants are recognized as having a right to health yet are simultaneously excluded discursively, politically, and economically from the social community.

Although engagement and collaboration are often also goals of research in human rights, it should be noted that this kind of research raises particular ethical and methodological obstacles. Out of concern for a particularly vulnerable population, “illegal” im/migrants, their perspectives were not directly included in this thesis. This is unfortunate as they are an integral

part of understanding the right to health in the Italian context. Another complexity of this research arose when professional ethics of doctors about how to treat patients were indistinguishable from their personal moral opinions about how people ought to be treated. While this is understandable, it follows then that some of the most valuable information can be gathered based on how medical personnel interact with patients. Obtaining appropriate ethical consent for these interactions can be difficult not to mention confusing, especially to the patients involved who often already want to spend minimal time in the clinics. Outside of clinics it could be valuable to investigate the role that social service cooperatives play in Italy as well as discussing the issues arising from work in the underground economy. Many of these illegal im/migrants arrive as healthy individuals looking for refuge or work but are quickly exploited by a system that requires a certain amount of surplus reserve labor (Merrill 2011). The economic system is tightly intertwined with issues of human rights, im/migration and legitimacy of “illegal” im/migrants.

Recent protests and tragedies have renewed the debate about im/migration laws in Italy. In October 2013 a boat coming to Lampedusa sunk killing more than 200 im/migrants. This incident received high media attention in Italy and abroad. The increasing im/migration problems are likely not to end soon and tragedies like this one will continue to happen if solutions are not found. After this tragedy EU political officials announced the urgency of meeting to resolve some of the issues of im/migration at Europe’s southern borders. In December of 2013 Moroccan and Tunisian im/migrants sewed their mouths shut to protest the detention and deportation laws in Italy. Aside from issues about detention centers, there had been a lot of debate among even the general public concerning Dr. Cecile Kyenge proclamation to amend citizenship laws in Italy. I came upon a rally of about sixty to eighty people in the middle of a square in Naples during my

fieldwork. There was a stage set up as well as many posters and banners. The issues Dr. Cecile Kyenge raised in Parliament created many debates. She was always a supporter of improving relations between African populations and native Italians. I also attended other public events in Modena that attempted to bridge these relations. While I think both events had good intentions, the promotion for the events seemed a bit sparse and I found there was disappointingly low participation.

Even while the “humanitarian” version of healthcare in Italy is legally superior to most other developed countries in providing care for much of the population, there is still a lack of *cura totale*. Further research could investigate the practices and medical services found in other regions of Italy in a comparative and longitudinal study. This could be followed up with a larger comparison between other European countries. A particularly interesting place to examine questions of right to health could be at detention centers around Italy, including Lampedusa which has received much attention in the media, especially in the last decade. At a policy level, Italy could implement legislation that more clearly outlines right to health across regions, standardizing healthcare while creating a more equitable and accountable system in practice especially at the primary care level. Considering some of the more comprehensive EU legislation regarding upholding certain human rights conventions and implementing regulations on visas across the EU, further research is warranted especially with respect to whether the EU intends to implement more homogenizing legislation regarding right to health or if such an intention is simply not feasible.

7. CONCLUSION

Human rights were conceived in the Universal Declaration of Human Rights as universal, indivisible, and interrelated. However, human rights are represented and adopted in various forms such as within the Italian context of right to health. Being universal and based on natural rights, human rights should also be apolitical or beyond politics, but this is not the case since human rights are social constructions. Yet, human rights are also powerful tools to combat inequality and injustice. In promoting human rights and combating inequality and injustice we can look to improve the health and well-being of humans through medicine. Medicine can be a pragmatic tool for engaging with human rights.

Within the medical setting in Italy at present, all people via their biological state, including “illegal” im/migrants, appear to have some degree of legitimacy, biolegitimacy. Beyond the medical setting they are once again excluded and seen as socially illegitimate. This alternation of legitimacy, in addition to Italy’s humanitarian stance for right to health, characterizes Italy’s moral economy as reluctantly compassionate. A legal framework for the right to health for all exists in Italy alongside a broader conception of exclusion often based on cultural racism, resulting in a lack of *cura totale*. There is a lack of sociopolitical integration of im/migrants. This lack of integration may stem from aggressive integration policies attempting to purge illiberal values that threaten liberal-democratic states and resulting from an interpretation of social illegitimacy especially of “illegal” im/migrants. This is the specific paradoxical complexity and messiness of the right to health in the Italian context.

Common themes expressed in the accounts given by the doctors, health authority and mediator included notions of belonging and inclusion based on dignity for humanitarian purposes, entitlement, or potential citizenship. On the opposite end of the spectrum, however,

there was the common theme of discrimination and exclusion based on cultural racism, ignorance, or a static mentality of Italy previously characterized solely by emigration rather than also immigration. Additionally, even though I was informed verbally about issues of discrimination, it was also clear from my visits in the clinics that there were a variety of services offered, especially in the Caritas clinics for “illegal” im/migrants. This represents the various commitments to right to health that each region and city maintains. In Reggio Emilia, there are two Caritas clinics with doctors of diverse specialties as well as mediators and this indicates a sensitivity to diversity as well as the means to provide care to people who present cultural and linguistic challenges. In Modena there was also a commitment to right to health but it translated into practice in different ways than in Reggio Emilia. In Modena there is one clinic designated to providing primary care to “illegal” im/migrants and although there are fewer doctors and they are general physicians, they are able to refer people that need to go to a regular public clinic and receive care. At the regular clinics in Modena, like the Center for the Health of Foreign Women, there are also mediators available. The variability in services even between these two cities indicates that while there is a commitment to right to health, it is on a spectrum.

In this thesis I have provided the perspectives of medical personnel in order to ethnographically research the right to health in a particular context, such as Italy. On a daily basis, medical personnel are the ones that work directly in support or not of the right to health. However, they are only one crucial component of the struggle to realize the right to health. The other crucial components include the moral and social aspects of how illegal im/migrants are viewed and how they in turn understand their own “deservingness” and acceptance in the community. For example, the right to health and its realization is juxtaposed with government legislation such as the restrictive Bossi-Fini law which border on paranoia concerning incoming

im/migrants. The crisis in Lampedusa where about a couple hundred people were killed revealed these sharp contrasts in policies between attempting to treat people with dignity and possibly inhumane reception centers that are poorly equipped. Such conditions and policies can contribute feelings of non-deservingness that im/migrants carry with them thereafter.

In order to contribute to the struggle for human rights, it is also important that researchers in medical anthropology recognize the action steps outlined by Willen et al. (2011). These steps include listening differently to all stakeholders involved, teaching differently to move outside the classroom, democratizing knowledge production, translating ourselves for non-anthropological audiences and writing differently in order to reach beyond the academy. All these steps are to integrate the other main components of medical anthropology, engagement and collaboration. Because of the explosion and continuation of im/migrants coming into the EU, further research on how right to health is actualized in other areas, particularly points of entry such as Lampedusa into Europe would contribute to a better understanding of how deservingness is constructed from the outset.

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