Introduction

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Medical Anthropology, Human Rights and Migration

On 10 June 2018, Matteo Salvini, minister of the interior of Italy and political leader of the Lega Nord, announced the refusal to allow the ship *Aquarius*, of the non-governmental organization (NGO) SOS Mediterranée to berth in any Italian port, as she was carrying 629 refugees who had been rescued from the waters of the Mediterranean. The minister's decision was accompanied by numerous tweets that had the tone of a declaration of war: 'As of today even Italy will begin to say NO to the trafficking of human beings, NO to the business of illegal immigration'. After days of political clashes, uncertainties and tensions, Spain declared itself willing to welcome the refugees and *Aquarius* sailed to the port of Valencia. Salvini, still on Twitter, gloated, writing: 'VICTORY! 629 immigrants on board the Aquarius ship in the direction of #Spain, first goal achieved! #chiudiamoiporti'.

Salvini's words are an eloquent example of the climate that has developed in recent years around the theme of immigration and the political manipulation of the so-called 'migration crisis'. Migration phenomena are certainly not new to European countries; however, between 2012 and 2016, crossings to Europe by sea steadily increased, and in 2014–2015 there was also a significant increase in arrivals by land. This trend, which began to reverse in 2017, has been described and managed as an emergency. In many contexts, the so-called 'migration crisis' has been accompanied by the rise of nationalist political movements, openly hostile to immigration, which do not

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hesitate to adopt xenophobic or, in the most serious cases, explicitly racist language.

The increase in migratory flows has overlapped in part with an economic recession and a widespread lack of confidence in the future of the European Union. As Holmes and Castañeda write, 'how displaced people are framed reveals a great deal about anxieties in Europe regarding diversity and change within a paradigm of limited good … informed by debt, austerity, and neoliberal disassembling of social systems' (Holmes and Castañeda 2016: 13). From the point of view of migration policies, the European Union has responded with increasingly restrictive regulations and with targeted strategies that create differentiated, and often discriminating, access conditions for migrants (Altin and Sanò 2017). In the last ten years the legal channels of arrival have been severely limited, and the favoured policies have been those that contain arrivals and strengthen security, with interventions aimed at the integration and protection of migrants.

A similar situation is observed in the United States. After an electoral campaign dominated by rhetoric strongly opposed to immigration, President Donald Trump adopted a policy of 'zero tolerance' towards migrants, which has led to a significant number of people, mainly from Mexico and other parts of Latin America, being detained and remanded for criminal trial. Trump's 'hard-line' approach has had a serious impact on minors, such that in the months of May, June and July 2018, the entire world saw the dramatic images of thousands of children, some less than a year old, being forcibly separated from their parents and detained, first in facilities unsuitable for their initial reception (the Customs and Border Protection facilities), and then in Immigrant Children's Shelters, places where they are accommodated for longer periods, without any certainty about their future or even about the possibility of reuniting with their families.

The situation is critical in other countries as well, and it is not surprising that many anthropologists – among other observers – have described these as 'dark times' (Sorgoni 2011; Fassin 2011; Pinelli 2013; Ben-Yehoyada 2015; De Genova 2017).

The images we have chosen to evoke in this Introduction are representative of the historical-political context in which the life experience of migrants unfolds and where the reflections contained in this volume are developed. In the following pages we will return in more detail to current migration scenarios; for the moment, it seems important to emphasize that, in our opinion, the choice to address the issue of the health of migrants from a perspective of interdisciplinary

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dialogue between medical anthropology and human rights, in addition to being effective on a conceptual level, also represents a political stance. We believe, as Willen, Mulligan and Castañeda (2011) have stated, that medical anthropology should play an active role in public debate on the issue of migrants' right to health, and has a responsibility towards the construction of more inclusive health systems. More than twenty years have passed since Merrill Singer (1995) called for a deeply committed and participatory position on the processes of social change; and more than a decade since Mark Nichter, then president of the American Society of Medical Anthropology (SMA), invited anthropologists to 'take a stand' in the field of public health protection policies (see Inhorn 2007). The words of these authors are more central than ever for our discipline.

Given the historical complexity of the relationship between anthropology and human rights, we must offer some brief preliminary reflections. Although today there is a fruitful dialogue between these two disciplinary fields, until relatively recently the relationship between human rights and anthropology has been ambivalent and critical. In 1947, a year before the publication of the Universal Declaration of Human Rights, the Statement on Human Rights was published, signed by the Executive Board of the American Anthropological Association (AAA). The document was drafted by Melville Herskovits,[1] and moved from serious criticism to the assumption of universality that was at the core of the declaration: elevating a system of principles and values that are the fruit of a specific culture to the rank of universal truth risked establishing the hegemonic superiority of this system with respect to others, thus creating 'a legal smokescreen for the oppression of one group of human beings by another' (AAA 1947: 542). Furthermore, colonialism and the many forms of oppression, including racial discrimination, which existed within the signatory states, were far from the ideals the declaration wanted to promote. 'There cannot be individual liberty,' Herskovits declared accordingly, 'if the social group with which the individual identifies is not free' (ibid.: 543).

Herskovits's concerns were not in fact unfounded. In more recent years, authors such as Ahmed An-Na'im (1992) and Talal Asad (1997) have highlighted the ethnocentrism of some of the most important concepts on which the declaration is based, and Lila Abu-Lughod (2013), following the war in Afghanistan, denounced the political use of references to democracy and human rights (especially those of women) to justify the American intervention.

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Meanwhile, new generations of rights have been added to the first:[2] humanitarian law has been progressively imposed as a social language with broad international recognition and has been increasingly used by native populations and minorities as a tool for political action. In field research, anthropologists encounter language and practices that focus on human rights, and it has become necessary to reconcile a critical approach to the hegemonic implications of this juridical-value system with awareness of the social (and important) role that it plays in each of the analysed contexts. Attention has therefore focused on the 'practice of human rights' (Engle Merry and Goodale 2007), which calls for the researcher to contend with complex, transnational processes, in which reality and rhetoric are inseparably intertwined.

In the field of migrants' health, the language of human rights is one of the most important tools for the protection of the individuals involved (health workers, policymakers, associations, NGOs, patients, activists and others). Health is in fact recognized as a fundamental right in international documents and agreements: from a legal point of view, this implies a positive obligation for the states that have signed the commitments in question, which have a duty to guarantee adequate access to medical care, even to irregular migrants or those living in poverty.

Furthermore, the right to health is conceptualized as an inclusive right; health protection should therefore include both access to adequate medical care and attention to the social determinants of health, or, in other words, all factors of a social, economic, environmental, cultural and political nature that affect the health and well-being of the individual. From this perspective, medical anthropology and human rights can help researchers to understand and respond to issues of health, illness and treatment, taking into account 'the interaction between the macrolevel of political economy, the national level of political and class structure, the institutional level of the healthcare system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology, and environmental factors' (Singer 1995: 81).

We believe that this attention to local contexts and the way in which body, health and illness intertwine in the life experience of migrants and their life stories, is the most interesting contribution that medical anthropology can offer to the interaction, with a perspective based on transversal and universalist principles such as human rights.

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Migration and Health

Migration phenomena, as explained in the opening of the recent World Migration Report 2018 by the International Organization for Migration (IOM), include 'a wide variety of movements and situations involving people of all walks of life and backgrounds' (IOM 2017a: 2). Defining migrants, then, is not simple: this expression, in fact, groups together people with different legal statuses and migratory histories; with variable levels of social capital for coping with the adversities of emigration; and with different cultural backgrounds, beliefs and worldviews. One of the cross-cutting elements is the distinction between regular migrants and irregular migrants, two categories often sharply demarcated: on the one hand the 'good', who 'deserve' access to public assistance; on the other, the 'illegal', who do not contribute to the growth of the nation and therefore do not 'deserve' to be recipients of the resources of the community. Although most people tend to move within the borders of their own nation, there are currently around 244 million people globally who have left their country of origin to look elsewhere for a new life.[3] This is about 3.3 per cent of the world's population, a figure that has increased significantly in recent years as a result of the increase in global economic inequalities, the growing economic and political interconnectedness of the world system, and the still widespread phenomena of violence, conflict and war. While in some cases migration can represent an opportunity for personal growth and can be a constructive experience, in many other cases it is the result of the need to escape intolerable living conditions or situations that endanger survival itself.

On many occasions, the migratory journey is itself a trauma. In dealing with dangerous routes often controlled by organized crime, migrants – especially if irregular – are subject to numerous forms of violence, discrimination and exploitation (Freedman 2016).[4] Things do not always improve upon arrival: even in host countries, human rights violations are the order of the day. Reception systems are often lacking, or are unable to cope with complex needs that are simultaneously social, psychological and health-related.

The path of assimilation is also fraught with difficulty. The migratory experience is often associated with poverty, unfavourable housing conditions, poor social recognition, exploitation and dependency. Some of the elements that can characterize a foreigner's everyday life are: linguistic challenges; the difficult task of inserting oneself

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into a new and often hostile situation; the loss of the relational and affective networks of the country of origin; the need to cope with a different culture; and being permanently placed in a hybrid, uncertain and marginal position. Added to this is the existential fatigue of migration, which has to do with a complex reorganization of the horizons of meaning, which is expressed in what Abdelmalek Sayad called the 'double absence of the migrant' (Sayad 1999).

One of the factors influencing the living and welfare conditions of migrants is their legal status. While maintaining some features of homogeneity, the legal categories associated with migratory phenomena vary significantly from one country to another and are closely linked to factors of a political, historical, economic and geographical nature. This volume clearly demonstrates the heterogeneity of local immigration regulations, as well as the strong contradiction between the universal (and universalistic) character that fundamental rights should have, and restrictive laws that drastically reduce the possibility of regularization of newcomers and, consequently, their ability to access adequate health protection.

At the same time, the volume shows to what extent the distinction between regular and irregular migrants is much less clear than it appears. As underscored by the International Organization for Migration itself,

> a person's immigration status can be fluid and change quickly, arising from circumstances and legal-policy settings. For example, many international migrants who may be described as 'undocumented' or 'irregular' enter countries on valid visas and then stay in contravention of one or more visa conditions. In fact, there are many paths to irregularity, such as crossing borders without authorization, unlawfully overstaying a visa period, working in contravention of visa conditions, being born into irregularity, or remaining after a negative decision on an asylum application has been made. (IOM 2017b: 20)

However, as Anahi Viladrich and Nolan Kline explain in detail in this volume, this distinction is often used in public discourse to legitimize inequalities in access to the health system.

Finally, a particularly important reflection is on refugees and asylum seekers. This theme, dealt with in this volume in the chapters by Chiara Quagliariello and by Hala Kerbage and Filippo Marranconi, is vast and has been the subject of numerous reflections in the field of anthropology, of which we cannot offer an adequate overview here.[5] It is worth remembering, however, that one of the issues that has

characterized the debate in recent years is the difficulty in making a clear distinction between asylum seekers and economic migrants. This difference, inevitable on the legal level, does not reflect the emic perspective. As Barbara Sorgoni writes,

> for individual migrants it may be impossible, or even meaningless, to distinguish and separate economic and political aspects from the motives behind their movements, or measure the degree of voluntariness of their choice to travel or flee, within the complex migratory trajectories often driven by several factors. (Sorgoni 2011: 15)

The juxtaposition between those who are 'entitled' to international protection and economic migrants, represented as 'less' worthy, has been used in public discourse not only with regard to the right to asylum, but also to legitimize/delegitimize access to welfare and health systems, disregarding the universal character of the right to health.

Borders and Boundaries

In recent years, the desire to build walls, gates and military zones that mark the separation between nation states has become one of the main political concerns in many countries worldwide. These trends clash with the idea of a 'global village', introduced in 1968 by Marshall McLuhan (MacLuhan and Fiore 1968). Although the wide circulation of objects, commodities, raw materials and information highlights the reduction of geographical distances between one part of the world and another (Appadurai 1996; Amselle 2000), the interconnected dimension of the global space does not affect the movement of human beings in the same way. The latter is more and more often allowed or denied according to national, economic, cultural and racial criteria. As pointed out by the anthropologist Didier Fassin (2011), the deployment of increasingly sophisticated military devices to stem global migratory flows highlights a 'return' to the idea of a nation state in which the presence of the foreigner is understood as a threat to the local population (Shryock 2012).

In the current context, the critique advanced by so-called border studies (Donnan and Wilson 1999, 2016) regarding the introduction of increasingly visible borders appears particularly pertinent. Authors such as Nicholas De Genova (2017) highlight how the 'rhetoric of invasion' supported by the nationalist parties in many countries of

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the so-called Global North has no correlation with global migratory flows. Consistent with these theories, the case studies collected in this volume show the extent to which migrations from the southern to the northern hemisphere represent only a part of global migratory movements. At the same time, authors such as Goldberg, Silveira, Barbosa and Martin in this volume emphasize how the functioning of neoliberal national economies rests in large part on the contribution of a labour force composed of migrants. Finally, the selection criteria and the limitations imposed for border crossings clash with the principles defended by the convention for the protection of human rights, such as the idea that all human beings are entitled to freedom of movement. On the contrary, as shown in the chapters by Viladrich, Kline and Quagliariello, the 'invention' of different categories of human being, each with different degrees of right to move from one country to another, has become increasingly evident in recent years.

The variability of the concept of border is a theme that encompasses the anthropological studies and reflections proposed in this volume. The border as a line of separation between adjacent territories or states is a category that is only applicable to some forms of border control (Cuttitta 2015). An example is the border between Mexico and the United States, previously evoked, where any attempted entry into the North American territory by migrants is enforced by physical rejection (Heyman 2016). In other cases, the border corresponds to a more complex and structured control system. The so-called Schengen area in Europe, where there is a 'double movement' of borders, concurrently facing inwards and outwards, is emblematic in this regard. On the one hand, there is collaboration between Euro currency members that, for a number of years, have decided to use a single currency and to abolish national borders to facilitate international mobility and economic exchanges. On the other hand, EU states members share the policy of 'blocking borders' to non-Schengen citizens, such as international migrants and asylum seekers. In particular, the Dublin III agreement signed in 2013 following the Libyan crisis of 2011 has produced a spatial separation between territories trying to function as a *unicum*, leading to a new juxtaposition between countries in southern Europe, which are directly involved in the phenomenon of migrations by sea, and countries that are geographically more distant from the Mediterranean. At the same time, the process of externalizing the borders through the restrictions on visas required for entry into Europe by people

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coming from other parts of the world has extended the borders of the old continent beyond the territories belonging to this geographical area (Menjívar 2014; Casas-Cortes, Cobarubbias and Pickles 2015; De Genova 2017). The control policies exercised 'at a distance' in the migrants' countries of origin, such as those of the sub-Saharan Africa area, underscore the extent to which the border is a 'mobile apparatus', and not something connected to a 'fixed' territory. This apparatus not only moves within areas and territories that are geographically ascribed – such as the European Union area – but can also assume a deterritorialized dimension, depending on the geopolitical interests of certain countries with respect to others. This is how the border apparatus can cover a larger space than that suggested by national boundaries, even involving two or more continents. The agreements established by the European Union with some sub-Saharan African countries and North Africa for the 'limitation' of migratory movements towards the Mediterranean are an example of the transfer of European borders to the African continent. The same goes for the agreements drawn up in 2016 between the European Union and Turkey, the purpose of which was to limit the arrivals of Syrian refugees fleeing to Europe through the territories of Greece (Christopoulos 2017).

If a border can therefore correspond to a space that extends beyond a national border, the chapters presented in this volume underscore the presence of numerous physical, social and symbolic limits – all of which have been summarized by several anthropologists in the category of *boundaries* (Fassin 2011; Bramilla et al. 2015) within national borders. The increasing number of migrants and political refugees arriving in the countries of southern Europe and in some areas of the Middle East, such as Lebanon, have led to the introduction of spaces set aside for these groups. The fact that migrants and asylum seekers are considered to be 'passing through' the national territories is reflected in the fact that these people have to live, sometimes for years, in tents, sheds, containers and buildings that are temporary, and some can even be dismantled and transported from one place to another. Likewise, the transformation of geographically isolated locations, such as the island of Lesbos in Greece or the island of Lampedusa in Italy, into legal-bureaucratic 'waiting areas' is representative of the desire to make migrant populations 'invisible' and keep them as much as possible 'at a distance' from the local inhabitants. Consistent with this type of approach, most refugee camps and migrant reception centres in Europe and the Middle East, are located

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on the outskirts of urban areas or in extra-urban areas that are poorly connected to public transport. As pointed out by the anthropologist Barbara Pinelli (2017), the decision to make newcomers reside in isolated places that are physically separated from those dedicated to local populations reinforces the separation between migrant and non-migrant people, often creating an irreducible distance between these two populations. The prohibition for the local population to enter the refugee camps, and the low investment in integrating migrant people into the local communities, feeds divisions between the 'native' and 'alien' populations who sometimes reside side by side, but who are forced to lead completely parallel lives. As highlighted in this volume, the condition of physical isolation and social marginality experienced by migrants and asylum seekers reflects a more widespread situation, which also involves other foreigners and minority groups. The physical separation from the local population represents, for example, a 'structural condition of life' for the Roma living in the camps located on the outskirts of the cities of Europe. The same situation of isolation is found, on the other side of the Atlantic, among Bolivian migrants living and working in the capitals of other South American countries, where life for them takes place inside industrial warehouses for the production of clothing items that will be exported abroad. A final example is the living conditions of Latin American migrants in the city of Atlanta, Georgia, where the presence of checkpoints for the inspection of documents limits migrants' movement within the urban space.

Embodying Borders, Migrant Bodies

Migratory experiences, and migration laws and policies have an impact on the bodies of immigrants. The social, political and cultural dimensions of the human body are one of the 'classical' themes of medical anthropology. Authors such as Nancy Scheper-Hughes and Margaret Lock (1987), Thomas J. Csordas (1990) and Mariella Pandolfi (1993) describe the human body as the main physical support of the person, but also as a material support upon which the collective and individual experiences are registered. The category of 'incorporation', introduced in 1990 by Csordas in accordance with the tradition of phenomenological studies, sums up the centrality of the body in the process of identity building, but also in the 'stratification' of successive events in the biography of each human being. The

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uses of the body change, furthermore, from one cultural context to another (Godelier and Panoff 1998). Critical medical anthropology emphasizes the link between cultural representations of the human body and the experiences of health and illness (Kleinman 1980, 1981; Good and Del Vecchio Good 1980; Augé and Herzlich 1984). From a bio-political point of view, the body is the main arena of control over human life for the institutions that regulate the functioning of societies (Foucault 1976), including legal and medical institutions (Fassin and Memmi 2004).

The thesis supported in this book is that it is possible to talk about the inscription of boundaries onto the body, or the incorporation of borders, on several levels. A first level is the onset of diseases, and other forms of illness, related to the strengthening of borders and the processes of externalization of the borders described above. As highlighted by various international agencies (Amnesty International 2016; IOM 2017b), the difficult travel conditions and physical deprivation experienced along migratory routes have an impact on the health of those who choose to leave. Lack of hygiene, malnutrition and severe dehydration are some of the conditions experienced by migrants during the Mediterranean crossing and their stay in countries such as Libya, where respect for the right to health, and to human rights more generally, is not guaranteed.

The incorporation of borders also takes other forms in the migratory experiences. Migrants' bodies can be defined as physical supports that carry the weight of borders upon themselves. These are bodies that, starting from a tangible otherness – for example, in terms of skin colour – make the borders visible. As was also revealed during the period of Western colonialism (Fanon 1952), encountering bodies with physical characteristics different from those of the local population often leads to the idea that migrants are dangerous entities and possible bearers of epidemics. The need to keep society's immunization high translates into a systematic implementation of health checks at the border (Redfield 2005). As was the case in the past for sea voyages by European migrants to the countries of North America and Latin America, health professionals are among the first representatives of the receiving state that migrants and asylum seekers meet today in Mediterranean harbours. The use of gloves and masks during medical checks at the border also reflects the consideration of migrant bodies as a possible threat to public health and national security. The need for the state to make sure that the bodies entering the national territory are healthy and

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'non-contaminating' underscores the extent to which the assessment of the 'quality' of individual migrants takes place primarily on the physical level. The policies aimed at the immunization of society also emerge in health checks carried out in the United States on South American citizens, or in the disease-prevention campaigns carried out in Europe against Roma populations. As highlighted in this volume, the association between the presence of foreigners from disadvantaged socio-economic backgrounds and the possible spread of diseases is a discriminatory phenomenon that has a national and international scope.

Another given highlighted in this volume is that, in some cases, individuals endowed with healthy bodies at the time of the migratory project became people with sick bodies during their stay abroad. The harsh working conditions faced by migrants, especially if they do not have a residence permit, can be at the root of diseases (Marmot 2005; Marmot and Wilkinson 2006; Fassin 2009; Aiach 2010). The same applies to housing conditions, which often scarcely guarantee respect for the right to health. The high tuberculosis rates among Bolivian migrants living and working in industrial warehouses located in the capitals of other Latin American countries is an example. Others are the high presence of allergies and respiratory diseases among Roma populations, and the numerous symptoms of illness among newly arrived migrants and asylum seekers residing in shelters and refugee camps in Europe and the Middle East. As Kerbage and Marranconi highlight in their chapter on the case of Syrian refugees in Lebanon, the response provided by the state to the pathologies manifested by this population – such as eating disorders, frequent headaches, insomnia, forms of anxiety and depression – is an exclusively bio-medical interpretation of these symptoms. Consistent with the theories proposed by the anthropologist Liisa Malkki (1995), this volume shows that the systematic tendency towards medicalization and psychiatrization of forms of suffering connected to traumatic experiences represents a form of depoliticization of the symptoms presented by migrants and asylum seekers. Reduction of different types of illness expressed through body language to a simple medical or psychiatric problem means not taking into consideration the subjective experiences or the difficult living conditions experienced by migrants in reception centres or refugee camps where daily life is often reduced to 'mere biological life' (Agamben 1998), and people are 'bodies to be kept alive' by guaranteeing basic needs, such as eating and sleeping.

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Vulnerability and Structural Violence

In the contexts analysed throughout the various chapters, indirect, invisible and institutionalized violence, which takes forms such as racism, discrimination, stigmatization, economic exploitation and poverty, can be observed across the board. Health inequalities are, in many ways, 'a mirror of inequalities in material conditions and in social and political structures within a society' (WHO 2013). The cases analysed in this volume by Goldberg, Silveira, Barbosa and Martin, and by Cingolani, highlight the pervasive nature of the connection between 'structural violence' (Farmer 1996, 2005), social marginality and health, which is expressed in the diseases of poverty, but also, more indirectly, in the incorporated forms of suffering and discomfort.

Economic inequalities, discrimination and marginalization produce 'bodies on the margins': 'other' bodies, in which the health consequences of the absence of real social inclusion clearly manifest themselves. This marginalization is reinforced by negative social images of migrants, which strongly influence self-perception. An inconvenient figure, the alien can be represented as an invader, as a potential terrorist or dangerous criminal, as someone who puts the nation's identity and values at risk, as an undesired and illegitimate competitor who takes resources away from the natives in times of difficulty. These negative images act as a mirror for the individuals, and lead to a complex imbalance in the sense of self: how one is perceived by others deeply impacts how one represents oneself and, consequently, influences individual agency.

The multiple asymmetries that characterize the relationship between the migrant and the host society place the foreigner in a position of 'structural vulnerability' (Quesada, Hart and Bourgois 2011). This concept was proposed by James Quesada, Laurie Hart and Philippe Bourgois with the aim of bringing attention to, in addition to the political and economic aspects that characterize the analysis of structural violence, the cultural and subjective dynamics that can be a source of suffering. The structural vulnerability category, therefore, has as its focal point the intersection between medical pathology, autobiographical experience and social suffering. This category, which we hope will become an instrument that is concretely applicable in the clinic, allows us to approach the health of migrants and other socially marginalized groups, not as the result of purely biological processes, but starting from the intersection of

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historical-cultural processes and life stories. The concepts of 'structural violence' and 'structural vulnerability' are therefore both essential in order to capture the multiple ways in which social forces shape the body, health and well-being of migrants.

Access to Healthcare

Some of the effects related to the primacy of the biomedical approach to migrants and asylum seekers' health include little consideration of the phenomena of violence and structural vulnerability described above, and the reduction of these people to organisms to be cared for through the 'classic' patterns of medicine and/or psychiatry (Kleinman 1987). A hierarchy of health needs implemented by medical staff itself sustains these tendencies in many cases. Contrary to the logic behind humanitarian and human rights, according to providers the bodies of (im)migrants do not all have the same value, and the needs registered in these bodies are not all considered equivalent. In this regard, one of the theses defended in this book is that the hierarchization of migrants' bodies and health needs is a phenomenon linked to the greater or lesser importance of clinical situations, but also to numerous other factors such as their gender identity, nationality, 'race', and even age. It is also on the basis of these elements that some migrants are considered more deserving than others of receiving medical assistance. As suggested by the theories of intersectionality (Crenshaw 1991), the interweaving of positive or negative forms of discrimination, linked to gender, race, class and generation is a particularly useful reading tool for reflecting on the inequalities within the fundamental right to health. An example is given by the importance attached internationally to the protection of maternal and child health. If, within migratory flows, female bodies are considered less dangerous and more vulnerable than male bodies, the case of pregnant migrants and asylum seekers is particularly exemplary from this point of view (Grotti et al. 2017, 2018). The latter, in fact, appear to be particularly deserving of medical assistance because of their physical condition. A second example is young migrants and asylum seekers, who are likewise considered to be more vulnerable than adult (especially male) migrants and thus more deserving of medical treatment. As highlighted by Viladrich in the case of the United States, from a cost–benefit perspective, assistance provided to young migrants is often considered a form of investment in the future of the nation.

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Another element that characterizes medical assistance provided to migrants and asylum seekers is an emergency-based approach to the right to health. This type of approach usually ensures that essential care and assistance are guaranteed in situations where human lives are in danger. Access to long-term care and specialized treatments – for example, when confronting chronic diseases – is more complex and nuanced. As highlighted in this volume, the opposition between *universalized* access to primary care and *selective* access to secondary care depends on the (more or less inclusive) functioning of national health systems, but also on the classification of health problems according to urgency. The situation described in Quagliariello's chapter on Lampedusa, where the immediate assistance provided to recently pregnant migrants who have miscarried is contrasted with the long waits experienced by migrants who request a voluntary interruption of pregnancy, highlights the extent to which what qualifies as a 'health emergency' depends on the point of view of the professionals rather than on the clinical needs of the patients.

As mentioned earlier, legal status is another factor that determines access to health care or, conversely, contributes to migrants' decisions to reject medical treatments. This dichotomy is particularly evident in the case of the United States, where the difficulties for foreign patients to enter the insurance system severely limits their access to medical treatment. As other case studies proposed in this volume show, having a regular residence permit or a temporary residence permit, however, does not automatically guarantee the right to care. At the same time, with regard to assistance to (im)migrants, asylum seekers and other foreigners, the need to respond to complex needs, which go beyond simple access to health services, clearly emerges. The lack of autonomy and/or the frequent mobility of foreign patients, which restricts the continuity of care, as well as the physical distance between the places of residence and places of care, are some of the fundamental problems that arise in case studies described in this volume. Furthermore, the economic cuts linked to austerity policies have reduced public investment in services for foreign populations over time (Knight and Stewart 2016). One of the situations that emerges in the contexts touched by the so-called 'migration crisis', such as the Middle East and South European countries, is the outsourcing of certain medical services to the humanitarian sector. The psychological support services NGOs offer in reception centres and refugee camps are an example of a model of integrated care in which the choice to delegate to health professionals working outside the hospital world fills the gaps of the public health system.

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Another of the responses to the limits of health-care systems encountered abroad is migrants' search for care in their country of origin or in third countries. This choice may also be linked to the need to integrate different healing models, such as 'modern' and 'traditional' ones. As will be highlighted in this volume, the transnational dimension of models of care carried out by migrant people presents multiple forms. In accordance with other spheres of daily life, therapeutic paths chosen by some groups of migrants and foreign populations – such as Roma groups living in Europe – go beyond a system of localized care whose limits correspond to geographical boundaries. The literature on medical tourism and medical travels (Kangas 2010) especially focuses on the situations of populations who belong to economically developed areas of the world but who turn to countries with weaker economies for the purchase of drugs and access to medical treatments – for example, those related to reproductive health problems – that may not be authorized or so readily available in their countries of origin (Whittaker and Speier 2010). Migrants, asylum seekers and foreign minority groups' search for and construction of 'therapeutic connections' in different places of the world is a less studied topic. As argued in the book, this form of 'transnational therapeutic syncretism' – a concept that differs from the category of medical pluralism, which mainly concerns the provision of care (Benoist 1996; Baer 2011) – is an integral part of the right to care and the right to health.

Beyond the Individual Level

In this volume, health inequalities are dissected and analysed as both a product of precise historical and political conditions and as a result of discrimination that affects specific groups. In both cases, observation leads the anthropologists who discuss health and illness to divert attention from pure biomedical data and to consider social, economic and political issues that influence the health of individuals. This means contextually shifting attention from a single individual to the group that shares certain characteristics with him or her, whether they be cultural, values-based or social.

The second part of the volume strongly emphasizes that dealing with health and migration means not only dealing with migrants as individuals, but also as groups. This means thinking about groups as agents of health; it means reiterating that health capital is both

individual and collective, and it ultimately means thinking about groups as social subjects.

Considering that groups have their own health capital and describing the structural conditions that lead them to lose this health capital inevitably leads to thinking about the meaning and the possibility of a community approach to treatment – that is, to treatment that takes into account both the collective dimensions of suffering and the social group as a resource for health.

A *community-based approach* to health and care contains both great risks and great potential. The chapter by Cingolani, analysing the case of the Roma minority in Italy, clearly shows how ad hoc interventions for specific migrant populations can reinforce stereotypes and increase social exclusion instead of enabling access to medical care and, in general, the exercise of their rights. The same chapter shows, starting from ethnographic examples, the risks that occur when health professionals think of the subjects as representatives of a social group, and consequently relate to them based on what they already know (or think they know) about their group of origin, thus depriving the patient of his or her subjectivity. The attitudes of the professionals identified by Cingolani are summarized as expulsive, re-educational, generalizing and culturalist. These approaches can also be found in the way in which the professionals described by Quagliariello relate to Nigerian women who are pregnant when they disembark at the island of Lampedusa and also in the way in which health providers perceive and relate to Syrian refugees, as described by Kerbage and Marranconi, who demonstrate either a widespread ignorance among professionals regarding the Syrian context or stereotyping towards patients. The authors note among the health-care providers a widespread representation of refugees as people who must be educated in relation to mental health, and as people who cannot independently evaluate their situations.

These cases highlight the presence of stereotypes and prejudices among health professionals. In order to understand the life contexts or the horizons of meaning within which people represent and recognize illness and psychological discomfort, much less attention is paid to the underlying representations of body, health and disease. The complexity of the meeting between health professionals and individuals from cultural contexts in which there are other visions of the body, health and illness opens up the question of the cultural competencies necessary to guarantee the right to treatment for foreign patients (Kleinman and Benson 2006). Misunderstandings related

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to the application of Western models to people who uphold other interpretative categories emphasize the need on the part of professionals to broaden their knowledge. As highlighted by Vargas in this volume, the integration of fundamental figures in hospital services, such as linguistic-cultural mediators, is a first step in this direction. At the same time, the analyses proposed by Vargas underline how the concept of 'cultural competence' of health-care providers has great potential, but also risks oversimplification, generalization and negation of individual agency. One of the dangers is the excessive use of the category of culture, or the reduction of any behaviour or choice by foreigners to reasons that have to do with the culture of origin. The need to take into consideration other elements that make up the individual identity of each foreign patient is described in this volume as a possible remedy for the numerous forms of discrimination and racialization, often summarized in the category of clinical racism for these patients (Bridges 2011).

Obviously the migrant doctor–patient relationship does not occur in a social vacuum, but in specific contexts characterized by open or closed climates. As Viladrich reminds us, the role of the media is fundamental in the construction of a collective discourse on migrants, and is often linked both to the circulation of stereotypes and to changes in terms of policies. Finally, it should be noted there is a risk that the widespread rhetoric, public speech and stereotypes of professionals will spread to patients and create a feeling of non-legitimacy about seeking health-care assistance. As Kline points out, the outcome of a stigmatizing discourse on migrants may be that the immigrants internalize sentiments of not belonging and of being undeserving of social services.

After briefly summarizing the risks associated with a collective approach to health and disease issues, we want to return to the aspects that make this approach necessary. From a reading of the contributions in this book it is clear that eliminating the collective aspect from an interpretation of the pathologies of migrants means depoliticizing suffering. In contrast, restoring centrality to the political aspect of pathologies and of psychological distress gives centrality to a suffering that is collective before being individual.

We therefore believe that a transition from the individual to the community with regard to health and illness is necessary both in order to recognize the political dimension of the disease, and to enhance the role that social networks can play for care and welfare in the broadest sense. To say that health capital is collective is to recognize the role of

social networks in its maintenance and also to define the absence of social networks as a risk factor for health (Kawachi 1999).

The presence of social networks can be a factor for reducing health-related risk and can facilitate access to treatment and understanding – both linguistic and symbolic – in the relationship between doctor and patient.

Agency, Resistance and Transformation

As pointed out earlier, over several years in various contexts we have witnessed the withdrawal of the state from welfare services (Ferrera and Maino 2011) and the appearance of entities of a different nature that provide additional services. The health arena is certainly an interesting field of analysis for observing the interaction between the public and private sectors, as well as observing new forms of welfare. The coexistence of different actors involved in health care emerges from different contributions in this volume and pushes towards the adoption of a *systemic approach* – that is, an analysis that takes into account the different contexts where treatment takes place. Among the non-governmental bodies that deal with various types of health, the examples in the volume include both formal organizations, such as NGOs and international bodies, and informal entities, such as the associations that advocate the rights of migrants described by Kline, the groups of volunteer doctors mentioned by Cingolani and the migrant associations that are the focus of attention in the chapter by Ferrero. Especially in some urban environments, these entities integrate with the public sector (Biglino and Olmo 2014: 10) and are sometimes perceived by users as more welcoming and more dedicated to protecting the health of migrants.

Here we are particularly concerned with overturning the logic of assistance and looking at examples that see migrants not in the role of people who need help, but in the position of active subjects who become social actors capable of triggering change in the contexts in which they live. This possibility emerges above all when one swaps the logic of emergencies for one of rootedness, and then observes the possible consequences of the integration path. To do this it is necessary to expand the concept of migration – and consequently that of migrants – to phases following the arrival, and thereby return this temporal dimension to the process. The images of the landings and the rhetoric of reception that have dominated over the last few

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years have quashed any discussion of migration in the early stages after arrival, detracting attention from what happens next, to the processes of settlement and inclusion. Restoring the element of process to the reading of migration removes foreigners from the category of victims, and returns to their bodies the social and political dimension of which they had been deprived (Agamben 1998).

From the temporality of the migratory process comes the development of the ability to resist. In terms of health protection this means that migrants themselves can become resources, recovering both an individual and a collective agency. The chapter by Vargas on cultural mediators, and that by Ferrero on the associations of foreigners, clearly show how foreigners can play an active role in improving existing services and in supporting newly arrived compatriots who are less able to manoeuvre in the context of arrival on the path to approaching these services.

The role of mediators and associations, however, is not limited to this. Vargas defines the mediator as a resource for humanizing care, while Ferrero defines migrant associations as entities that can fill the gap between caring and curing. This shows, on the one hand, how the presence of social networks can be a factor for reducing health-related risks, and on the other, how having social networks can facilitate access to treatment and understanding – both linguistic and symbolic – in the relationship between doctor and patient. Migrants' associations can therefore represent a tool for increasing access to services but also for implementing the right to health when they establish themselves as people who possess a cultural capital that they make available to others – for example, to newly arrived compatriots or people who do not speak the language of the host country.

In Part I of the volume it is stressed that the right to health is not something universal, but an abstraction that takes shape in precise local contexts. The same applies to the resources activated by migrants. Vargas points out that, far from being a neutral process, mediation is a social process situated within an area of non-neutral sociopolitical forces. Likewise, Ferrero's chapter, describing the associations that the author has observed, contextualizes the results of her research in a specific urban milieu.

The presence of mediators in services and the role of foreign associations break the dichotomy between universal services and services dedicated only to foreigners, representing instruments in which a universalistic service can adapt to heterogeneous users and thus become more welcoming. In particular, networking reformulates the relationship between supply and demand, bringing it to a more equal level, and

increases the social capital of immigrants (Tognetti Bordogna 2008). Above all, the relationship between migrants and welfare reveals the gap between holding and exercising rights that also occurs in inclusive systems. To be entitled to a right does not necessarily mean being able to enjoy it, and the existence of self-organized and community forms of protection can give back to the migrants part of that agency that has been undermined by the migratory process.

These reflections appear to be a useful tool to counteract the rhetoric describing migrants simply as individuals who burden the welfare systems of the host countries. To make some reflections that go beyond the emergency it is essential to divert attention from the moment of arrival and to turn to the possible integration paths that demonstrate how foreigners can play an active role in improving services aimed at the migrant populations and, therefore, ultimately be crucial actors on a path towards more inclusive and welcoming services. These resources, increasing the degree of health literacy of the communities, contribute to spreading a more conscious use of health services – a process that will benefit the entire population, and not just the migrants. In conclusion, it seems that viewing migrants as people who are able to speak for themselves and making changes to standardized care systems helps us to think about health literacy, not as a one-way process that involves passing information from doctors to users, but as a two-way exchange that includes both an increase in awareness and an increase in cultural competency.

Structure of the Book

This volume has as its starting point a multidisciplinary research project on migrants' right to health in Turin (Italy) with the Fundamental Rights Laboratory (LDF).[6] The chapters included in the volume are a selection of papers based on the findings of this research project, integrated with other contributions relevant to the topic.

The protagonists of this volume are people who fall within the category of 'migrant', but whose life paths are marked by experiences very different from each other: some have moved by choice for reasons of work or family reunification; others have moved by necessity as asylum seekers or refugees. In some cases these people are from historical minorities, like Latinos in the United States and the Roma in Italy, while others have taken part in more recent flows, as in the case of Syrians in Lebanon. Among the cases analysed in the volume we

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find some with regular residence permits, some with temporary visas and others who remain in a state in an illegal situation. Thus, one of the volume's primary tasks is to show, beginning with descriptions of the local contexts, the complexity of the 'migrant' category. Moreover, our contributions demonstrate how the theme of global health is intertwined with health systems and rules on accessing services that are rooted in national and local contexts. These settings are characterized by different legislation or a different social fabric that can either favour or hinder the entitlement to a right and the effective possibility of exercising this right. These local contexts are found in spaces that can geographically be very distant from each other. Pursuing the objective of enhancing the plurality of perspectives within the same discipline, the volume attempts to remedy an often Eurocentric view of the migratory phenomenon by including contributions on the United States, Latin America and the Middle East.

The concepts of 'migrant' and the 'right to health' are thus categories used by the authors, according to what they mean in the contexts qualitatively investigated in their chapters. Ethnographic methodology and in-depth observation are characteristic of each contribution, but it is interesting to note immediately the presence of different facets that show the richness and the heterogeneity of the research on health in the anthropological field. In the volume we find an ethnography of the media in the chapter by Viladrich; the figure of the activist researcher in Kline's contribution; a regional comparative perspective in the work of Goldberg, Silveira, Barbosa and Martin; an interdisciplinary angle in the chapter by Kerbage and Marranconi; and the multi-sited methodology of Cingolani. In our opinion this clearly indicates the number of ways available to achieve the 'thick description' (Geertz 1973) that is typical of the anthropological approach, and allows us to bring attention to the anthropologist as a field-maker, or as an individual who actively chooses the portion or portions of reality that he or she intends to study, reducing the initial indeterminacy of reality (Candea 2009: 27) and modulating the qualitative methodology according to that decision.

The volume is divided into two parts. The first is titled *Borders and Inequalities*, and focuses on the intersection between the concepts of frontier and structural vulnerability. Observing how migrants embody the 'border' – according to the meaning that the volume intends to give this term – means describing how people incorporate social and political inequalities that vary from context to context. However, similarities between the cases allow general conclusions to be drawn on the effects that vulnerability has on the health of people who

often live in conditions of social, economic and housing marginality. In the first chapter, Anahi Viladrich describes the passage of DACA (Deferred Action for Childhood Arrivals) in 2012, which granted temporary protection status to unauthorized youth and barred them from inclusion in Obama's health-care reform. The chapter examines US mainstream media constructions of deservingness after the passage of the US Affordable Care Act. In the second chapter, Nolan Kline continues to reflect on the concepts of 'deservingness' and 'undeservingness'. Drawing from a year of ethnographic fieldwork in Atlanta, Georgia, the author shows how immigrant policing can result in some immigrants internalizing sentiments of being undeserving of social services and, ultimately, how policy efforts may be used to maintain social hierarchies based on categories such as race and immigration status. With the contribution of Alejandro Goldberg and colleagues, we move from an analysis of policies to that of working conditions. These anthropologists created a multifocal ethnography in Buenos Aires (Argentina) and São Paulo (Brazil) through which they compared the health status of Bolivian immigrants employed in the textile industry. In this case the tuberculosis many Bolivians suffer from is analysed as a side effect of precarious and dangerous working conditions, and becomes, in the last instance, an incorporation of structural violence that the authors describe in terms of neo-slavery. In the fourth chapter, Chiara Quagliariello focuses on a border that has often been at the centre of the news in recent years: reaching the Italian island of Lampedusa does not, in fact, mean just entering the island but entering Italy and Europe too, and that is why the context of this chapter can be widely described as the Southern Europe borderlands. She introduces gender, intersectionality and maternal and child health into the discussion, analysing gender-based violence against women during the migratory journey from the African continent to Europe. The difficulties women face in order to access 'voluntary termination of pregnancy' (VTP) and the impact of living conditions in the Italian reception system on their overall health lead the author to argue that the structural violence and discrimination that pregnant African women are subjected to continues after their arrival in Europe.

The second part of the book is entitled *From the Individual to the Community*, and aims to reflect on the issue of health from a collective perspective. The concept of structural violence, extensively described in the early part of the text, leads the discussion on health to conditions that are purely biological and, therefore, individual, and to the observation of the health status of individuals as a symptom of

social, political and economic conditions. Given that these conditions are often shared by a certain category of people or a group, moving from the individual to the collective dimension, we emphasize the social and political dimension of many health problems. This concept is clearly expressed in the contributions by Pietro Cingolani and by Hala Kerbage and Filippo Marranconi.

Cingolani's chapter deals with the Roma, one of the groups with the worst health conditions and with whom medical professionals have strong relational difficulties. The concept of 'cultural difference' is often used to explain these difficulties, while the author places at the core of his analysis the social exclusion that this group has experienced over decades. In addition to illustrating the relationship between doctors and Roma patients, the author highlights how social exclusion can be reproduced and perpetuated along transnational paths, underscoring how transnational treatment paths can be the answer to an exclusion that is experienced as much in the context of departure as in that of arrival.

The sixth chapter, by Kerbage and Marranconi, focuses on the mental health of the Syrian population in Lebanon. The context of displacement in a post-war setting as well as the social adversity that refugees are exposed to have been associated with mental health problems, mainly depression, anxiety and post-traumatic stress disorder (PTSD). Beyond these diagnostic categories, qualitative studies in this context revealed that refugees may suffer from the loss of role and social networks, isolation, feelings of helplessness and hopelessness, loss of a sense of meaning and purpose, and an inability to imagine a future. Mental health services might pathologize ordinary human suffering in reaction to horrifying events and hinder important aspects like social history and political justice; on the other hand, restoring the collective aspect of suffering can re-politicize the mental health discourse of Syrian refugees in Lebanon.

The final two contributions continue the reflection on migrant communities by shifting attention from the conditions that generate marginality and health inequalities to resources that can be activated by migrants themselves in order to support access to and proper use of health services by other migrants. Ana Cristina Vargas describes intercultural mediation in the Italian context, one of the strategies promoted by the European Union. After an overview of the figure of the mediator, the author describes the contexts in which this figure participates in the social and health services setting. Mediation is usually represented as a neutral technique, whereas the author describes intercultural mediation as a social process within an area of non-neutral sociopolitical forces.

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While Vargas highlights the limits and potential of the presence of mediators in the health sector, Laura Ferrero in the last chapter describes how migrant associations can sometimes informally play the role of mediators between services and compatriots living in situations of marginality. Through observations conducted at five associations of foreigners active in the city of Turin (Italy), the author shows how the obligations of these entities can be transformed into an element that facilitates both access to and the success of the medical encounter.

Laura Ferrero obtained her PhD in anthropology and has been a postdoctoral fellow at Turin University, where she teaches Anthropology of the Middle East; she is also research fellow at the Fundamental Rights Laboratory, Turin. She has conducted research in Italy, Egypt and Palestine. Her main research interests are: migration studies; migrants' access to health and housing; as well as gender and family in Arab-Muslim societies.

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Notes

This introduction is based on the three authors' shared work. Parts 1, 2 and 4 were written by Ana Cristina Vargas; parts 3, 5 and 6 by Chiara Quagliariello; and parts 7, 8 and 9 by Laura Ferrero.

1. The document was the result of a request from UNESCO to Herskovits for his opinion, as president of the Committee on International Cooperation in Anthropology of the US National Research Council. Once the document was drawn up, Herskovits submitted it to the AAA board, which elected to endorse it.
2. In addition to civil and political rights, also called 'first generation' rights, economic and social rights, or 'second generation' rights to which the individual is entitled, are particularly relevant in the field of the right to health. In more recent years a 'third generation' of rights has developed, which, unlike the first two, has a collective character, because the holders of these rights are not individuals but communities.
3. We will not dwell here on the phenomenon of displacement, but it is worth noting that the latest estimate by the UN has found a figure of 740 million migrants and internally displaced persons.
4. United Nations General Assembly, 'Report of the Special Rapporteur on the Human Rights of Migrants', Doc. A/69/302, 11 August 2014.
5. See *The Oxford Handbook of Refugee and Forced Migration Studies* (Fiddian-Qasmiyeh et al. 2014).
6. The Fundamental Rights Laboratory is a research centre that investigates social and health inequalities and other forms of social injustice associated with the implementation of human rights in the Italian and other European contexts. It is member of the Comitato per la promozione e protezione dei diritti umani and of the European Human Rights Research Network. The Fundamental Rights Laboratory is made up of legal scholars and social scientists who carry out research work together in an applied and interdisciplinary perspective.

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