The Health Consequences and Healthcare-Seeking Strategies for South American Immigrant Careworkers in Genoa, Italy

Patti A. Meyer

University of Kentucky, meyer.patti@gmail.com

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Patti A. Meyer, Student

Dr. Mary K. Anglin, Major Professor

Dr. Hsain Ilahiane, Director of Graduate Studies
THE HEALTH CONSEQUENCES AND HEALTHCARE-SEEKING STRATEGIES
FOR SOUTH AMERICAN IMMIGRANT CAREWORKERS IN GENOA, ITALY

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Liberal Arts at the University of Kentucky.

By
Patti Ann Meyer
Lexington, Kentucky

Director: Dr. Mary K. Anglin, Associate Professor of Anthropology
Lexington, Kentucky

2013

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ABSTRACT OF DISSERTATION

THE HEALTH CONSEQUENCES AND HEALTHCARE-SEEKING STRATEGIES FOR SOUTH AMERICAN IMMIGRANT CAREWORKERS IN GENOA, ITALY

This research on healthcare strategies of home-based, low-wage, immigrant careworkers contributes to the ways medical anthropology, migration studies and social science understand human-economy-family care relationships and health and carework as commodities in today's global economy. It reveals the consequences for workers as they defray the costs of care for the Italian government and contribute to their home economies. This research was conducted in Genoa, Italy, which has the largest percentage of people over the age of 70 in any city of its size in the world and a tradition of sending and receiving immigrant workers. The main question was: Under the circumstances of providing labor-intensive, in-home supportive services, how do immigrant workers respond to their own health needs?

The researcher collected data from interviews with 50 careworkers, 25 professionals who provide services to the careworkers, and 23 administrators in the health system, government agencies, labor unions, and the Catholic Church. The careworkers interviewed were women from South America, as they do most of the carework jobs in this city. Long-term participant observation and interview data were analyzed to: 1) produce empirical data on health concerns of and healthcare resource use by migrant careworkers; and 2) investigate the relationships between health concerns, living/working conditions, and healthcare resource use of transnational immigrants in the informal economy.

The data showed that the Catholic Church promoted immigrants as able workers, aided their elderly parishioners, and provided necessary mental health support to careworkers who experienced stress. The data also revealed that the health care system of Italy functioned well to address the physical health concerns of immigrant careworkers. The relationship between the client and the worker was important for the general well-being of the worker and her ability to maintain her general health, have time for medical appointments, socialize outside of the workplace, and attend community events. This study examined: strategies for using health resources; responses of the Italian medical system personnel to anti-immigrant legislation; use of non-State resources to meet health needs; the health consequences of caring for an elderly person in the private home; and ways to address these health consequences.
KEYWORDS: carework, transnational immigrant, healthcare strategies, informal economy, Italian healthcare system

____ Patti Ann Meyer
Student’s Signature

April 5, 2013
Date
THE HEALTH CONSEQUENCES AND HEALTHCARE-SEEKING STRATEGIES
FOR SOUTH AMERICAN IMMIGRANT CAREWORKERS IN GENOA, ITALY

By

Patti Ann Meyer

Dr. Mary K. Anglin
Director of Dissertation

Dr. Hsain Ilahiane
Director of Graduate Studies

April 5, 2013
Per
Carmen e Gilberto
Antonio Guerci
e, ma certo,
Giacomo
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Chapter One: Introduction to the Dissertation

This dissertation addresses my interest in understanding the ways in which immigrant careworkers maintain their own health and in uncovering how their work influences their health and well-being. In addition it examines how economic situations position these workers in the transnational economy and how Italian state forces such as the Security Package are influencing the well-being and health of immigrant careworkers “on the ground” in Genoa. This research examines the experiences of a group of women clustered by profession and continent of origin (South America), who often work in the informal economy (Laitner 2006b). I contextualize these economic exchanges in the intimate context of the home and in the important histories of immigration, labor unions, feminism and Italian state policy development. The overarching question guiding this research focuses on the health experiences of the workers and the type of healthcare resources they utilized, mitigated by the work-life conditions of the workers themselves. Healthcare resources provided by the Italian state vis-à-vis its national healthcare system, and healthcare and social support provided by the state-like institution of the Catholic Church receive particular scrutiny in this research. Between October 2009 and November 2010, I spent 12 months in the city of Genoa, Italy, conducting my fieldwork.

Around the time I arrived to begin my fieldwork, I met Lisa1, who had just arrived in Genoa from Ecuador. Lisa was the grown daughter of Virginia, a 64 year old mother of two, who had been in Genoa alone for eleven years and was a “typical” careworker-participant in my research. Lisa was seeking work as a cleaner or careworker, with hopes of securing an employment contract that would put her on the path to gaining

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1 Pseudonyms are used for all research participants. Any identifying characteristics are obfuscated as needed to protect anonymity. Careworkers’ pseudonyms are used to highlight their experiences, other research participants are often referred to by their title or role, such as “social worker” or “health clinic administrator.”
documentation so that she could remain in the country legally. The first time I had an extended conversation with mother and daughter they were walking to the hospital near my home for an outpatient appointment. Virginia explained, “It is really an appointment for me, but I called my doctor and told her about my daughter being here and she said to bring her in, so she can be enrolled in the (healthcare) system.” Later, during our scheduled interview, when I asked about the appointment, Virginia reported,

She (the doctor) was delighted to meet my daughter, and I am so proud of her (the daughter), and of my son who is still alive in Ecuador and is a wonderful teacher and husband and father. I want the best for my Lisa and I was worried with the new laws you hear about on the TV, that she could not get care…But my doctor told me it is good that Lisa has the temporary health card and Lisa can make appointments to see my doctor again.

Lisa was in good health and so there was not an immediate concern, but Virginia was interested in getting Lisa off to a good start in Genoa, and had already lost one of her children to complications related to HIV. Virginia reported that she helped her son die right before she immigrated to Italy to earn money so that Lisa could finish high school and enroll in college. Virginia referred to the laws that limit access to many public services for undocumented immigrants in Italy, which had been passed as part of the Security Package of laws in August 2009, just months before our conversation and interviews. I arrived in Genoa to learn how immigrant careworkers like Virginia and her daughter were able to care for themselves, maintaining the important asset of their healthy reliable selves so that they could arrive at work every day to care for the client in their care. However, the Security Package was present, always as a specter, and at times headlining the news, or as a topic under discussion when South American immigrants gathered before Spanish-language church services.

I interviewed many women like Virginia, careworkers with a work (and health) history in Genoa, to find out which healthcare resources they used, how they strategized to access those resources, and which barriers limited their access to care. The Italian
National Healthcare System (INHS), represented in this situation as Virginia’s doctor, emerged quickly as one resource used by immigrant careworkers. The family and social networks that Virginia described were often part of the strategies used to access this resource. For instance, the day of her doctor’s appointment, another family member, Virginia’s sister, now employed part-time as a house cleaner, was spending the afternoon with Virginia’s elderly client. It was in fact Virginia’s afternoon off, as specified in her work contract, but her client was having a hard week, and Virginia felt reassured to have someone with her while she was away. Virginia and Lisa lived with Virginia’s sister, brother-in-law and niece. Virginia was at “home” one night most weekends, when she was not caring for her elderly client and living in the client’s home. Lisa and Virginia contributed to the household of Virginia’s sister in turn.

There were two barriers evident in the situation described above. First, taking time away from a client’s home could be difficult, even when by law it was mandated for those working with a legal contract. Second, the anti-immigrant rhetoric accompanying the passage of the Security Package, and the uncertainty about exactly how the laws limiting healthcare for undocumented immigrants would be enacted made Virginia and Lisa concerned. During her time in Genoa, Virginia had worked with five different elderly and disabled clients with a variety of conditions, and she had learned a great deal about how the INHS functions. Her experience provided her with knowledge and strategies for her own navigation of the system, and she had a trusting relationship with her own primary care physician. However, for this savvy, confident documented immigrant the Security Package had introduced a germ of uncertainty, especially because her daughter had not yet entered into the status of being documented.

The Research Project Focus

The opening vignette describes several of the main issues examined in this project. Virginia and her daughter Lisa had accepted the fact that they would likely not
be considered suitable for any employment in Genoa other than as careworkers or cleaners, and were focused on getting and maintaining a foothold in the economy. The vignette also hints at the historical trajectories and global economic market forces that have brought Virginia and Lisa to Genoa as domestic workers. In a follow-up interview with Virginia, I was drawn into the sphere of carework she inhabits as a live-in worker. The basic constructs of anthropology are well-suited to studying carework, an activity based on exchanges that occur in the intimate space of the home and embedded in social relations (Polverini, et al. 2004). Ethnography and anthropological analysis examine the situation at the most intimate scale and in its global context.

The combination of demographics and immigrant labor practices in Genoa make it an ideal site for studying home careworkers. Care for the elderly is an acute concern in Italy, where the population is aging while Italian women (the traditional family caregivers) have joined the labor force in record numbers and family size has decreased, as seen in the extremely low birth rate of this country for the past five decades (Anderson 2001). Migrant workers support the health of the elder population by filling low-wage, in-home, careworker positions, thus subsidizing the healthcare system of this industrialized country (Anderson 2004; Degiuli 2007). Italy itself uses privately paid careworkers at twice the rate of any other EU country, has some of the lowest rates of institutional care for those 85 and over, and has a high concentration of elderly citizens, with 20% of the population over 65 (ISTAT 2009b). In addition, the home care workforce in Italy consists primarily of non-Italians--an estimated 86% are foreign nationals (Lamura, et al. 2006). Genoa is the largest city in Liguria, the region with the highest concentration of people over 80 (Guerci and Consigliere 2002). For this reason, some have called Genoa the "Miami" of Italy.

This dissertation focuses on a particular group of transnational workers, beginning with their health as a lens through which to view the processes and institutions
that influence their work and health experiences. The work of caring for an elder at home includes a wide variety of tasks influencing both the physical and the mental health of the person doing this labor. This research makes visible the consequences of this labor for the well-being of the low-wage home-based immigrant careworker in Genoa.

More specifically, one finding is that individual agency and collective action influence the quality of life for careworkers in elders’ homes, in part by mitigating the stress associated with the labor of in-home, low-wage care. Focusing on transnational fields and the dialectic relationship between structure and agency (e.g., Bourdieu 1977; Ortner 1989), I use a definition of individual agency as being “both constituted by and constitutive of culture” (Buckner 2008). In examining how the Italian state and the state-like institutions in Genoa influence the well-being of immigrant careworkers, this research also demonstrates that the nation-state continues to be influential at a variety of scales. Thirdly, the policies, resources, and economic conditions in Genoa, Italy combine to create a situation that positions the immigrant careworker into an inflexible slot in Genovese city culture, even as it utilizes the labor power of the flexible global worker. Finally, a specific contribution of this research is to point out that there are consequences for industrial societies that rely on unwaged (family) labor, which is often transformed into low-wage immigrant labor. The demographic situation driving the burden of care evident in Genoa, will be visible in other regions of Italy in ten more years, and countries such as the United States in 25 more years. What are the personal consequences for migrant workers as they defray the costs of reproductive labor for the Italian state and contribute to the economies of Southern nations? In more specific terms, I used the following questions to guide my research:

How does employment influence the types of concerns, both job- and health-related, that migrant careworkers report?
How do various life conditions influence the use of healthcare resources and reasons given for seeking out these resources? These work-life conditions include: employment-residence (living in or living out as a condition of employment); documentation status (with or without work permit); and length of time in Italy.

How do working conditions influence the well-being of careworkers and their health concerns? How do these working conditions influence their use of healthcare resources? Working conditions include: the relationship with supervisor/client; the amount of autonomy and/or surveillance; the quality of basic daily life, i.e., food and hygiene; and, working hours and opportunity for breaks.

What kinds of social institutions and relationships do immigrant careworkers draw from for support as they utilize healthcare resources to sustain their mental and physical well-being?

This project was designed to address these questions by focusing on the experiences of women as they navigate official healthcare systems and less formal healthcare resources, make time from their time- and labor-intensive carework jobs to take care of their own health, and, in some cases, experience living across transnational boundaries as immigrants from South America living in Genoa. This current micro-scale ethnographic research project has: (1) produced empirical data on health concerns of and healthcare resource use by transnational migrant careworkers; and (2) investigated the relationships between health concerns, living/working conditions, and healthcare resource use of transnational migrants in informal work settings.

Theoretical Issues and Relevant Literature

There are four bodies of work which inform my analytical approach in this research project: (1) the literature on carework in its broadest iteration, from biomedicine to labor studies; (2) the medical anthropology literature on stress; (3) critical medical anthropology, used in combination with the important idea of intersectionality from a Black feminist intellectual tradition; and, (4) the literature on transnationalism and gendered labor.
Carework Literature

Care as Work

My research project prioritizes carework as work, regardless of the relations between the person doing the work and the care recipient. The immigrant careworker takes on responsibility for another person’s well-being, providing reliable, skilled care to support the aged care recipient. Many elders can function and flourish at home if the right person is there to maintain a steady presence in their weekly and daily home life (Cantor and Brennan 2000; Hicks and Lam 1999; New York Community Trust., et al. 1993; Scharf and Wenger 1993). The Italian government’s approach to care for elderly citizens assumes that elders will get the help they need to remain functional at home from family members (Lyon and Glucksmann 2008; Saraceno 2003). However, in the last few decades, due to the long pattern of low birthrates and a change in labor patterns for women, many Italian families have met their obligation by hiring a low-wage immigrant woman to be present and perform tasks that allow the elderly client to function at their best while living at home (Lamura, et al. 2006). As of 2006, more than one in ten Italians (10.2 percent) over sixty makes use of domestic workers or careworkers (Lyon 2006:218-219). Many households hire immigrants, often without a legal contract, because they are seeking the lowest cost of care (Lamura, et al. 2006). Currently, the Italian economy is populated by irregular migrants ready to work and irregular employers ready to use (or exploit) their labor.

Many elders deal with more than one chronic condition as they age, and when an acute event takes place (such as a bout of pneumonia or a badly-sprained ankle) it can create a situation that requires more care. For example, some elders may require help with personal intimate tasks such as using the toilet and bathing. Other elders need assistance with shopping, getting to appointments, and heavy cleaning, but attend to all personal intimate tasks on their own. While the specific care tasks vary widely in the
examples just given, the person performing the tasks must be present in the home of the elder. The family member and/or careworker may arrive to address a variety of needs and may shop, clean, cook, escort, bathe, launder, change diapers, and/or provide companionship, but the care provider must arrive, and remain physically present in the home on a regular basis, i.e., be reliable.

In order to be that reliable person, arriving every day to perform the relational tasks, decision-making, and physical labor of care, the immigrant careworker (or the family caregiver) must maintain her own health and general well-being. Whether the position is live-in or live-out, and regardless of the level of care required to maintain the well-being of the elder client, the careworker still must be physically present in the home.

In addition to being reliable, the in-home careworker must possess a wide variety of skills, detailed in chapter 5. Thus, the psychological well-being and overall mental capacity of the worker are essential for her to complete the diverse tasks that home-based work requires.

Whether and how this work is valued, or not, is related to the skills required to perform it. The labor of care is often associated with the labor of women, to the degree that it is “naturalized.” Women are seen as naturally caring and therefore especially suited to do carework (Gunewardena and Kingsolver 2007; Karides 2002:164-166). Thus, the gendered labor of carework gets glossed as “unskilled” labor, when it is in fact highly skilled labor. This skilled labor is often done for zero wages by a female family member or at a low wage by an immigrant worker, as in the setting of my research. The female immigrant careworkers in this study are a cheap source of quality care for elders in Genovese homes.

While the phenomenon of women moving to large Global North cities to provide carework is well documented and theorized (for example, see Lan 2006 regarding migrants to Taiwan; Naples and Desai 2002 for a large-scale analysis; Weir 2005
regarding the prevalence of this phenomenon) much of the analysis has been at a meso- or macro-scale, and none of it begins with a focus on the health of the in-home, privately-employed, immigrant careworker to the elderly client.

Consequences of Carework

My research project builds on the relevant findings from biomedical and social science research on front-line health workers and family caregivers in order to highlight the consequences of the work of care. This research informed my analysis in three important specific ways. First, there were empirical findings directly connecting the work of care to the physical and mental health consequences for the person doing this work. Second, a look at this body of literature revealed that the context and working conditions of labor influenced the health of the worker. Lastly, the literature revealed that relationships of the careworker influenced how the work of care affected her health.

Because this analysis seeks to see how the work of the immigrant low-wage careworker affects her health, the studies most directly related to in-home carework are described here. In 2006, a group of epidemiologists (Muntaner, et al. 2006) examined the effects of organizational-, workplace-, and individual-level variables on symptoms of depression for workers in nursing homes. Of particular interest for my work, was their finding that “the emotional strain, related to providing direct care to elderly and disabled clients, had a statistically significant association with symptoms of depression among nursing assistants” (Muntaner, et al. 2006:1461), with females in caregiving roles particularly vulnerable to psychological distress (Marshall, et al. 1990:206). This was in

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2 There is a rich body of literature regarding the health and well-being of family members who have become primary or secondary caregivers for elders, written by medical professionals, social scientists, gerontologists, and social workers. The rigor, large size and breadth of this body of family caregiver literature attends to many issues: changing relations between provider and recipient; signs of caregiver physical and psychological stress (Cannuscio, et al. 2004); general well-being of both care recipient and care provider; specific disease incidence and outcomes for caregivers (Schulz and Beach 1999); the influence of the care required on the provider’s health, well-being, and social involvement (Sink, et al. 2006); and the analyses of the specific care situations, i.e., a person with dementia (McConaghy and Caltabiano 2005); a person with mobility limitations (Wiles 2003), or a person with communication disorder.
line with the research finding that women in the wider population, not grouped by profession, generally experience depression and anxiety at significantly higher levels than men (Kendler, et al. 2001; Sherrill, et al. 1997).

The nursing and health literature has paid the most attention to the health of the paid elder care provider. For instance, for Zeytinoglu, et al. (2000) and researchers from the U.S. National Institute for Occupational Safety and Health (NIOSH) reviewed reports of musculoskeletal injuries experienced by elder care providers, including a large sample of formal home care providers (Galinsky, et al. 2001). NIOSH found that “compared to other healthcare workers, aides and geriatric nursing personnel have the highest rates of work-related musculoskeletal injuries” (Galinsky, et al. 2001:60). More recent research, focused solely on a large (N=2,800) cohort of home health workers in the United States by Kim, et al., documented a high level of musculoskeletal injuries, in particular persistent back problems that developed in direct response to the job (2010).

The conditions of work, including the physical work setting and the supervision structure, have been shown to influence the health of careworkers. In the large NIOSH study described above, as of 2001, “musculoskeletal injury rates have been shown to be higher in home healthcare workers than in many other groups studied, including construction workers, park workers, hospital nurses, nurses’ aides, paramedics, cleaners, kitchen workers…” (Galinsky, et al. 2001:62). Notably, a 1993 study by Myers also pointed to the home setting as a factor in work-related injuries. He found that the annual rate of low back injuries for home health aides was nearly three times the annual rate of these injuries for hospital nursing aides (Myers 1993).³

³ Their examination of working conditions and incident reports of low back injuries was based, in part, on employer records from two home care agencies and a hospital. Also notable was that all of the home-based health aides involved in this study were women, compared to 60% of the hospital aides (Myers 1993).
Context is also important in the approach taken by Denton, et al. (2002) in researching the mental health of visiting home healthcare workers in Canada (who work for an agency, sometimes with a government contract) and correlating mental health risk with the type of supervisory structure used (Denton, et al. 2002:3). These authors placed the worker in a context and began with the conditions of work when designing their study. In the biomedical literature on family caregivers the carework environment was viewed as containing “triggers” for careworker stress (Bialon and Coke 2012; Goode, et al. 1998), or as a site of physical risk (Carayon, et al. 2007). In addition, particular work conditions were connected to stress (Andren and Elmstahl 2005; Payne, et al. 1999).

In addition, I draw upon findings regarding the relationships of care providers in their work settings, especially in how these relationships influence care provider well-being and strategies for coping. In studies conducted by social workers (Leece 2010), medical researchers (Mausbach, et al. 2007; Prince, et al. 2012; Vidotto, et al. 2010), gerontologists (Lorig, et al. 2012) and social scientists (Keigher, et al. 1999; Woodward, et al. 2004), a typical finding is that the importance of interpersonal relationships with both clients and coworkers is correlated to the “emotional exhaustion and depersonalization of home care workers” as in the research done with workers in an elder care agency in Japan (Fujiwara, et al. 2003:317). The group of workers (N=892) participating in the study in Canada by Denton, et al. were “professionals” (therapists and nurses) and “non-professionals” (“home support workers”), which provided an opportunity for comparison, yielding new insights. In this comparison, the emotional aspect of the work appears to be more important to the home support workers than to the nurses and therapists, both positively and negatively in terms of work related stress. As the authors point out: “Home support workers spend more time with a client than their professional counterparts….many form a close personal bond with the client.” (Denton,
et al. 2002:20). Research on workers in mental health institutions (Kristensen 2006; Lundgren and Browner 1990) and in eldercare institutions (Diamond 1990; Morgan, et al. 2002) found that social support in and out of the workplace influences positively the ability of low-level workers in the healthcare hierarchy (psychiatric technicians, health assistants, certified nursing assistants) to mitigate the mental stress they attribute to their work.

My project also builds on the family caregiver research findings and applies them to the lives of low-wage immigrant in-home careworkers. The work on family caregivers was very useful for this research project because, like many family caregivers, the in-home low-wage worker has prolonged contact with the client and works in the home environment. Thus, the paid in-home careworker was susceptible to many of the same challenges and risks associated with the work of the family caregiver (Calvete and Lopez de Arroyabe 2012; Krevers and Oberg 2011; Singleton 2001). Some research focused squarely on the relationship between the elder person and the caregiver (Paoletti 2002; Rudd, et al. 1999; Shellenberger, et al. 1989) and on specific ways to support family members who experienced stress (Navaie-Waliser, et al. 2001), useful in my examination of the ways in which careworkers draw upon social support.

**Labor Studies and Care: the Careworker and the Supervisor/Client**

Eldercare is a term that implies that more than attending to the physical needs of an elder needing care is taking place. It suggests that the person addressing the needs of the elder also is invested in a relationship with the client, even as their labor power is exploited. My work differs in focus from the important ethnographic and theoretical contributions by Anderson and other social scientists working in Italy and other European countries (for example see: Parreñas 2001, 2005; Andall 2000, 2004; Degiuli 2007, 2011; Gori 2001, 2003; Solari 2006) in that I look at the ways in which this exploitation is revealed in the health and well-being of the women who do this carework.
My approach to carework as labor does not eliminate the idea that relationships and emotions are involved in care. In fact the relational aspect of carework is a factor in the exploitation of the worker, as described by Parreñas, in her work on Filipina domestic workers in Rome, when she found that employers took advantage of the emotional ties formed between client and worker to extract more labor than agreed upon in advance (Parreñas 2001a:181-191). While Parreñas and others (Degiuli 2007b; Stacey 2011) found that workers also “leveraged” the relationships they had with employers as a negotiating tool, I build on their work to examine how utilizing the relationship between employer and work is part of the set of strategies used by the worker to mitigate the consequences of the labor on her own health and well-being. In addition, I highlight how these immigrant workers develop strategies to access healthcare and maintain their most important work asset, their “reliable” self, which is important for them to fill the job of careworker, with their necessary and skilled presence in the home of an elder needing assistance.

This analysis uses concepts from labor studies to examine the negotiated and contested relations between workers, clients and employers, especially evident in chapters 5 and 8. The ideas of *surplus value* (Dalla Costa and James 1972), reproductive labor (Duffy 2005b; Tung 2000), and *emotional labor* (Hochschild 2000; Parreñas 2005) are central to the discussion on labor migration, household-based work, and gender. *Reproductive labor* is used in this project to refer to the activities, typically unpaid, done to address basic needs such as for food, shelter, and social communication. This labor of *social reproduction*, which “reproduces the culture” (Kunz 2008), includes the care of children, disabled adults, and elders (Duffy 2005b; Nakano Glenn 1992). Related to this is *surplus value*, the worth of a product or service in excess of the cost of production to the worker. Surplus value is necessary for capitalism to
thrive, as it is necessary for the accumulation of capital (Hantzaroula 2004:771,775; Marx 1976 (1990)).

Dalla Costa and James posit that “housework as work is productive in the Marxian sense, that is, is producing surplus value” (1972:7). These scholar-activists, along with many other scholars developing socialist feminism (Eisenstein 1979; Hartman 1979) were responding to the original idea of surplus value from Karl Marx, which did not account for the ways in which reproductive labor (“housework”) was essential for surplus value to exist. This early critique emphasizing work in the home is explicitly named here to highlight the labor of caring. In the case of home-based elder care, this labor includes the responsibility to be present, and to perform tasks involved in the care of another person. In some ways these job requirements are similar to work attending a machine in a factory or being near a phone in an office.

Finally, emotional labor is a concept first defined by Hochschild as the “management of feeling to create a publicly observable facial and bodily display” (1983:7). Her work came from a study examining the details of the daily labor of airline attendants. Hochschild points out that the employers’ “control over the emotional activities of employees” (Hochschild 1983:187) meant that the employees’ emotional state must be disregarded. This terminology is central to scholarly analyses of care, writ large, including nursing, human service occupations, and the labor that is associated with the home, such as the work of nannies, attendants to disabled persons, and the intimate care of elders (Glomb, et al. 2004). Emotional labor is used in my analysis of the tasks of work in chapter 5. Though many scholars have interrogated and used Hochschild’s idea (for example, in occupational wage analysis, Glomb, et al. 2004; in nursing, Henderson 2001; in medicine, Larson and Yao 2005; in immigrant domestic workers, Magat 2003; and in considering care more broadly, Zelizer 2010) I find Parreñas’ application in her ethnography of Filipina domestic workers in Rome directly
useful to my analysis of the way underemployed workers respond to being under scrutiny in the intimacy of the home. Also, I draw from the more recent work of Stacey and the way she uses Hochschild’s concept in her research on the relations between worker and client in the home care setting (in the U.S.). When Stacey applies the idea of emotional labor to her analysis of home careworkers she takes it one step further, moving beyond Hochschild’s dichotomy of “deep acting” and “surface acting” (Stacey 2011:70-72, 159). *Surface acting*, as described by Hochschild, is when the emotion displayed does not match the emotion felt by the worker doing the display. Hochschild acknowledged that the worker who displays a caring persona when in fact she does not care (surface acting) may eventually experience a certain level of stress in the workplace. On the other hand, Stacey found that the careworker whose visible caring persona did in fact align with her true feelings for the client (*deep acting*) had two general outcomes. First, such a coincidence provided motivation and a higher level of job satisfaction for the worker. Second, it resulted in a high level of stress when the worker witnessed the suffering and/or death of her client, a person with whom she felt emotional closeness. Stacey found that many of the agency home careworkers in her study experienced both of these outcomes. The social locations, subjectivities, and acts of agency endemic to these home care situations are examined using the approach of feminist anthropology to reveal the processes, emotions, tensions, and relations attached to care.

**Stress, Social Suffering, and Health Inequalities**

The idea of distress and stress, experienced at the community and individual levels, is linked to the ways in which medical anthropology has interrogated mental health over the past four decades. By theorizing the body, i.e., not considering it a given, but as an important constructed subjective site (Biehl, et al. 2007; Schepers-Hughes and Lock 1987) medical anthropology began its interrogation of the Cartesian division of
mental as distinct from physical (Lupton 1995; Sargent and Johnson 1996). In medical anthropology important developments for mental health have included the idea of culturally-bound concepts of mental illness and health4 (Adelson 2000; Cohen, et al. 2002; Izquierdo 2005; Kleinman 1988; Low 1989). Medical anthropology has, as an extension of the mind-body dichotomy critique, engaged with the problem of naming categories of normal as creating related pathologies, often using ideas from Michele Foucault (1983) (for examples, see: Hahn 1983; Kagawa-Singer 1993; Litva and Eyles 1994; McMullin 2005; Young 1982). In using critical medical anthropology I privilege the idea that “issues of power, inequality, exploitation and the like create the social environment within which the individual level is actualized” (Baer, et al. 1997:50) which includes, in this chapter, the study of social suffering.

The concept of social suffering highlights the response to trauma (Batniji, et al. 2006), inequalities that influence everyday life conditions, and the rapid changes in community and family life that are typical in the unequal distribution of globalizing resources (Han 2007; Navarro 2002; Patel and Kleinman 2003). Saillant and Genest (2007) view the concept of social suffering as the “new critical medical anthropology” which they consider to differ in one way from the political economy approaches of Singer and Baer (1995) because it has slightly changed “the cut-off point between macro and micro” (Saillant and Genest 2007:xxvii-xxviii). By this they mean that social suffering as a hermeneutic tool provides an easier entry point into multiple levels of the construction of suffering experiences and the subjectivities inherent to them (Saillant and Genest 2007).

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4 One culturally-bound idea that came to mind was the idea of nervios, which has been much-discussed by medical anthropologists, as an idiom of distress manifest when encountering political and economic trauma and exploitation (Jenkins 1996). Others describe this as a chronic condition that often involves headaches and anxiety brought on by unending life stressors (Davis and Low 1989 and Baer, et al 2003) None of my careworker-participants used this word. When I introduced the term into interviews, the interviewees dismissed the idea that what they experienced was nervios.
The experience of being an immigrant was one subject position all the workers in my study occupied, another was being a low-wage home-based worker. These are also racialized, ethnicized, and gendered social positions. It is critical to examine the multiple positions that the immigrant women simultaneously shape and occupy (Denis 2006; Düvell 2011; Pagnotta 2008) as the work of caring is perceived as not only gendered but also “raced” and related to class positions (Bubeck 1998). The ways in which these multiple subject positions may influence their political and economic power and experiences of stress are examined in this project using two theoretical perspectives, critical medical anthropology (CMA) and intersectionality.

**CMA and Intersectionality Theory in Combination**

Critical medical anthropology examines the relationship between health and socioeconomic inequalities, and in this study is used in conjunction with intersectionality theory. CMA recognizes that health is a political issue (Navarro 2002) and positions health and illness as based in history, multi-factorial, and linked to systems of power (Abbott, et al. 2006; Castro and Singer 2004; Fassin 2007; Nguyen and Peschard 2003). CMA is especially effective at highlighting linkages among systemic, economic forces and health (Macinko, et al. 2004), viewing individuals as economic actors and/or class members (Coburn 2000; Sargent and Larchanché 2011), which is an important perspective for this analysis of the well-being and strategies of careworkers (Pelto and Pelto 1996). The use of a critical medical anthropology framework, specifically focused on health, provides a way to pinpoint and analyze the power relations and household needs in tension with institutional, organizing forces. These institutional forces include the state (Adams 1988) and state-like actors (Cornell 2002; Gupta and Ferguson 1997; Webster 1976) such as the Catholic Church and labor unions. The political forces in this research include the role of the state in care provision for the important actors in the care situation – the careworker and the elderly client. In Italy, the state has shifted the burden
of responsibility of eldercare to the family of the elders, who in many cases have in turn shifted the burden on to low-wage immigrant laborers. As explained below, the Italian state as an active agent of care is seen in the policies and operation of the national healthcare system (INHS) (chapters 2 and 7) and in the policies that require the family to care (chapter 3). The Italian state is also visible in immigration laws that maintain a pool of immigrant women to take low-wage careworker jobs, and a hands-off approach to the regulation of household employment so that the informal economy can flourish in this work sector (chapter 4). CMA also serves to describe the experiences affected by the various scales at which economies, decision-making processes, and individuals operate (Manderson and Whiteford 2000).

Intersectionality is useful for parsing out the social and economic context within which caring takes place, and the negotiated and contested positions of power of these immigrant careworkers (McCall 2005; Mullings and Schultz 2005). However, intersectionality shifts the analysis to examine the specific multiple interstitial social locations which individuals inhabit. This approach, originating in Black feminism (Crenshaw 1991; Hill Collins 2000), and developed in feminist medical anthropology (Mullings and Schulz 2006; Schulz, et al. 2006) highlights how various forms of oppression combine, thus requiring multiple lenses, e.g., immigrant and female, through which to study the dynamics and health effects of oppression. As Patricia Hill Collins and her co-authors (2002:82) explain,

The notion of interlocking oppressions refers to the macro-level connections linking systems of oppression such as race, class, and gender. This is the model describing the social structures that create social positions. Second, the notion of intersectionality describes micro-level processes — namely, how each individual and group occupies a social position within interlocking structures of oppression described by the metaphor of intersectionality. Together they shape oppression.

Thus Collins, et al., specify the creation of the term social position and clarify the interlocking aspect of the theoretical framework of intersectionality. Also, using Collins’
categories of macro-level and micro-level to describe processes, I build on the work of critical medical anthropologists who have included in their analyses the individual experiences (micro-level) interacting with the large structural forces (macro-level) that influence health and well-being. The analyses of, for example, Becker (2004); Manderson and Whiteford (2000); Scheper-Hughes (1992) accounted for the large powerful economic forces and political realities without situating these forces as totalizing, and thus recognizing the agency of individuals. Even so, critical medical anthropology has focused on how health disparities are linked to the unevenly accelerated economic trajectories associated with the transnational movement of capital (Baer, et al. 1997; Castro and Singer 2004; Sargent and Larchanché 2011).

In combining and applying CMA and intersectionality, I look to other scholars and their important work. For instance, Mullings and Wali (2001) operationalized this theoretical approach in their study of reproductive health in Harlem, in which the team of researchers “sought to analyze the meaning of inequality in everyday life: the ways in which race, class and gender structure differential access to such resources as employment, housing, recreation, healthcare and consequently health…” (Mullings 2002:32). Thus, daily practices and social location and identity are tied to differential or unequal access to the resources of everyday existence, which in turn are linked to historical and political-economic contexts, constraints and resources, and the multilayered experiences of women seeking healthcare (Mullings 2002).

The current study focuses on the complex interactions of multiple axes. For instance, along the axis of citizenship status, the immigrant careworkers in my study could occupy two “social positions”; these are “documented” or “undocumented”—but never “citizen” or “native-born citizen.” In addition, any of these careworkers could occupy a position on several other axes, for example, worker skill level (in this case, low-level “unskilled”); ethnic other (ethnicity in relationship to Italians); gender (female);
income level (low); and employment security (precarious). It is at the intersection of these axes that the individual careworker is situated in a particular social location of difference (Crenshaw 1991). This project examines these factors, in combination, as they influence healthcare resource use. Intersectionality—and evidence of this focus on social locations—is also used in the examination of gender, identity construction, and migration status of working men in San Francisco by Walter, et al. (2004). The study examined how these interlocking identities positioned the men and influenced their approach to healthcare for their working bodies. Harlow, et al. (1999) did not explicitly use intersectionality in their study of domestic workers (1994) but did highlight social location in their discussion of social stratification, gender, and the lived experiences of women in studying women’s health (Harlow, et al. 1999). While Harlow and her colleagues did not use the terms intersectionality or social position they did take theoretical steps toward these ideas. In a similar fashion, Meadows, et al. (2001) did not use the exact language associated with Crenshaw’s theory, but in examining immigrant women’s health they focused holistically on the various roles that the women occupied, and in doing so moved toward intersectionality and toward informing my approach.

Intersectionality theory views an individual’s social location as mutually constitutive with social categories such as class, gender, ethnicity, generation, migration status and national identity (Duffy 2005b; Mullings and Schultz 2005). In this research, a critical medical anthropology perspective is combined with intersectionality to emphasize the individual careworker’s social location and specific set of health-seeking strategies. Using the lens of health to examine the constraints, everyday acts of resistance, creative responses, and work experiences of immigrant careworkers, we can see how individual acts of agency add to our understanding of global processes being played out in tandem with individual processes of everyday practice.
Transnational Carework

The specific term “transnationalism,” defined as the “people, money, goods, and information” circulating across nation-state boundaries (Carducci 2000:14) and conceptualized for this study as operating in social fields, has engaged anthropologists in debate for two decades (Glick Schiller, et al. 1995; Glick Schiller 1992:3-6; Ong 2006; Trouillot 2003). If one considers transnationalism as a new term to describe the processes associated with migration, the field of anthropology has been involved in this analysis much longer (Cornelius, et al. 1982; Gumina 1978; Hirschman 1982; Kirk 1969; Loomis 1947; Mol and Research Group for European Migration Problems 1961). The transnational practice-focused research on migration related to labor and gender is of particular importance for this study, which builds on ethnographies that analyze living and working conditions to examine “gender, power, and agency in transnational capitalism” (Thomas, et al. 2002:37).

This study connects global citizenship and economic activity to intersectionality theory by beginning with the individual careworker, and fully considering her through the transnational fields which she inhabits (Appadurai 1991). The shifting changing global political economic forces have made the market economy of carework a transnational one; it is a well-established pattern that women from poor countries emigrate to provide care in countries of more wealth (George 2005; Hawkesworth 2006; Naples and Desai 2002; Padilla and Peixoto 2007). The uneven distribution of resources in global economic processes has often been linked to neoliberalism—used here to refer to the economic approach that privileges the free market in how nation-states approach the provision of social welfare and economic growth (Goode and Maskovsky 2001:8-9). Deregulation of markets, removal of government subsidies and other involvement in basic services (such as energy and water) are typical of the neoliberal approach (Enloe 1989; Hawkesworth 2006). The specific social position of the immigrant careworker-
research participants in the global economy makes it necessary to add a transnational framework to this analysis.

Migration anthropologists have researched transnational identities and migrant labor markets in European and Italian contexts (Cole and Booth 2007), many with a specific focus on domestic work (Anderson 2001; Anderson 2004; Lagomarsino 2005). Carework provides a useful entry point into an informal economy where reproductive labor is exchanged for cash (Tung 2000; Ungerson 2000). In this study the informal economy refers to a set of activities that would be lawful if reported to tax authorities and subject to work regulations (Portes and Haller 2005). In a broader analysis, these many one-on-one agreements add up to a significant labor market, which fills a need developed during the past two decades in European countries (Lyon 2006). A number of reasons account for this need developing between the late 1980s and today: (1) the changing educational and economic opportunities for women, visible in the increased rates of women in the paid work force; (2) the demographic situation of an increasing number of elders living longer than at any point in recorded history; and, (3) the lack of available family members due to the extremely low birthrate, which has existed for decades (Guerci and Consigliere 2002a). This market thrives in a neoliberal setting such as Italy, which has removed many social services and turned toward the free market in unprecedented ways (Gori and Pasini 2001; Sassen 2007) (Gori and Pasini 2001; Lambert and McDonald 2009; Sassen 2007). Feminist scholar Wendy Pojmann points out that the reasons named above function in a patriarchal context (Pojmann 2006:41), leading the European Women’s Lobby to point out that “many European families consider the undeclared and low pay domestic work that immigrant women are carrying out as a ‘solution’ to balance their work and home life” (European Women’s Lobby 2004). One implication of this patriarchal viewpoint is the assumption that carework is women’s work. Operating in tandem with this assumption is another
incorrect assumption, that carework is low-skilled work. In fact, carework is highly skilled work delivered for a low wage in many industrialized “Northern” cities (Mattingly 2001).

**Gendered Transnational Care**

Two related themes emerge from anthropological analyses of gender and transnational labor practices: (1) most often women are responsible for the (unpaid) carework in their own families and households (Chang 2006; Christopherson 2006; Hochschild 1989; Parreñas 2005); and, (2) most often women are employed in the home-based sector in (largely) Northern hemisphere countries (Gulati 2006; Tastsoglou and Dobrowolsky 2006:5). Many careworkers are migrants who must leave their families in order to care for them financially by way of remittances (Grigolini 2005; Levitt 2001). These women migrate across national boundaries, often traveling great distances to earn a living as careworkers in another family’s home, while still contributing to their home country’s economy (Hall 2005; Orozco 2003). For example, in the year 2008 remittances coming into Ecuador totaled four billion dollars constituting almost 8% of the GDP of the country (Bertoli, et al. 2011; Latin American Herald Tribune 2009; Ratha, et al. 2011).

Immigrants’ carework, in the intimate space of the home, is an intensely personal and local form of a problem uniquely produced by globalization (Appadurai 2000:6). The crisis of social reproduction (Mattingly 2001; Radcliffe, et al. 2004) results in the international transfer of caregiving, which develops a social, political, and economic connection between the women hiring careworkers and those migrating for these low-wage jobs. In the receiving country this complex relationship occurs at the intersection of power, gender, class and xenophobia, played out in the confines of the work household (Anderson 2006) and in the broader community (Parreñas 2001a). The crisis of social reproduction refers to the inability of communities, consisting of individuals and households, to care for and educate one another and to sustain themselves and their
community. One important idea regarding this crisis is that “the reprivatisation of social reproduction refers to a double process, whereby the responsibility for providing social reproduction services is increasingly shifted to the household, or left to the market, i.e., commercialized” (Bakker and Gill 2003; Kunz 2008).

The current study considers the subject position(s) of the individual women who shape Genovese culture even as they are influenced by it. In the global marketplace these workers are the ideal “flexible workers” (Brenner 1998; Sassen 1998) in that they are temporary workers (not citizens), quickly “re-tool” to be ready to do the job at hand, have motivation to obtain work under less-than-ideal conditions, and even leave a minimal footprint in Italy in that they often arrive alone and live where they work and therefore do not make a visible presence in an ethnic enclave in the city.

Often women migrate to do waged carework in order to care financially for their families, but a need for care remains in the community they have exited, thus creating a crisis of social reproduction back home. These transnational actors respond to and shape the global forces that affect their work and migration; this study focuses on their strategies regarding health and work, and how social location, e.g., citizenship status, work-life conditions, and ethnic identity, is interrelated with opportunities and constraints. These theoretical ideas are brought into conversation with the feminist scholarship on care and transnationalism by viewing care as both the activity which restores and maintains health and the commodity for sale in the burgeoning informal economy.

**Organization of the Dissertation**

Chapter 2 describes the research setting, including the city of Genoa and its relevant history. The funding and use of the Italian National Healthcare System (INHS) are described early in the dissertation, for two reasons. First, INHS was the most oft-used resource by immigrant careworkers for their own healthcare and a system they access as they do carework for elderly clients. Second, access to this system by
immigrants was one issue of what was at stake as part of the new anti-immigrant legislation. Chapter 2 also details research methods and the ways in which feminist traditions and recent social science scholarship on migrants in Genoa inform this research. Chapter 3 reviews how care has been conceptualized by scholars and the ways in which the policies of the Italian state influence care in Genoa, and underscores the importance of home-based carework there. Chapter 3 describes the linkages among carework and feminist traditions in Italy, and among labor unions and careworkers.

Chapter 4 provides historical context for the research project, specifically regarding the arrival in Genoa of significant numbers of immigrants from South American countries and the ways in which Italy has responded to this shift. This includes the histories of immigration between Italy and South American countries, as the careworkers who dominate the carework sector in Genoa are from countries such as Ecuador, Peru, and Bolivia. The English-written anthropological scholarly work regarding Europe, the EU, and Italy inform my discussion of Italy’s position in the European Union; and the role of local settings, the nation-state, and supranational organizations for individual and collective identity development. This discussion informs an understanding of the recent political movements in Italy, which led to the passage of the Security Package. The policy context of carework is described in a summary of recent relevant immigration legislation, which is critical for understanding the context within which the careworkers function in Genoa.

In chapter 5 the voices of the immigrant women who work in the homes of elders are used to describe the job of careworker, including working conditions and the issues involved in the private home as the workplace. The role of the Catholic Church in the lives of immigrant careworkers and their elderly clients is outlined in chapter 6, which brings in the perspectives of those who serve the South American immigrant community in Genoa. The Security Package, the specific portions of it which influence the quality of
life and well-being of immigrant careworkers, and the various reactions to this national-level legislation by various stakeholders are the foci of chapter 7. In chapter 8, using data from interviews with those who directly serve immigrants and the immigrant women who work in low-wage care jobs, I trace the relationships between work and health. I also describe the myriad ways in which immigrant careworkers care for their own health.
Chapter Two: The Research Setting and Research Methods

Introduction

This chapter introduces the reader to the context of and the methods utilized in my research. The physical arrangement of Genoa and the role of the neighborhood in daily life influenced immigrant careworkers’ everyday activities and are described here to provide background for the chapters that follow. The history of the city is traced in terms of economics, politics, and migration in order to provide a more complete context for examining immigrant careworkers’ well-being in Genoa. The context of carework includes the economics of universal healthcare in Italy and the basic strategies used by immigrants and elders to access healthcare resources. These resources are important to immigrant women in carework positions as they use them in performing their job, and as they attend to their own healthcare needs. The last half of this chapter presents the ways in which my research framework builds on feminist research traditions, and then details the methods and analysis used to provide data for chapters 5 through 9.

Research Setting

In 2008, documented immigrants from South American countries, primarily Ecuador and Peru, comprised 38.7% of all immigrants in Genoa (ISTAT 2009a). Most of the women in this group worked as domestics, and in Genoa, this most often meant caring for an elder (Erminio 2001; Erminio 2007c; Vento 2004). These immigrants were, and are engaged in the recent history, the present, and the future of the city. Because of the demographics visible in Table 2.1. there is a large population of elders who are potential clients to careworkers.
Table 2.1. Age of Population, City of Genoa as of January 2010

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 18-59</td>
<td>65.1%</td>
</tr>
<tr>
<td>Aged 60 and over</td>
<td>32.4%</td>
</tr>
<tr>
<td>Aged 70 and over</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

(ISTAT 2012b)

The demographic situation of the city of Genoa (low birth rate, high rate of longevity) is a laboratory in which to examine the relations involved in the global marketplace of care, and to observe the situation that will be evident in other regions of Italy and in other industrialized cities.

**Genoa as a Site for Research on Carework**

The topography and neighborhood-orientation of Genoa are important for understanding the lives of careworkers and their clients. Due to the number of steep narrow streets, with stairs that can only be negotiated on foot, without the help of scooters, motorcycles, cars or buses, Genoa is a city with a physically challenging environment for any person dealing with limited mobility. Genoa became an independent city after the downfall of the Roman Empire (circa 476 A.D.), in part because it is in a spot on the Ligurian sea that functions well as a natural defendable harbor (Killinger 2002:6,42). The rocky shoreline extends less than a mile inland in some places before cliff faces and mountains appear, so that the city occupies a long narrow sliver of land along the northwest Italian coast (insert map of m). There are not many unoccupied spaces in the city of Genoa, which is one reason why there are few institutions for health or elder care, and few are planned for the future. Walking and using the AMT public transportation system in Genoa, which includes buses, trains, elevators, and funiculare (cog/cable railway, used to cover vertical distances) is the way most elders and their careworkers make their way throughout the city. Many elders and careworkers in Genoa do not use cars (Civitas 2006).
Neighborhoods are important for the daily life of home-based elders and those who care for them. Buying supplies at the nearby small focused businesses such as the fish vendor, bakery, deli, butcher, fruttivendolo (fruit and vegetable vendor), pharmacist, and newsstand are part of daily routines as are the passagiata (afternoon stroll) and visits to the local Catholic church for mass (religious ritual) (Willson 2010:180). Supermarkets and “superstores” exist but in the city of Genoa, the supermarket chains have entered neighborhoods in multiple small pre-existing spaces. Because of the high population density and the arrangement of having small businesses, such as a deli, combination café-grocery, and newsstand within a few minutes’ walk of most apartments or condominiums, the home-based elder is supported by the layout of his or her neighborhood. In both neighborhoods where I lived in during this research, I observed a variety of food-related businesses making deliveries to individual homes in apartment buildings. These included arrangements made by cell phone in which a basket containing cash and a list of needed items was let down from an apartment window to the street and the purchases were sent back up via the same method. Careworkers were found in every neighborhood in all of the Districts that together form the city of Genoa.

Genoa has a long uninterrupted history as a city, remaining intact since it was founded, through a variety of geo-political arrangements. In describing the historical context for this research, I begin with Genoa during World War Two. During Mussolini’s rule, in the early days of the war, Genoa flourished as an important port. In 1941, there were 23,000 sailors stationed there, and 8,000 dockworkers were still employed, even when much of the maritime infrastructure had been reduced to rubble (Gibelli 1968:74-75). The importance of engineering, shipbuilding and steel industries grew under Mussolini as resources served to expand state-owned companies, such as at the Institute for Industrial Reconstruction, which controlled the Ansaldo company, a producer
of metal parts and employer of 30,000 workers (Ginsborg 2003:19). Following heavy Allied bombing at the end of the war, heavy storms further damaged the port in 1954 (Caselli and Gozzi 1994). By 1956, the rebuilt and modernized port facilities combined with post-war industrial development to lay the groundwork for rapid economic growth in the city. This activity was financed in part by the Marshall Plan and the European Economic Community (Killinger 2002:162-163). The integration of the Western European Economies, which included Italy, heavily and positively influenced the economy of the northern Italian industrial triangle of Milan-Genoa-Turin (Kirk 1969). A boom in the manufacturing sector (Killinger 2002:126) brought many Italian workers to Genoa in the decade 1955-1965 from cities and towns in both Northern and Southern Italy, increasing and stabilizing the middle class in the city (Bini, et al. 2010).

By 1960, the state-run factories developed after the war reached a level of great success, especially in Genoa. The European Common Market and associated exports led the economic boom that peaked in the 1960s. In Genoa steel, coal, shipbuilding, metal fabrication, and textiles were produced, packaged, and exported. The move to privatize the industrial state enterprises beginning in the 1980s, especially in shipbuilding and steel production, was acutely felt in Genoa, which was still referred to as a “ghost city” by the end of the 1980s (Ginsborg 2001:16-17). As in many other European cities, the economy of Genoa moved from an industrial base to one of service and tourism starting in the late 1980s (Vento 2004). In 1998, Italy met the government financial standards named in the 1992 Maastricht Treaty by cutting government spending on welfare (pensions, social programs), lowering interest rates and cutting the national debt (Killinger 2002:171-173). The currency change from the lira to the Euro began in 1999 and was completed early in 2002.

In the late 20th and early 21st centuries the cruise ship industry, logistics and container ship management, tourism, and medium-sized firms (such as software,
pharmaceutical, financial institutions) have prospered and have been accompanied by a resurgence in the shipbuilding industry. Genoa’s port is the largest in terms of goods moved for export and import in Italy, and it remains important in the Mediterranean for container and passenger ships. The choice of Genoa as the 2004 European Union Capital of Culture (an annual EU distinction to highlight history and culture) was seen as a key moment in establishing Genoa as an important tourist destination with a well-developed service industry (Bini, et al. 2010). In 2009 the Italian census (ISTAT) counted the population of the city of Genoa to be 609,746 (ISTAT 2012b).

History of “Anti-Establishment” Ideology

There is a tradition of anti-establishment ideology in the city of Genoa, discussed here starting with the partisan anti-Mussolini, anti-fascist activity during World War Two. Notably, Genoa was the only city in Italy in which the occupying German forces surrendered directly to the partisans, almost 24 hours before the arrival of the Allied forces. On April 26, 1945, more than 3,000 resistance partisans stormed the Nazi headquarters located in the city center (Gibelli 1968:95-97). Soon after the war’s end, an anti-fascist protest in Genoa erupted when the Italian Social Movement (MSI) political party proposed having its national congress in Genoa. The MSI was formed by supporters of Mussolini in 1946, and the strong anti-fascist sentiment in Genoa turned violent for a portion of a 24 hour protest when factory workers streamed into the city center. The MSI congress was held in another city later that year (Ginsborg 2003:119).

In the early 1960s, the local government acted on secular interests of the citizenry of Italy, in opposition to the interests of the Catholic Church and its associated political party, the Christian Democrat party. This occurred even with the conservative Cardinal Siri, a powerful official from the Vatican, serving as the Archbishop of Genoa. After local elections, Genoa formed a center-left administration to govern the comune
(city-county) of Genoa and the region of Liguria, bringing the Christian Democrat (DC) and Socialist political parties slowly toward each other (Ginsborg 2003:258-259).

The visibility of the 2001 G-8 international summit in Genoa was an opportunity for international anti-capitalists to contribute to this historical trajectory of anti-establishment rhetoric and activity, this time directed against a multi-national organization. The participation of Genovese households in support of the G-8 protesters was one notable example of anti-establishment activity. Then Prime Minister Berlusconi, arriving in Genoa prior to the G-8 summit to make diplomatic arrangements, had noticed the traditional household laundry lines in use, and requested that citizens’ underwear be removed during the summit. The mayor of Genoa found an old unenforced law that prohibited use of laundry lines to display underwear and asked citizens to comply out of support for the G-8 meeting (Behan 2001). International and local protesters marched in visible underwear, and locals hung underwear on laundry lines, including in areas where summit meetings were held (Behan 2001; Corriere Mercantile 2001). This anti-establishment trajectory continues today, and is seen in the Ligurian (regional) and Genovese (comune) tendency to resist or circumvent the national agenda of the Italian state. This is discussed in more detail in chapter 7.

Three Waves of Migration

The first wave of migration to Genoa important to my research was in response to the manufacturing boom of 1955-1965, described above. This internal migration of industrial workers from all over Italy can be seen in the population today (Killinger 2002:126). These Italians are now in pensione (retired) in Genoa, some at relatively young ages, others constitute part of the large population of elders requiring some level of care at home. The second major migration was from outside the country in the decade 1985-1995, when many North Africans, primarily from Senegal and Somalia,
arrived seeking work and/or refuge in the city. A number of these migrants decades later have obtained documented status and have become established in a variety of ways in the neighborhoods of Genoa (Erminio 2007a; Erminio 2007c; Vento 2004). The third major influx of immigrants was directly related to this dissertation as in the years 1995-2005 the majority of immigrants arriving in Genoa were from South America and in search of employment (Bini, et al. 2010). These three major migrations to Genoa are visible in the population of the city as of 2009, seen in the following table.

Table 2.2. Selected adult populations of city of Genoa, January 2009

<table>
<thead>
<tr>
<th></th>
<th>Italians, 65 and over</th>
<th>North Africans, 18 and over</th>
<th>South Americans, 18 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>(%)</td>
<td>27%</td>
<td>1%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

(ISTAT 2009a) 6

There are significant numbers of South Americans in other cities in Italy, but Ecuadorians do not dominate any other city or the carework sector in any other Italian city in the same way. For example, Filipina immigrants dominate the carework sector in Rome (Magat 2004), Peruvian immigrants in Torino (International Training Centre 2004; Vannoni, et al. 2005), and Romanians in Ancona (Turai 2010). The Italian state has enacted immigration policies and maintains a family-based approach to elder care that has created this heavy dependency on immigrant labor for carework, discussed in more detail in chapter 3. The Italian state also has created a national healthcare system, a key resource for the well-being of careworkers and their clients in Genoa. Careworkers quickly encountered the INHS in their job on behalf of their clients as virtually all citizens in Italy over the age of 60 utilized this national system (Fattore and Torbica 2004; ISTAT 2009b).

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6 These numbers represent only immigrants counted in the 2008 Italian census as citizens as citizens or legal immigrant workers. There are more undocumented immigrants living in Genoa who identify as North African and South American.
The Italian National Healthcare System in Genoa

The Italian National Healthcare System (INHS) is a regionally-based national health service that provides universal coverage at the point of service (Lo Scalzo, et al. 2009:xx; Piai and Cattaneo 2011:7). Italy established INHS in 1978 based on two main ideas: “1) it is a universal system that views every Italian and foreign resident as having the right to be provided with healthcare services; 2) it is a comprehensive system, i.e., it covers all the necessary treatments” (Francese and Romanelli 2008). Because INHS is important to the well-being of Genovese elders, immigrants, and other inhabitants, I explain its basic organization, resources, and funding here. This information is needed for subsequent chapters, especially chapters 7 and 8.

INHS is organized into three levels: (1) the national level, represented by the Ministry of Health, which is responsible for setting standards of care and ensuring essential levels of health services across the country; (2) the 20 Regional Health Authorities (RHAs), which have significant autonomy to organize services, allocate financial resources, and monitor and assess performance; and, (3) the 200 Local Health Authorities (ASLs, Azienda Sanitaria Locale) to which are disbursed funds and the responsibility for delivering care by the RHA (Giannoni and Hitiris 2002:1830). The Ligurian RHA coordinates five ASLs, one of which serves the city/county of Genoa. This ASL3, the Genovese Health Authority, includes nine ASL-directed hospitals, two research institute hospitals, two hospitals that serve INHS patients via contractual arrangement, six dialysis centers, and one large public hospital (Azienda Ospedaliera, AO). All of the hospitals and centers provide extensive outpatient clinic and diagnostic services. The ASL3 also reimburses a variety of clinics, labs, diagnostic facilities, rehabilitation centers, and providers in Genoa (Region of Liguria 2011). Emergency rooms respond to all who arrive seeking treatment, regardless of citizenship status or ability to pay. Chapters 7 and 8 provide more details regarding emergency rooms.
INHS Funding and Resource Use

The INHS is an enterprise that in 2009 had expenditures well over 110 million Euro (153 million USD)\(^7\) (Tremonte 2010:41). This was 9.5% of the gross domestic product, equal to the average for all OECD countries for healthcare spending as a percentage of GDP. Italy ranks “slightly below the OECD average in terms of health spending per capita” (OECD 2011). Liguria spent 3.027 million Euro (4.15 million USD) on INHS healthcare services and facilities in 2007; this same year the country’s total INHS budget was 101.143 million Euro (138.566 million USD) (ISTAT 2009b). In 2009 the Ligurian INHS spent 1,998 Euro (2,777 USD) per person; the average per capita expenditure for Italy was 1,800 Euro (2,502 USD) (ISTAT and Ministero dell'Economia e delle Finanze [Ministry of Economy and Finance] 2012:89).\(^8\) In 2007 the Ligurian Regional Health Authority along with ASLs and AOs controlled the specific use of 80% of these funds. By 2009, the percentage of the budget under the direct control of the regional health authorities had risen to 90% (Bordignon and Turati 2002; Cappellaro, et al. 2009; Giannoni 2006; Lo Scalzo, et al. 2009:xxi and xxiv; Nuti, et al. 2012).

The increased regional control of healthcare funds was by design. The federal government restructured the INHS in 1999 following Italian Legislative Decree No. 286/1998 (Mapelli 2000) to a more fiscal federalist model of funding. Fiscal federalism moves authority and responsibility for resources away from the central government to the regional government. The result of reforms (Giannoni 2006:12) was that more funds were given “back” to regions along with the responsibility for deciding how to allocate

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\(^7\) All conversions from Euros to US dollars computed using the annual average derived from the daily rate reported by the US Federal Reserve System. The rate used was from the year in which the currency was spent. (Source: Board of Governors of the (USA) Federal Reserve System, http://www.federalreserve.gov/releases/h10/hist/, accessed 3/4/12).

\(^8\) Because there is such variety among regions, e.g., population, physical area, economic activity distribution, even two with uniquely increased autonomy (Trento and Bolzano), policy analysts generally use expenditure per capita as one useful figure to use when making comparisons. For examples see Bordignon, M. and G. Turati (2002), Lo Scalzo, et al. (2009), and Nuti, S., et al. (2012).
this money (Lo Scalzo, et al. 2009:179). Scholars and policy analysts generally agree that these reforms have fallen short of their goal to deliver basic healthcare to all Italians and to eliminate large resource disparities by region but have met the goal of increased accountability as regions have gained more autonomy and responsibility for healthcare resource use (Lo Scalzo, et al. 2009:192; Mangano 2010; Nuti, et al. 2012). The move to regional healthcare resource autonomy is part of the overall move towards fiscal federalism in Italy. In October 2010, one month before I exited the field, the Italian parliament approved a legal decree that continues “the progressive strengthening of regional powers to deliver and finance healthcare and also a parallel delegation of managerial authority to hospitals (meaning AOs) and ASLs started during the 90ies” (Piai and Cattaneo 2011).

Publicly-funded healthcare is mainly funded by earmarked national and regional taxes (76%) with out-of-pocket payments accounting for 19% of funds (OECD 2008). The OECD has reported that 77.9% of health spending in Italy was funded by tax-based public sources, above the average of 71.7% in OECD countries at that time (2009) (OECD 2011). The regional taxes include a tax on petrol (all regions), a motor-vehicle tax (some regions), regional personal income tax, and a business tax (IRAP) which includes taxes contributed to the Italian state by employers, including households. The national taxes earmarked to fund health in regions include a value-added “sales” tax which is often used to supplement INHS budgets in regions to ensure adequate resources to provide the basic health benefits mandated by the Ministry of Health (Lo Scalzo, et al. 2009:53).

Liguria distributes resources to each ASL based on demographic criteria, using a blend of 50% inhabitant population in the ASL geographical area and 50% of the INHS services consumption patterns by age/sex groups (Lo Scalzo, et al. 2009:60, 178-181). Liguria is among the “richer” of the twenty regions, in that it has one of the larger overall
INHS budgets and one of the higher rates of spending per regional inhabitant (ISTAT and Ministero dell’Economia e delle Finanze [Ministry of Economy and Finance] 2012). As described in more detail in chapters 7 and 8, Liguria has used its decision-making power to spend resources to serve its large elderly population and the increasing immigrant population. The following table displays the way Liguria spent funding on healthcare.

**Table 2.3. Liguria INHS Resource Use (2007)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly Provided</td>
<td>59.43%</td>
<td>Bulk of this was in-patient hospital services. Remaining portion was public health initiatives and INHS-employed primary care doctors.</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursed Services</td>
<td>33.76%</td>
<td>Descending order of funds used: pharmaceuticals, “thermal springs and rehabilitation facilities,” private care facilities, INHS-contracted primary care doctors, and outpatient facilities (such as dialysis and day surgery units)</td>
</tr>
<tr>
<td>Administrative</td>
<td>6.81%</td>
<td>Includes appointment centers (Centro unico di prenotazione, CUPs)</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Liguria is one of four regions that consistently devotes a larger percentage of its budget to hospital care services⁹, reflective of the large percentage of elders in the population (Abadie, et al. 2011:6). A *directly provided* service is healthcare provided by INHS employees, typically in INHS facilities using INHS equipment. A *reimbursed* service refers to INHS paying money to a non-INHS employee provider to deliver healthcare to an INHS patient, e.g., a primary care doctor or pharmacist. It also refers to healthcare provided to an INHS patient at a non-INHS facility such as a dialysis clinic or rehabilitation facility. The multi-million Euro INHS enterprise influences daily life for immigrant careworkers in two ways: 1) the elderly clients of the workers are patients of INHS; and, 2) INHS is used by experienced immigrant careworkers and their families.

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⁹ Liguria is unique among the 20 regions in that it allocates one-third of its health budget directly to public hospitals (AOs); most regions funnel this money through the ASL budget on the way to public hospital use (France, et al. 2005:191).
Also, the availability of INHS for certain categories of immigrants was threatened by legislation introduced during my fieldwork, discussed in chapter 7. An understanding of how the patient utilized INHS in Genoa is important for the context of my research project.

How the Patient Accesses INHS

There are some standardized procedures that operate for patients in any clinic in Italy, regardless of region. For instance, every legal immigrant and adult citizen has a primary care physician. Initial assignment of physicians is random if the individual does not name a particular general practitioner (for adults) or pediatrician (for children), but the patient has the option to request a change. Citizens and legal immigrants register at any local health authority (ASL) facility, with their fiscal code (equivalent to social security number in the U.S.), certificate of birth (citizen) or permit to stay (legal immigrant), and copy of income tax document, which will display payroll taxes paid to the government earmarked for INHS (Ferrari 2008). If the citizen or legal immigrant has not worked in a job that contributed to INHS, they pay 338 Euro (470 USD) per year for INHS benefits. There are a variety of situations that result in the waiver of this fee (2011). Access of INHS differs for non-documentated immigrants, explained in chapter 8. The process of changing physicians was reported (in interviews) as easy to do by both patients (including citizens and immigrants) and providers. Patients begin with their physician to receive referrals for diagnostic procedures (such as mammograms) and for specialists (such as dermatologists). Women without children often have their gynecologist as their primary care provider. Each child in the household is associated with one parent and that parent’s primary care physician as their entry point into the system, but then is eventually assigned a pediatrician associated with one parent. Copayments are required for non primary care, some diagnostic procedures, and some

Generally, patients I spoke with in Genoa reported that getting information from their primary physician (such as a phone call to get a refill on a prescription) or making an appointment within in a short time frame with their primary physician was relatively easy. Once a referral is made for certain procedures (such as a mammogram) or to see a specialist there may be long wait times (Nuti, et al. 2010). For example, participants in this study, both female immigrants and INHS workers, reported the wait time to get a mammogram as being from less than one month to up to 6 months. Health and policy researchers have found this same pattern all over Italy, namely: (1) primary care is easily accessible with a short wait time for an appointment (Carrieri and Bilger 2013; Tanner 2008); and, (2) wait times for tests and appointments with specialists vary widely, sometimes by region (Cappellaro, et al. 2009; Francese and Romanelli 2008; Mangano 2010).

Appointments with primary care physicians and inpatient hospital care are free. Many basic lab tests, such as blood draws for cholesterol evaluation, are free. Ambulatory specialist services (such as mammograms or dermatology appointments) and drugs generally require a copayment (France, et al. 2005:199). In 2009 the copayment for each ambulatory specialist service referral could not exceed 36.15 Euro (50.25 USD) (Lo Scalzo, et al. 2009:55); copayment policy for prescription outpatient drugs has fluctuated with political decisions over the past 15 years. While this category of pharmaceuticals is technically “free” at the national level many regions have instituted copayments; in Liguria INHS users pay a maximum of 4 Euro (5.60 USD) per prescription (Fattore and Jommi 2008:35; Fattore and Torbica 2004). Other conditions that determine if a co-payment is assessed have been written into law. For example, as of 2001 some procedures associated with cancer prevention were delivered free of
charge within the following guidelines: mammography every 2 years for women aged 45-
69; pap test every 3 years for women aged 25 to 65 years; and, colonoscopy every 5

There are many INHS users who do not have to make copayments because they
secure an exemption, “based on income, age and health status (including pregnancy,
permanent disability and certain chronic conditions and rare diseases)” (France, et al.
2005:199). Other specific categories of people who do not have to make copayments
are: elderly people with an annual income less than 36,152 Euro (49,528 USD), people
with certain chronic or rare diseases (on a 1999 Ministry of Health list), disabled people,
The political battle over who gets these exemptions has been much debated and is likely
to change in the future (Fattore and Jommi 2008).

The work on the health and well-being of immigrants in Italy and critical inquiries
into the way the Italian health system works (or not) for immigrants has appeared in
medical and public health journals (Baglio, et al. 2010; Fedeli, et al. 2010; Gualdi-Russo,
these studies the “immigrant” is viewed as one-dimensional; regardless of characteristics
and experiences all non-natives are viewed as a homogenous group. The current study
focuses on one particular group, South American women operating in one work sector.

Research Methods

Feminist-Informed Research

Feminist-informed research, which focuses on inequalities, attends to social
location. It has proven to be effective in operating at different scales, is well suited to
this project and reflects my own position as a developing scholar (Harrison 2007). My
research methodology is feminist-informed in three primary ways. First, I consider the
position and power of the researcher, motivated by what Sandra Harding termed “strong
objectivity” (1993), which requires that researchers “self-reflect on what values, attitudes, and agenda they bring to the research process” (Hesse-Biber 2012:9).

Next, the use of groups for data collection, a method I first learned when I did women’s health clinic-based research, has proved to be effective in eliciting data from women about health concerns and healthcare strategies (Garcés, et al. 2006; Ivanov and Buck 2002). Since the late 1990s the use of focus groups and group interviews as a way to gain insight into “women’s shared stories” has emerged as a feminist research method (Madriz 2000; Toner 2009:180; Wilkinson 1999). While I consider a focus group to be a research group formed with intention, and the participants gathering with knowledge of the issue to be discussed, I also find the qualities associated with focus groups are present in many group interviews (Bianchi 2011; Carlander, et al. 2011; Warda 2000). These include: multiple and varied perspectives on an issue and the increased number of ideas that often emerge from synergistic group energy (Esposito 2001). The opportunity to have a group of women discuss a topic among them helped to flesh out nuanced information and their attitudes about the issues surrounding the topic in a way that may not emerge in a one-on-one interview (Toner 2009:188). Women were eager to challenge concepts, disagree, support another’s idea and invest in a lively discussion, in what is an expression of their collective power (Pollack 2003). I conducted one focus group and three group interviews for this research, discussed below.

Third, it is by explicitly centering this ethnography on the lived experiences of the female immigrant careworkers as related in their stories that I prioritize their perspectives (for examples that highlight the stories of women, see: Howard, et al. 2007; Perilla, et al. 1998). A related goal of feminist research is to conduct studies that add to our body of knowledge regarding the human condition and to recognize that the record is heavy with projects focused only on the experiences of men (Dyck 2005). Thus, my choice to focus only on women’s experiences is a politically-conscious decision (Hesse-Biber 2012:12;
Nielsen 1990). I chose to interview only female immigrant careworkers, to bring attention to what is a very “typical” migration story – a woman leaving her family in her country of origin to labor in the home of a family in an industrialized “global” city. In Genoa I talked with South American immigrant men, but did not conduct data collecting interviews with them.

I began my fieldwork by conducting in-depth interviews with careworkers. I remained focused on the careworkers when I interviewed individuals who provided social or health services. Finally, in the interviews with administrators of systems that served immigrants and/or careworkers, the focus remained on the immigrant careworkers’ experiences with those systems. Below I discuss my own position in relationship to the immigrant women whose stories constitute the center of this ethnographic project. This is one way to act on the value and tradition in feminist-centered research to acknowledge power in the researcher-participant relationship (Harrison 2007:29-30).

The Researcher’s Position with the Women Who Do Carework

Reflexivity, defined by Finlay as the “continual evaluation of subjective responses, intersubjective dynamics, and the research process itself” (2002:532) is one useful way to attend to inequalities and social locations. Considering how immigrant careworkers in Genoa viewed me is the way I describe my social location, especially relative to participant-observation and interview settings. Because Genoa is a busy port city with immigrants from many countries and a modest tourist and cruise ship industry, my presence was unremarkable. However, in the semi-private spaces of non-profit agencies and church buildings, it was noticed. At first, my presence in the Catholic parish churches and non-profit agencies where I spent a great deal of my time created a mild stir of curiosity for the “regulars” there. I was a student, but appeared older than what is considered “student age.” I looked like one of the English-speaking tourists that
occasionally wandered into the Latin American community center at Santa Lucia to admire the artistry in the sanctuary, but I showed up every week to help clean the toilets in the adjacent immigrant center. I spoke Italian with a non-native accent, but participants could not “place” me. I did not look like a Latin American immigrant, but kept showing up at their classes and community events. I understood more than half of the written and spoken Spanish language I encountered, but I did not speak the language.

I more closely resembled some of the immigrants from Eastern European countries. In fact, several times when attending the caregiver training and placement at Santa Lucia, a helpful more experienced immigrant would let me know that “down the street at Santa Zita is where they speak Russian and other languages from the East, and those classes are for you.” I observed during group formal settings, e.g., language classes. And sometimes one of my participants would say, “Those ladies were asking about you, I told them you are okay,” or a small group of women chatting on the stairs outside Don Bosco church after the Spanish language mass would say, “Listen, we were just talking about you, why do you keep coming here?”

In acting on one mentor’s advice to “follow the immigrants,” and the admonishment of another to “exercise exquisite courtesy,” I was able to establish sufficient credibility so that I could gather my data for this research. Because of relationships built with gatekeepers at these various immigrant-focused spaces, I was allowed to enter. Because I behaved with respect for norms and answered questions consistently, the word spread among the Latin American community regarding my work. Generally, this worked in my favor. For example, one woman approached me on a bus following my participation at an event to hand me a slip of paper with her phone number because her friend told her about my work. Conversely, the active circulation of news in the female Latin American community “warned” some others about my research agenda.
At the end of a birthday lunch, as we were walking out of the restaurant where many women had just volunteered their contact information, one woman said quietly, “I will probably not talk with you, I am sorry, I just won’t.” I was surprised that she felt the need to offer this remark, but attributed it to a sort of peer pressure felt during the flurry of activity at the end of the long meal.

The reader of this work should know that I was a paid in-home careworker for an elderly woman 20 years ago as a second job in Minneapolis for 20 hours/week. I also worked as an unpaid family caregiver, and as an occasional employer of careworkers to my mother-in-law in her home 11 years ago. These roles undoubtedly shaped my views and biases, the way that I listened to the women in this study, and, in some cases, the way they talked with me (Pyett 2003). I infrequently shared my own caregiving experiences with the women I interviewed, which usually elicited surprise that anyone in the United States cared for an elder at home. On a few occasions, when the careworker participating in the interview seemed hesitant to discuss the tasks of personal hygiene in her work, such as aiding with an enema or changing diapers, I would remark upon some of these tasks as I had done them in my own past. This seemed to elicit more details about the careworker’s own work life.

There are not very many native English speakers in Genoa, and very few Americans, even as tourists. Generally, my uniqueness as an American worked in my favor, for instance, in initiating a conversation. My position as a childless woman was often of interest to the immigrant women I met; others asked me about my birth family and the health of my ageing parents, and joked, “You should think about hiring me, I am

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10 In addition my experiences and position of relative power may have shaped my analysis of the data, especially as reflexivity involves returning to the data and re-examining the analysis, as Pyett opines “As how might my knowledge, position, and experience be shaping my analysis?” (Pyett 2003: 1171).

11 Italians and Latin American women immigrants also expressed surprise that I could cook, something I often did to participate and contribute at group events. One vegetable vendor said, “I thought you all just ate McDonalds and peanut butter over there!”
ready to move to the United States!” In this way I was more like the women who supervised their work. In my role as an “outsider” and a non-native Italian speaker in a city not known for embracing visitors, I was in a very minimal way similar to the careworkers.

Even if seen as a potentially credible employer, an outsider in Genoa, or a loyal family member to the immigrant women in Genoa, the position I held as the privileged white woman with resources and options was always visible and set me apart from the women I interviewed, especially regarding the power to act on opportunities and options. Some women commented on this saying, “Listen, I was like you, going to an office every day, taking classes at night, learning English for my job and now. …” Rosa’s remark points out the decline in job status that many careworkers have experienced and the ways in which their obligations limit their opportunities to move – in the world, in the city, or even out of the home away from their client. Despite having worked as a paid careworker and sharing the experience of being an outsider in Genoa, there were many differences between the participants and myself, especially in personal power. The power imbalance also is seen in that I had a higher level of education than most of my interviewees, and the luxury of doing research rather than working for an hourly wage in Genoa.

Methods

Data Collection

Early Days in Genoa

I arrived in Genoa intending to talk with immigrant women with significant work experience in the homes of elders, and during pre-dissertation fieldwork there in summer 2008, I had met women from many different home countries. A “significant” amount of work experience was defined as a woman who had worked and lived in Italy for at least four years. When I made the move to focus only on women from South American
countries who had lived in Italy for at least four years, I became concerned about my ability to find enough careworkers from this more specific pool of people willing to talk with me. In the limited research literature on the health of home-based workers, the challenges of recruiting participants are named as: the inability to find illegally-hired workers laboring in a private space; the difficulty in entering the private home sphere or getting past the employer-gatekeeper; and the need to find time and a place away from the home workplace to conduct an appropriate interview (Harlow, et al. 1994; Neufeld, et al. 2001). Another challenge was finding immigrants in a precarious situation (vis-à-vis employment or immigration status) who were willing to participate in research. An undocumented immigrant woman laboring in a private home six days a week was not visible, often by her preference. Finding these invisible workers was the focus of my first months of fieldwork.

Finding and Recruiting an Invisible Workforce

To ensure that I was finding which immigrants were doing the carework, I participated in language classes at Sant'Egidio, a church-based non-profit organization that offered classes twice weekly to meet the needs of immigrants at various Italian skill levels. I also attended Italian as a second language classes at the Communist Political Party office for six weeks. Once assured that the Latin American women formed a majority of the experienced eldercare workforce and determining that my study would focus solely on this portion of the labor force, I continued with weekly attendance at Sant'Egidio, in order to understand the organization’s role in serving careworker immigrants. In a suburban parish, I attended the weekly meeting for careworkers, which functioned basically as a support group. I received contacts for recruiting research participants at all of the above locations, where all activities were conducted in Italian.

Because the economic crisis and its consequent unemployment had arrived in Italy, there were many unemployed experienced careworkers who attended caregiving
and language training classes. This also aided my work of recruiting interview participants, as time is scarce for most employed careworkers, especially if they are maintaining close family relationships long distance. I did not conduct interviews with anyone except careworkers until I had interviewed at least 12 women; I wanted to ensure their trust in me. If I had been seen interviewing a Red Cross psychologist who spoke to the caregiver training group, for example, they may have been less trusting in sharing their health- and work-history details with me. The majority of data collection was done using semi-structured interviews and participant-observation.

Participant-Observation

Between October 2009 and November 2010, I spent 12 months in the city of Genoa, conducting my dissertation research. During that time I lived in the same neighborhood that houses some of the Latin American immigrant women whom I would eventually interview. In order to gain an understanding of the context in which the careworkers live and work, and in some cases to recruit careworkers, those who serve them (known here as “servers”), and the systems that influence their everyday lives, I participated in a variety of activities. Because of the work schedules of careworkers, which dictated that they would have Saturday afternoon and evening and all day Sunday off from work, the weekends were sometimes concentrated periods of research work. For example, some weekends I attended three church services in order to maintain relationships and participate in Latin American community events. I made a decision to focus on the Catholic Church activities, even though there was an Evangelical Latin

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12 Genoa is divided into eight districts and I met Latin American immigrants who lived in every district of the city. There was starting to be a Latin American presence in Sampierdarena; groceries, restaurants, other shops related to South American countries, and a parish church with Spanish-speaking services (Don Bosco) were all in the neighborhood where I lived. There is not a distinct physical neighborhood where most Latin American households are located; I also did not observe ethnic enclaves for any of the non-South American immigrant careworkers. This is likely related to the fact that so many immigrant women live where they work, especially in their first eldercare jobs. Many people may remain in their initial neighborhood, especially as other aspects of their life change due to the precarious nature of employment in elder carework.
American community in Genoa. The Catholic Church sites where I participated and/or observed included four which I considered to be ethnographic anchors for my research. (See descriptions of Santa Lucia, Don Bosco, Sant’Egidio, and San Giacomo in Appendix A.) I attended a non-religious Latin American women’s group every Monday for 8 months. Generally I had to write fieldnotes immediately after (and not during) most of these activities, as my writing in a notebook or on a piece of paper drew attention, made others uncomfortable and/or prompted questions which interrupted the flow of activity.

My participation in some casual conversations and some observations were limited by my lack of fluency in the Spanish language. Italian was the only language used at two of my ethnographic anchor sites. At a third, Santa Lucia, Italian was used in the careworker trainings and Spanish was used in the religious celebrations and the conversations that took place before and after formal activities. At Don Bosco, the religious rituals were in Spanish and the monthly community meetings and activities were conducted in both Spanish and Italian.¹³

I did not employ a Spanish language translator. I realize now that I was so focused on gaining the trust of individual women in order to conduct in-depth interviews that I did not want to involve another person. I had temporary translators in that women translated for me as they asked me to join a conversation. In extending this courtesy, they often switched the language of the conversation from Spanish to Italian. My ability to understand written and spoken Spanish is much greater than my ability to speak the language. Because I was not fluent in Spanish, and did not understand everything spoken, I sometimes asked for a translation or clarification in Italian. My limitation with the Spanish language meant that I did not understand the nuances of the conversations

¹³ The Latin American women’s (secular) group meetings were in Italian approximately 60% of the time, as non-Spanish-speaking women (from Haiti and Brazil) were often in attendance.
that took place before and after church activities, for example, especially those with new immigrants who spoke only Spanish. In this way I was not fully participating and observing. I could not eavesdrop or fully participate as families greeted one another before church activities. This likely resulted in my research participants having more control of the way they presented themselves and their stories to me.

I chose not to observe immigrant women in their workplaces, the private homes of Italian elders, because I was concerned to not create any new challenges in the daily lives of my research participants. Many of the immigrant women doing this work operated within several layers of uncertainty. I did not want to increase the precariousness of their position in daily life or jeopardize their safety or job security. Some women were in the tenuous position of working without an official contract and/or were in Italy as an undocumented immigrant. Others had family members in one of these precarious positions. The laws affecting immigrants (detailed in Chapter 7) went into effect as I entered the field and had they been enforced according the letter of the law some of my research participants could have had to pay fines, and/or endure being arrested.

Careworker Interviews

I assumed that most women working as careworkers would only have time on Saturday evening and Sunday to meet with me. However, many of the women I interviewed had experience in dealing with employers and were aware of their right to time off during the work days Monday thru Saturday. Some were very directive in their work households, saying, “It is up to me, I tell the elder’s son when I need the time off, a few days ahead is fine. Let us set an appointment.” I made a point of telling potential interviewees that I would meet them anywhere/anytime that was comfortable for them as I wanted them to participate in the interview without concerns that others could hear them. This ethical concern was especially important for those workers who did live-in
work. After a woman I observed to be very communicative with her peers at the immigrant center asked me to meet her at a train stop on the outskirts of town at an early morning hour, and I arrived on time, it seemed to help establish my credibility with more participants.

Because so many immigrants are undocumented or may have family members living in Genoa with this precarious status, I made it a point to not directly ask about documentation status. I also did not directly seek specific age, marital status, or plans for retirement or return to home country. The focus in the careworker interviews was on their work history in Italy and their history with seeking healthcare in Italy. Questions about marital status and age seemed invasive in the context of my interviews. In Appendix B, which describes the 50 careworker interviews analyzed for this project, I included age and marital status only if they were offered in the course of the interview. For instance, women often offered information that allowed me to estimate their age. I conducted 55 individual careworker interviews with women from South American countries who had lived in Italy for at least four years. I used data from 50 of these interviews in my analysis; Appendix B summarizes the characteristics of this group. The “typical” woman in the group of fifty careworker participants in my research was originally from Ecuador, in her 40s, and a mother who had arrived alone to work in Italy seven years ago. Approximately three-fourths of the women were from Ecuador, the average length of stay in Italy was 7.5 years, and all were fluent in Italian and had lived in the country for four years or more, and 90% named economic concerns for their family as the reason for their migration. Interview time ranged from 20 minutes to 3 hours and 30 minutes.

Immigrant home-based careworkers were interviewed in locations other than their workplaces, usually a café, a public plaza, a semi-public area of a church space, or the live-out careworker’s home. In these primary interviews, one set of questions
solicited descriptions of working conditions in the homes of elder clients, including: the perceptions of linkages between work and health by the careworker and a general description of working conditions by the careworker. Another set focused on practical concerns: healthcare sources, timing of healthcare activities, places to seek solutions for health problems, recent recollection of types of health concerns, and events or situations that prevented access to care, which usually led to a discussion, initiated by the worker, of documentation status. Secondary interviews were conducted with 12 careworkers who had experienced primarily live-in work arrangements and 12 women who had experienced primarily live-out positions. These in-depth interviews regarding work and healthcare histories focused on the connections between employment situations, general resources and documentation status in Italy, social relationships, relationships linked to work, and healthcare resources.

Non-Careworker Interviews

I also conducted semi-structured interviews with 25 individuals who offered direct services to immigrant careworkers, described in Appendix C. These are referred to as servers throughout this document. Included are nurses, union workers, social workers, church workers, pharmacists, psychologists, doctors, clinic administrators and NGO leaders. The time of these interviews ranged from 25 minutes to 2 hours. The server interviews focused on: What are the strategies, opportunities, and challenges for immigrants seeking healthcare resources? What are the health and job-related concerns specific to migrant careworkers? How do migrant careworkers with/without documentation maintain their health (or not)? This often led to discussions about the Security Package (of laws), which went into effect in August 2009, right before I arrived in Genoa.

In October and November 2010 I focused most of my time in the field on interviewing administrators of various systems and institutions (n=22). These are
referred to as *administrators* in this document and described in Appendix D. These individuals had decision-making or other administrative responsibility in institutions such as: the Catholic Church, labor unions, hospitals, emergency rooms, clinics, the city-county (Genoan), the regional (Ligurian), and the national governmental health and human services agencies. If the person made decisions in a system that influenced the quality of life for immigrants and/or careworkers and/or Italian elders, an interview was attempted. Decision makers at INHS, the Catholic Church, non profits associated with the Catholic Church, and *comune* and regional health and human services agencies most obviously met these criteria. By fall 2010, my increased knowledge of the Security Package laws led me to realize which Ligurian region and Genoa *comune* elected officials and public administrators were appropriate to interview. These interviews generally conducted in the interviewee’s office, and the average time of interview was 50 minutes. Many of these interviews were focused on the administrator’s view of the life conditions of home-based careworkers, sometimes with a focus on the Security Package, which had been in effect for over a year at the time these interviews were conducted.

*Group Interviews*

I also facilitated three group research activities, described in Appendix E. A variety of groups exist in Genoa to support careworkers, focused on the following, sometimes in combination: social support, job skill development and employment, legal issues and questions for immigrants (such as regarding family reunification), and stress management. I attended group meetings at several parish churches on a regular basis, which were facilitated by Latin American leaders, mental health professionals, job employment counselors, church workers, or Italian volunteers. One group of these served as the basis for a focus group for this research. This was a focus group in that all of the nine participants understood the purpose of the discussion-interview ahead of
time. Three of the careworkers from the focus group also participated in individual interviews. The topic of this focus group, which lasted 70 minutes, was the influence of the Security Package on the lives of immigrant careworkers in Genoa.

Two group interviews yielded a great deal of information as the conversation turned quickly to stories about anonymous friends and their experiences. These were group interviews and not focus groups in that the participants were not invited ahead of time to specifically focus on a particular topic. These detailed stories of work-health history sometimes tell of experiences that may not be revealed by an interviewee in an individual interview and so provide insight into a community view of health concerns (Lagomarsino and Torre 2007a; O'Reilly 2005). Both group interviews became lively discussions. One was formal and held in a café following a caregiver training class and seven women participated for 50 minutes. The other group interview was informal and spontaneously developed at the end of a formal careworker support group/course at Don Bosco; five women participated in the discussion for 35 minutes, four more came and went during the course of our group discussion, which was loosely guided by my interview questions.

Archival Material

Quantitative data specific to Genoa from the Italian Ministry of Labor, the Ministry of Interior, and ISTAT, the Italian census bureau, are used to create the annual Dossier on Immigration Statistics (for Italy). This publication, produced by Caritas, a Catholic Church agency, has provided historical and current contexts for "women’s stories and practices" (Harrison 2007:26), detailed in chapters 3 and 4. Demographic data by Caritas (1990-2009), provides a profile of South American women who have immigrated to Genoa since 1990 and some information regarding employment and documentation status. These data by Caritas significantly improve upon those from the Italian census (ISTAT) regarding immigrants residing in Italy, as they use data consistently collected at
the many Caritas offices in Italy and look closely at the number of immigrants with applications about to be approved by the Italian immigration agency. These data, which utilize government office and academic research sources, are respected and utilized by demographers (Di Sciullo, et al. 2009a). I reviewed the “Dossiers” from 1999 through 2009 during pre-dissertation fieldwork and then again as I exited the field, to increase my knowledge of historical migration and employment patterns.

Cataloging photos of signage and copies of publications that surrounded the March 1 immigrant strike provided me with data that were accessible in a different way away from the activity of the field. I have also reviewed and categorized the materials that the national health system and the non-profit agencies used to promote programs aimed at immigrant clients and patients in general.

Managing and Analyzing Data

Individual and group interviews were conducted by me in Italian. No research assistants or translators were utilized for this research. All fieldnotes were written in English and I translated the recorded interviews from Italian into English. When the interview could not be recorded, notes were taken in English, or in Italian and then rewritten in English. As I translated and transcribed the interviews, I made an initial coding of data to create thematic categories. I then returned to key sections of notes and transcripts for more specific coding into new sub-themes that organized data. Following this, the thematic categories were analyzed to find points of connection and usefulness for answering the research questions and using the guiding relationships described below. Data analysis focused on three guiding relationships. First was an analysis of the relationship between the living and working conditions of the careworkers and their use of healthcare resources. Field notes, group interviews, a focus group, server, administrator and careworker interview data were examined in relation to: live-in
vs. live-out employment; the kinds of social relationships called upon for support; and documentation status.

The second relationship for analysis was that between careworkers’ health concerns and type of resources utilized. Data from careworker primary interviews, servers, and fieldnotes were sorted into categories of a matrix. One axis contained data on the reasons for seeking healthcare, separated into acute health event, chronic health, and health maintenance categories. The intersecting axis was determined by the type of health resource used (Formal state, Formal NGO, and Informal). As expected, careworkers generally “take good care” of their own mental and physical health by using a variety of resources, as their laboring reliable selves and good judgment are essential to maintaining employment.

Finally, I analyzed the types of healthcare resources the careworkers used, and their perceptions of the factors that influenced the choice of a given resource, as revealed in interview, group interview, and focus group data, to provide a more complete picture of the research setting and highlight the experiences of the women workers. This analysis, focused on workers’ social support practices, healthcare resources, and healthcare needs in their descriptions of live-in and live-out positions, also describes and situates the diversity of experiences among careworkers, their collective and individual complex sets of strategies, challenges and resources, and their position(s) in a socio-economic context. This uses in-depth data from the ethnographic sample in a meaningful context; as Hirsch notes, “the idea is to study people embedded in social networks, instead of stripped from them” (2003:33).

Summary

This chapter provides a necessary description of the political and economic forces present in the research setting, especially important for understanding the environment within which the immigrant careworkers operate. By providing information
about the historical, economic and political context of the city of Genoa and the pervasive, powerful Italian National Healthcare System (INHS), I lay the groundwork for an analysis calling upon the critical medical anthropological tradition. The Italian state has been a more visible actor in care provision for the general population since the inception of INHS, and is encountered in Genoa as INHS policies are enacted at the regional (Ligurian) and comune (Genoan) level. The physical and historical contexts of Genoa are important to how carework operates in this city and the ways in which the women who do this work experience well-being and health.
Chapter Three: Care as a Concept and Carework in Italy

In this chapter I provide a context for the analysis of the relationships involving care as manifest in Italy, moving from the broadest (conceptual and global) to the most local scale. The discussion begins with care as broadly conceptualized in the scholarly literature, then moves to the worldwide economic exchange of care, to the way care operates within the policy milieu of Italy and finally to how carework gets done “on the ground” in Genoa. Care has been conceptualized in many ways; I situate care and carework as reproductive labor within larger structural forces, including the global economic market. The next part of the chapter considers how care arrangements in Italy have been influenced by the intertwined historical trajectories of domestic labor, worker movements, and feminist traditions in Italy. Next, I outline the policies that require the family to take responsibility for care, the immigration laws\textsuperscript{14} that maintain a pool of immigrant women to take low-wage careworker jobs, and a hands-off approach to regulation of household employment so that the informal economy can flourish in this work sector\textsuperscript{15}. I end with a brief discussion of how the recent scholarship on immigration and work in Genoa shapes my own analysis.

The Concept of Care

Care as a concept has been discussed in the health and nursing literature for decades, to include the application of nursing’s concept of care to the care that home health careworkers provide and to the motivation of these providers (Leininger and Watson 1990; Warren 1998). In reviewing the historical and social forces that have helped define the act of caring, the situation of nurses was a useful case study in that it

\textsuperscript{14} The specific immigration laws that influence South American careworkers are detailed in chapter 4, and the way that immigrant categories operate in individual lives is considered in chapter 5.

\textsuperscript{15} The Italian state is also obviously an important player in the policies and operation of the National healthcare system (INHS), described in chapter 2, and considered in chapters 7 and 8.
displayed how the historical development of gender, the emotions ascribed to care, and the tasks of care were intertwined. Reverby (1990) pointed out that while caring was important to nursing work, the relationship between the idea of caring and the work of nursing required another analysis. Duffy (2005a) and Reverby (1990) pointed to feminist scholarship and increased capitalist influences as reframing “caring” as both a way of being and work (Graham 1983). For instance, the work tasks of caring for an elder include: reminding, making appointments, communicating with family and/or health providers, assisting with walking or any of the following, bathing, feeding, reading, administering medication, shopping, cleaning, and cooking. Reverby argued that much of the work in women's studies and nursing was useful in highlighting the problematic status of care, but lacking in that this literature ignored the social and cultural forces that combine with power relations to create the concept of care.

Reverby’s analysis of the history of nursing in the U.S. translated to the present home-based care situation in Genoa in one important way. In the historical development of the institution of nursing practice in the U.S. context the reproductive labor of the home was extended to institutionalized and regularized systems of care. Nursing in the United States (and in other countries) emerged from the tradition of women performing unpaid reproductive labor in the home or a religious community caring for others (Nutting and Dock 1907; Tombaccini, et al. 2008). In the same way, the tradition of the multi-generational household in Italy assumed that an adult female would attend to the needs of the disabled, elderly, or children in the home. The Italian state has extended this into policy arrangements that insist on family responsibility for elders, which has fostered the development of the informal marketplace of care by immigrant workers to elders in their

16 Women met the needs of other household members (for the wealthy in European countries and in the United States) or those poor and in need (especially true in countries in which nursing grew out of female religious communities (Tombaccini, et al. 2008:22-23)) and eventually the expertise developed into the profession of nursing.
homes (Anderson 2010). In Genoa, as in many other communities, i.e., the United States (Dill 1988; Meyer 2003; Potter, et al. 2006), Israel (Lecovich 2007), Germany (Lutz 2007), and Columbia (Meleis and Bernal 1995), the households hiring a careworker were purchasing "affections" and a set of practices that were necessary to ensure the health and safety of elderly people. The distinction is important between care as work and care as a concept because these two definitions of care are inextricably bound with one another (Abel and Nelson 1990). Care as work is especially visible in the marketplace; care as a concept is what motivates policy and community discussions of who is to care and how to value care.

Reverby also pointed out that "the crucial dilemma of American nursing has been the order to care in a society that refuses to value caring" (Reverby 1990:133). Her historical "unraveling" of the relationship between nursing and womanhood in the United States during the past century underscored the way one society had come to value (or undervalue) care work. For instance, a family may value their elder member in need of care and want only the best care possible. However, this same family may balk at the cost of the care options available, and undervalue the work involved in providing care to the family member. This is applicable to the social location of female immigrant careworkers in many industrialized cities, and aids in an examination of how power concentrates and circulates in the interlocking relationships involved in care arrangements. In home care situations, these relationships evolve among the low-wage, immigrant careworker, the elderly client, and the person who brokers the care (usually the client or one of his or her family members).

Directly useful to my analysis are the ideas emerging from work done outside of the institution by sociologist Clare Stacey (2011). She highlighted the "surplus care" often provided by workers in her analysis of the relationships of in-home careworkers in a community in the U.S. (Stacey 2011:79-83). This was care that was not expected by
the agency employing the careworker or included in the job as defined by the household member directing the care (in some cases the elderly client). The research participants in Stacey’s study often referred to “the system” as being inadequate to meet the needs of a particular client. Sometimes “the system” under scrutiny was the agency at which they were employed and its rules, at other times it was the state payment system for client-directed in-home care, or the federal/state payment system for those utilizing services for the disabled. The workers named their own personal contributions of time, activities, or material gifts as being done in opposition to the system or to make up for it. This reaction to the structural forces imposed on what they perceived as more than low-wage labor was linked to their idea of being a person who not only did the work of care but also was emotionally caring to the client. Of course, workers reacting to poor working conditions or a difficult situation may react in a less than generous way. Stacey (2011) and others (Caciula, et al. 2010; Daskalopoulos and Borrelli 2007) acknowledge the potential for the low-wage worker frustrated with working conditions to vent their frustration on to the client, which can result in elder abuse.

**Larger Structural Forces and Care**

**Public Policy**

In an international context, examining public policy on care illuminates how care is valued in a society. Sevenhuijsen (2002) reviewed the trajectory of care policy changes in the Netherlands. She called for care to be conceptualized as democratic practice and good citizenship. This scholar viewed care as the responsibility of a civil society, the entire community, and not just the responsibility of the family of the person requiring care. The Netherlands’ system included government-funded salaries for family

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17 She uses the theoretical framework of Tronto (1993) to analyze the Dutch governmental policies regarding care, benefits and paid/unpaid work. She builds on Tronto’s idea of caring as intimate involvement with others and as part of a broad network of social, political and economic relations of caring.
members or family- or elder-hired workers to provide care for elders at home. Some of these payments, seen as part of a social welfare system in this nation-state, were under threat of being reduced by a government edging toward a more neoliberal approach to care at the time that her research was published, 2002. Sevenhuijsen recommended that the following values remain central to care policy development for the Netherlands: "attentiveness, responsibility, competence, responsiveness, and trust and interacting to form a framework for democratic processing of caring practices, both on an individual and societal level" (2002:26, emphasis added). This was in contrast to the prevalent belief in Italy that care was clearly the obligation of the family, not the wider society. In Italy and Southern Europe care was associated with being a good family member (Lyon 2006; Zanatta 1999). The Italian family members who purchased care by hiring and supervising a low-wage immigrant careworker were seen as fulfilling their family obligation (Anderson 2004; Degiuli 2007b). Responsibility for the safety and well-being of elders clearly rested with the family, not the state.

A comparison with another EU country helped to underscore the role of the state in the way the work of care is acknowledged (or not). The social welfare approach of the Netherlands was in contrast to neoliberal approaches to care, seen in many EU countries and discussed below. In the case of the Netherlands otherwise unpaid labor, i.e., the carework of family members, was paid with a salary from the Dutch government. Hired careworkers and the reproductive labor they contribute were also acknowledged vis-à-vis the policy of the state which required a standard “living wage” as the salary to the person providing care. In the Italian policy, unremunerated labor in the home is what the state views as the family responsibility of care. This reproductive labor, done by “invisible” female family members, was transferred to another set of equally invisible workers and barely remunerated. These examples have been chosen to underscore the
fact that the ways in which public policy operates in the household have influenced the ways in which carework was valued, or not.

The Italian policy is visible in the case of South American migrants working as elder careworkers in Genoa. These women are in a situation in which they sell their capacity to be a “caring person” along with their labor power of performing the work tasks of care in the thriving informal economic market place in Genoa, even as Italian family members claim responsibility for “caring for their own.” As Tronto points out, “one way to understand a group's social power is in seeing whether it is able to force some other people to carry out its caregiving work” (2002). The distribution of caregiving work thus reflects power (also see, Nakano Glenn 1992; Tung 2000). Tronto pointed out that there was an incorrect assumption that only elders, disabled, and juvenile family members require care, when in fact the “able-bodied breadwinner” was a recipient of care. This breadwinner description illustrated social reproduction as the maintenance of the workforce in that the breadwinner described had the time to focus on a wage-earning job because of the many care services that “satisfy one's basic caring needs: edible food, clean clothing, functional, attractive shelter” (Tronto 2002). While Tronto imbued care with an ethic that tied it to society, she also recognized how power was tied to care and assumptions about who actually was requiring care (Tronto 1993). She pointed out that the household full-time employee may have the most economic power, which may obscure the fact that this person is a recipient of care. In Italian household-based research, the work of Anderson (2002), Degiuli (2007b), and Sarti (2005) also offered this critique along with the observation that individuals with economic power and social power began to normalize the idea that female family members and immigrant women the household females supervise were “destined” to do care.

Many researchers have noted the transfer of the care associated with reproductive labor by immigrant women from their own families to their clients (such as
elders or children) as a strategy that helps these working immigrant mothers and daughters deal with the emotions that accompany separation from loved ones (Hondagneu-Sotelo and Avila 1997; Parreñas 2005; Tung 2000). Care is commodified and the material expression of care is obvious in the very tangible form of a remittance sent monthly to the family of the worker “back home.”

**Transnational Exchange in the Global Marketplace**

The international transfer of caregiving (Parreñas 2001a) refers to a social, political, and economic relationship between women in the global labor market. In this organization of care labor, the worth of reproductive labor declines as the socio-economic class of the family needing care declines. Parreñas states succinctly, "As care is made into a commodity, women with greater resources can afford the best-quality care for their family" (Parreñas 2001a:73).¹⁸ This explicitly introduces class into the relationship among the women involved in care, either as employers, workers, or unpaid “givers” of care. This characterization of care also essentializes it, assuming that carer = female. This global chain of care concept introduced by Hochschild (2000) highlights not only the decline in the value of labor but also the interlocking relationships among women in different locales.

Related to two of the major concepts central to this literature, reproductive labor and emotional labor, is the practice of leaving one’s family in order to care for one’s family (Anderson 2006; Parreñas 2005). Zimmerman, et al.(2006) reflected on earlier scholarship on U.S. racial-ethnic minority families that showed how working had been part of the construction of good family care, or motherhood. For centuries it has been

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¹⁸ Thus, in one example, the market value of the labor needed to care for an elder is highest in an upper-class Italian household in which an Ecuadorian woman is employed, lower for the woman hired to provide caring and cleaning for the Ecuadorian woman’s family in Guayaquil, and the very lowest level, often nothing, for the eldest child of the woman now working in the transnational careworker’s home in Guayaquil who is taking care of her younger siblings and/or grandparents as a substitute for her mother.
true that work outside of one’s own home but in that of another woman has long been part of the experience of mothering and providing. The new phenomenon has been that transnational mothers are “physically separated from their children for long periods of time and by vast spaces” (Zimmerman, et al. 2006:206). This long-distance transnational parenting is felt in significant ways by individual family members with kin relations to a transnational careworker. In addition, the transnational transfer of capital, jobs, and workers affects large economic processes in the workers’ countries of origin.

When examined at the macroscale of the transfer of capital in exchange for carework among nation-states, the wages of immigrants totaled significant economic support to the economy of their “home” nation-states. Structural adjustments in Southern hemisphere countries have altered economies and undercut social supports from country governments that have led to the large numbers of women leaving to earn household income to improve the lives of their children (Chang 2000). In many cases it has been women in “sending” countries who shouldered a disproportionate amount of the work that has had to be provided by the household when government provision of social services was cut (Bergeron 2001; Harrison 1997). The remittances sent back to the country of origin serviced the debt accrued through first world “loans” to Southern countries (Boccagni and Lagomarsino 2011; Enloe 1989; Grigolini 2005; Sassen 2007). One important example of this was Ecuador, which in 2008 had remittances totaling $4 billion from migrants, the majority of whom worked in one of three countries: Spain, the United States, and Italy. These remittances represented Ecuador’s second-leading source of foreign currency after oil export revenues, which between January and

In the United States alone examples span history and include a breadth of experiences. Some examples are: African-American women who labored as slaves caring for the owner’s family members, then more recently as low-wage maids and nannies (Dill 1988); immigrants from European countries such as Ireland and Sweden who worked as domestics in the late 1800s and early 1900s (Lynch-Brennan 2004); rural women who were expected to work for low wages for relatives in towns and cities (Lynch-Brennan 2004); and Mexican-American and Mexican immigrant maids (Hondagneu-Sotelo 2001).
November of the same year (2008) brought in $10.26 billion (Latin American Herald Tribune 2009). As of 2005, two million Ecuadorians, 15% of the population of this nation-state, were working overseas (Hall 2005). The presence of Ecuadorians and immigrants from other South American countries is discussed in more detail in chapter 4.

Care is a series of work tasks, a set of behaviors, to be completed. However, an important issue in the literature on care concerns the emotions involved in the relational work a key part of what transforms a behavior such as washing into an act that constitutes care (Duffy 2005b; Twigg 1999). It is this relational work, the set of behaviors that utilize emotion and communication, that is an important factor in the lived experience of work-related stress for the women who do the work of caring (Dodson and Zincavage 2007; Vitacca, et al. 2011). This stress influences the workers’ health in this research, discussed in detail in chapter 8. Other issues of unpaid labor and low-wage labor linked to gender roles have emerged in the lives of women in Italy, both native- and foreign-born, in ways peculiar to Italy’s history. These are explored in the next section.

**Domestic labor, worker movements, and feminist traditions in Italy**

In many ways the discussion today by women and feminists in Italy regarding care and reproductive labor is similar to that in other industrialized countries such as the United States – the class/racial/ethnic/citizenship divide is palpable and sometimes uncomfortable between employers, middle- and upper-class native women, and the employees in their home, the immigrants working for low wages with little job security. However, the trajectory that led to the situation in Italy is different in some important ways from the trajectory in the United States. The focus of this section is the convergence of three different historical pathways. One difference is the pervasiveness of labor organizing in Italy, which is also considered in chapter 5 in a discussion of working conditions for careworkers in Genoa. Labor unions in Italy have deep cultural and historical roots and are visible in every neighborhood (Pojmann 2006:32-33;
Zincone 2000:5). However, in spite of the continuous strength of labor unions, most immigrant careworkers are not members of a labor union. These organizations have an important but limited role in the lives of the workers who care for elders in their homes.

Another difference is seen in the often-stated Italian societal value of the family and, by extension, the particular position of the domestic sphere in everyday life. This is often linked to the role of women in the Italian family household (Degiuli 2007a; Lyon 2006). As feminism developed in Italy, the activity in the household was brought into focus in a way that reflected this role for women (Dalla Costa 1988:23-25; Stein 2001). The value of the family as an important center of Italian cultural life was reinforced by the historical patterns of patriarchy, the Italian state vis-à-vis various policies, and the state-like Catholic Church. The result was the development of a tiered feminism (Glenn 1992; Parreñas 2001a), where the low-wage domestic worker supported the idea of the family for Italian employers of means, even as the domestic worker’s own family made other arrangements.

A third difference is that in Italy the development of feminism has been influenced by both the ongoing influence of the Catholic Church (Giammanco 1989; Scaraffia and Zarri 1999) and the legacy of Fascism (De Grazia 1992:190-192; Willson 2010:61-64). The intersection of these histories is illustrated by an analysis based on the work of three scholars, to examine how one labor union, ACLI-COLF20, has interacted with domestic workers in Italy during the past 60 years.

Mariangela Maraviglia (1995) has provided an historical review of ACLI-COLF and historian Wendy Pojmann (2006) has reviewed labor unions in the context of her history of feminist organizing by native and immigrant women in Italy. In analyzing the

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20 ACLI is an important organization for “workers aiming to promote Christian values”; it has existed since the end of the second world war and participates in a variety of work sectors (Maraviglia 1996). ACLI-COLF is the domestic labor sector-focused arm of the larger labor union (ACLI-COLF 1979; Di Nicola 1994) and has 6,000 subscribers (ACLI-COLF 2007).
important publications from the archives of this labor union since its inception in 1946, Jacqueline Andall (2000) told the story of how domestic laborers fit into the trajectory of feminist traditions in Italy. These important works together emphasized the following: (1) that ACLI-COLF was established exclusively for domestic workers and has operated continuously as the marketplace of domestic work has expanded and included global actors, i.e., immigrant women (Maraviglia 1996:32-33; Pojmann 2006); (2) that the focus of the organization changed from originally providing a “counter perspective to socialist and communist goals” regarding labor, to one with a “radical class approach,” to one emphasizing gender (Andall 2000b:147); and, (3) ACLI-COLF continues to be one of the two most relevant and powerful labor organizations serving immigrant careworkers today.

ACLI-COLF has information counters, immigrant information centers, and regular union offices in many neighborhoods of every mid-to-large sized city in Italy (Patronato Acli 2007). Every time there has been any change in the Italian legal immigration code, these sites served as important sources of information, presenting informational programs, outreach tables, and walk-in or appointment counseling. The immigrants (and employers) seeking help did not need to be members (or documented or legally employed), and most often were not members (Watts 1999:14). The assistance given to household employers seeking to uphold the law or keep a valued worker by moving her from “the shadows” of irregular work into being a contractual immigrant worker with documents was seen by some social researchers such as Magat (2004:355) as another example of how organizations such as ACLI-COLF prioritize the needs of Italian employers and encourage workers to avoid conflicts with them (Andall 1998).

Unlike some other European nations post-WW I, the presence of the domestic worker or servant in the home was not interrupted in Italy (Sarti 2005:11). Mussolini’s views on the importance of women to the role of family supported the idea that any poor
and/or single woman heading a household was naturally suited for the domestic work sector (De Grazia 1992:59-60, 186-190). In a similar fashion, Catholic Church ideals about women led to the establishment of an internal committee of ACLI-COLF, aimed at “protecting women who worked outside the home and safeguarding the institution of the family” (Andall 2000a:90) by charging employers to be paternalistic and workers to view their role as “collaboration with the family and the means to love God with all one’s soul” (Crippa 1961:10). This idea of domestic work as a “Christian vocation,” still seen today, stands in sharp contrast to a class analysis. It is explored further in chapter 6 of this document.

In her analysis of the ACLI-COLF archives Andall concluded that several shifts in the approach of this important organization had taken place since it began in 1946 as an Italian worker-focused agency with class-based ideals that started when only poor (often Southern) Italian women were domestic workers. Its class-based ideology created a genuine opportunity for the inclusion of immigrant women in this important domestic worker organization through the 1960s. In the 1970s ACLI-COLF “pre-empted both the national government and the more progressive arena of women’s politics in responding to the specific situation of migrant women” (Andall 2000a:240), but given that most domestic workers were immigrant women it would have been impossible for this organization to take any other position. While this inclusion was seen as a radical positive step, it did not fundamentally change working conditions.

The next shift occurred early in the 1980s, when ACLI-COLF adopted a philosophy based on “gender solidarity,” subsuming, in the process, class, citizenship status, and ethnicity. This call for solidarity, which ultimately placed a disproportionate amount of sacrifice on the low-wage immigrant worker, was similar to the “Common Victim” syndrome so eloquently proposed and critiqued by Mary Romero (2002) in her study of the situation of Mexican immigrant domestic workers in the United States. This
idea, considered part of first wave feminism, pointed out that structural forces (patriarchy) keep all women in a situation of too many obligations. However, as many important scholars have pointed out for decades, sisterhood was not possible because of the power imbued in class, immigration status, ethnicity, sexual orientation and other social locations. For examples, see Mignon Duffy (2005b) and Valentine Moghadam (2005) in the United States’ context, Sonia Alvarez (1998) and Caroline Moser (1993) in Latin American contexts, Grace Chang (2000), Shellee Colen (1990), and Nicole Rousseau (2009) regarding women of color, and Chandra Mohanty (2003) and Lilia Rodriguez (1994) for Southern hemisphere perspectives.

Notably, in her analysis of the union’s history, Andall pointed out what these social critics had noted in other parts of the world, that in the web of tensions and conversations about reproductive labor and the home, there were important omissions. In reviewing an ACLI-COLF Charter of Responsibilities and Rights drawn up for domestic workers in 1985, Andall noted the Common Victim syndrome central to the document, which included a direct call for solidarity with the employer, also assumed to be a woman. The actors—household employer, worker, care recipient—named in the ACLI-COLF pronouncement occupied different power positions related to class, nationality, citizenship, and ethnicity as well as gender, but this was not acknowledged. Andall wrote: “Notably absent from the section dealing with the domestic workers’ rights is any suggestion that female employers should also make sacrifices as a contribution to women’s struggle, let alone encourage their male partners to make some” (2000b:161). Andall was objecting to the union’s failure to recognize how class was involved and its tacit acceptance of patriarchal forces.

Three other authors have noted the shift of ACLI-COLF in the 1990s to make initial attempts at internationalizing the union in small practical ways by retooling cultural and social programs to address the practical needs of immigrants (Pojmann 2006:33).
and in recognizing “migrant women’s need for more political space and autonomous representation within the association” (Andall 2000a; see also, Maraviglia 1995). The general consensus among these scholars is that the unions were useful to immigrant workers in practical ways, but operated with ideological assumptions about the inevitability of non-European immigrants as being suited for domestic work. Thus, the unions viewed migrant women’s presence in the live-in sphere as a straightforward and useful reconciliation of supply and demand, and used the identity of “worker” to ignore the variety of experiences represented, lumping all immigrants into a single category (Andall 2000a:248; Pojmann 2006:33-34).

Even with the pervading histories of regionally-based class divisions in Italy, Fascism, and the steady presence of the Catholic Church, feminism was visible in many important ways. For instance, Mariarosa Dalla Costa, an Italian, and her American colleague, Selma James, introduced in their seminal work *The Power of Women and the Subversion of the Community* (1972) the ideas that formed the basis of the “wages for housework” campaign. This document was seen as radical at the time, and appeared one year before the convention of ACLI-COLF that led to the important 1974 national collective bargaining agreement for the domestic work sector. This agreement moved domestic work into the status of being a “protected” work sector by acknowledging the rights of women in domestic work, outlining working conditions, specifying contractual expectations of the employer/employee, and reducing the number of work hours allowed by law in this profession; these were also seen as radical departures from a view of domestic work as an opportunity to serve. One of the sections of Dalla Costa’s essay is titled “Socializing the struggle of the isolated labourer,” which was upon face value applicable to the situation of the careworker in the elder’s home laboring unseen for at least 12 hours most days of every week (in Dalla Costa and James 1972:5). However, further analysis reveals that she wanted to call attention to the invisibility of reproductive
labor and its value as surplus labor, and in the process make it visible. Surplus labor is the amount of the value of the work in excess of the value of the wage for that work, conceptualized in a capitalist society. In many ways, Dalla Costa’s important 20th century document on work done in the private home by family members does not seamlessly transfer to Genoa today due to the very different status of the immigrant low-wage laborer in the home when compared to a female family member. Italian women are not invested in wages for housework while they can continue to hire low-wage precariously-employed immigrant women; immigrant women may be interested in wages and job security for very pragmatic reasons quite different from the original intent of the “wages for housework” document by Dalla Costa and James. Nevertheless, it has helped to lay the groundwork for issues at stake in the lives of immigrant careworkers laboring in Italy today.

Policies that Influence the Care of Elders in Italy

Italy’s Care Policy Compared to other European Union countries

Policy analysts (Daly and Lewis 2000; Esping-Andersen 2009), political scientists (Menz 2006; Swank 2002), and economists (Bettio, et al. 2006; De Santis 2011) focused on the care sector consider Italy to have a Mediterranean-familialist style welfare regime, one of four categories in the typology for European countries. This regime type, also aligned with Spain, Greece, and Portugal, is characterized by a high dependence on family members to provide care, few state-supported services for elders, and a shortage of policies that reconcile care and work (Esping-Andersen 2009; Woods 2006; Zanatta 1999; Zanatta 2005). In this section I situate Italy in the larger context of the European

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21 Though some policy analysts argue for a typology with three regimes and include Italy in the conservative-corporatist-Bismarckian model, I have chosen the four-regime typology. These are not rigid types, but merely an organizing tool. Leibfried (1992), Ferrera (1996) and Bonoli (1997) also concluded that the Southern, Mediterranean countries constitute a different (fourth) welfare regime type with its familial characteristics and its immature and selective social security systems granting poor benefits and lacking a guaranteed minimum benefit (Muffels and Fouarge 2003:8).
Union regarding welfare benefits related to elder care. The United Kingdom is a classic example of the *liberal* welfare regime, with a heavy dependency on individual savings by retirees to ensure well-being in old age by utilizing the private marketplace of care options. This regime provides funding and services to a very small portion of the elderly population, one that qualifies via means-testing for assistance via “entitlement rules that are…strict and often associated with stigma; benefits are typically modest” (Esping-Andersen 1990:26).

The *conservative-corporatist-Bismarckian* model is exemplified by Germany’s approach to providing for elders, which finances the welfare state through employment-related charges and “eligibility for payment is linked to (previous) employment status, with limited redistribution and limited provisions made for individuals with little or no employment history” (Menz 2006:404). In countries with this approach to care and welfare of elders (in addition to Germany, France, Austria, and Belgium also fit into this category) voluntary associations organize social services for elders supported by public financing in a neo-corporatist arrangement (Daly and Lewis 2000:289-290). The fourth category in this typology is the *Scandinavian-social democratic* model, which is the most unlike Italy’s welfare regime, and is seen in its most extreme form in the government of Sweden. In this regime “payments for personal caring, set within a context of a (still) widespread network of public care services” are the level of support which Swedish citizens expect from their government, which they hold accountable to help all in need; another term used to describe such a welfare approach is universalism (Daly and Lewis 2000:293).

In the examination of how various EU country governments provide for elder citizens, these analysts used the term “welfare” to describe services to citizens with needs (during old age, illness, disability, or unemployment). In my project, the focus was on services to elders or disabled adults requiring care. The welfare system in place in
Liguria before neoliberal changes did not provide services for in-home care to most elders. Individuals who received assistance were often very poor and/or disabled. Welfare reform in Italy had meant that the very small pool of funds allocated to fund services for the most needy was now even smaller (Cochrane 1993; Muffels 2002; Schierup, et al. 2006). After the cuts dictated by the neoliberal approach taken in the early 1990s in anticipation of entry into the European Economic Community, there were even fewer resources (such as services and payments) for Italian families caring for a dependent adult (Natali 2004). This low level of public service provision continues today (Lamura, et al. 2008). For instance, in 2008 the number of requests to government agencies for home care help was more than four times the total responses to such requests; that same year an “integrated home care” service reached “just under 4.9% of all older persons, ensuring on average not more than 24 hours of care per year per client” (Di Santo and Ceruzzi 2010:5-6). Neoliberal policies have also influenced the non-familialist welfare regimes; for instance, in “Ireland, Britain, Germany and Austria among other countries, the payments are more identifiable as substitutes for formal care, either because of a lack of necessary public services or because of state withdrawal from providing them” (Daly and Lewis 2000:293).

The general view of eldercare policy in Italy was that it places the responsibility on the family of the elder (Saraceno 2003), that the services provided were far from adequate to meet the bulk of the population requiring care, and that there was a lack of coordination and efficiency associated with existing services (Bettio, et al. 2004; Lo Scalzo, et al. 2009:xxiv). Two stated targets of Italian policies were: to keep elders in need of care at home; and, to facilitate female labor market participation (Di Santo and Ceruzzi 2010:24-25). The state failed to meet these goals, and a huge informal market has developed to fill the need for care. Bettio, et al. effectively labeled the shift from a ‘family’ model “to a ‘migrant in the family’ model of care” (2006:272).
Italy’s policy stands in contrast to many other European countries that fund public elder care programs and make payments directly to the family member providing care or to the elder requiring care. The Italian state expects family members to care for “their own,” including family elders. One social worker told me that sometimes nieces and nephews, and first and second cousins may be contacted to be held responsible for an elderly relative that a government agency has learned is in need of care and/or resources.

Eldercare Services and Their Use in Liguria

In Italy, there are a variety of eldercare services at the city, regional and national level, not always well-coordinated and described as a “network of formal services …rather weak and scarcely used” (Di Santo and Ceruzzi 2010:24). Generally, social non-medical services are the responsibility of the municipal government and healthcare services as provided by the Region; and money in the form of attendant allowances and tax reductions are the responsibility of the Italian state. The possible mixtures of these limited sources of support result in “remarkable local differences” (Di Santo and Ceruzzi 2010:24).

While 99% of the municipalities in the region of Liguria have “home help with social care services,” these resources, from government, non-profit and for-profit agencies, are utilized by only 1.1% of the population of the region (ISTAT 2009b)—elders make up 27% of the inhabitants of Liguria (ISTAT 2012a). Home help services may include help with housework, shopping, companionship, “and in cases of extreme disability, personal services including hairdressing, manicures, and pedicures” (Degiuli 2007b:47). Most municipalities in Italy also have meal delivery (Polverini, et al. 2004) and may coordinate with non-profit organizations such as Caritas or Sant’Egidio to provide food and clothing to poor elders (Di Santo and Ceruzzi 2010; interviews with social workers October 2010). However, according to some evaluations by scholars,
these services generally do not reach more than 3% of the elderly population in areas where the services exist (Pesaresi and Gori 2005) and they often provide only limited hours of support and are not a substitute for institutional or extended time home care (Da Roit 2007:252; Degiuli 2007b:159-165).

INHS regional health authorities in Liguria, and local health authorities in Genoa have invested resources so that most prescription-only pharmaceuticals are free for disabled and elderly individuals (Fattore and Jommi 2008), optometry care is provided to elderly citizens with high medical need, and assistance with transportation to medical appointments is provided for the elderly and disabled (Francese and Romanelli 2008; Region of Liguria 2011). While there are some INHS pilot programs to coordinate in-home care with health prevention activities and delivery of healthcare, there is no INHS system-wide expectation of home care support (ASL 2011; Sarti and De Marchi 2009).

The Minister of Health (Ministero della Salute 2008) found that only 0.2% of the population had access to ‘Integrated Home Care’ when discharged from the hospital in 2007. In addition, the national health system, as manifest in Liguria, has not invested in creating the number of beds in institutions, such as rest homes, that would be proportional to the large number of elders residing in this region. Some reasons named for this include: lack of foresight and wisdom on the part of regional policy makers and health administrators, the tradition of family care as part of Italian culture, and the lack of available spaces for such institutions (Degiuli 2007a; Lyon 2006; Lyon and Glucksmann 2008). If the care industry was not largely informal and most of the jobs were not filled by undocumented migrants, the basic care needs for many Genovese elders would not be met, which would result in chaos (Lamura, et al. 2006; interviews with INHS medical administrators October 2010).

The Italian state provides financial transfers to the family – providing disability and pension payments for household maintenance, more than other Mediterranean
welfare regime nations. Until recent changes due to the economic Euro zone crisis, pensions have generally been generous for those who have a long record of work in Italy (Bettio, et al. 2006:272). Italy also has a “national cash benefit, a non-means tested attendance allowance paid as a flat rate of about 470 Euro per month” (Di Santo and Ceruzzi 2010:6). This “attendant allowance” is paid to the “dependent elder with severe disabilities” (Bettio, et al. 2006:272) and is given only after the person is certified as unable to care for himself and in need of assistance with most Activities of Daily Living (ADLs). Some regions also provide cash directly to the elder, in some cases only to elders that legally employ a careworker, in hopes that this will prevent illegal arrangements. Liguria provides a regional “care allowance” to those who qualify for the national cash benefit and are in households that receive less than 40,000 Euro per year in social security and pension benefit payments; but the legality of the careworker arrangement is not monitored (Sarti and De Marchi 2009:10). Even with all of this talk of cash transfers, it is important to remember that one must qualify and that the state is still positioned as a “carer of last resort” to elders (Bettio, et al. 2006:272).

**Immigrant Workers in the Informal Economy**

The governmental resources available to elders at home are inadequate, and so immigrant careworkers are necessary. Elders in need of care who are assisted by immigrant careworkers far outnumber those assisted at home by public services (Di Santo and Ceruzzi 2010). Italy, in general, has extremely low birth rates, a high numbers of elders, and a thriving informal economy; all of these factors are magnified in Liguria. In Genoa there is a twenty-plus year pattern of migrants working in elders’ homes, and a high concentration of elders who need assistance with activities of daily living in order to remain at home. Care of elders is an important enterprise in Genoa because it is the largest city in the its region (Liguria) with the biggest proportion of the “oldest old” (over 80 years) in Italy (Guerchi and Consigliere 2002b).
Because of an aging or “aged-out” workforce and a burgeoning need for workers in the service sector, including elder carework, there is ample motivation for Italian authorities to maintain a healthy informal economy. The monetary transfers described above are higher than in other Southern European countries, which allows even low-income families who have qualified for the care allowance or the attendant allowance to hire a low-wage immigrant careworker (Bettio, et al. 2006:272). With the shift in demographics and the influx of a large pool of low-wage immigrant workers, what used to be seen as a service or a luxury only for upper class Italians, domestic help, is now found in all but the poorest households in Italy (Anderson 2001; Degiuli 2011; Lamura, et al. 2006). This is especially true of in-home careworkers to the elderly and nannies/babysitters that care for children in the home as it has become the norm for even lower-middle class households to have a cleaner and/or nanny and/or elder careworker.

In the past (until the early 1980s), the domestic worker’s role has been associated with being a poor female Italian (often from the South of Italy); in these arrangements the difference between the supervising lady of the house and the maid was primarily economic class (Lutz and Schwalgin 2004:302). Over the past two decades, the domestic worker role has become aligned with female immigrant identity (Capacci, et al. 2005:65; Lutz and Schwalgin 2004:313). During my time in Genoa, I learned of a few Italians who worked as domestic helpers, most often in specialty roles, such as: tutor to a child with special needs; masseuse for a very wealthy Italian woman with chronic pain; cook for a wealthy household with two elderly family members; care coordinator for an elderly person needing in-home care whose adult child was living in another country. In all of these instances, the Italian is not the one changing the diapers, cleaning the floors, or remaining at home to help the family member requiring care with basic “minute-to-minute” needs.
According to Lamura, et al., the homecare workforce in Italy consists largely of
non-Italian citizens. In a report based on 2003 Eurofamcare data, they classified as
foreign nationals 86% of all home-based, privately hired careworkers to elders (2006).
Although the number of careworkers who live in, reside in the home of the elder for
whom they do carework, is difficult to determine, this is a well-established practice in
Italy. Many Italian families hire migrant careworkers, sometimes having them live with
the elderly persons in order to keep costs low. And such employment often occurs on
an undeclared (non-legal) basis, by the hiring of illegal immigrants (who are particularly
inexpensive), or of legal immigrants but without a legal contract (Polverini, et al. 2004;
Sarti and De Marchi 2009). Other scholars have found that many families in Italy feel
they do not have family members available to do the carework, and/or funds to hire
documented migrants or Italian citizens with a legal contract at a commensurate salary
and so they rely on immigrants working in nero (illegally, literally “in the black”)
(Anderson 2006; Pojmann 2006:41). Even when employers hire immigrants legally, or
use a private legal service they are likely to have an immigrant careworker;
approximately 25% of families with a member over 75 years of age rely on some sort of
outside care (Pojmann 2006:41). In Genoa these careworkers are most often from
Ecuador and Peru (Erminio 2007b; Vento 2004).

The family carework sector has changed over time in Italy, and the work is no
longer seen or used as short-term, transitional employment for female unmarried less-
privileged Italians or migrants. The pattern has changed to include careworkers who are
older married women with childcare and eldercare responsibilities in their own families,
in Italy or in their country of origin (Parreñas 2005; Vento 2004). The maternal role
taken in the recent past by the Italian “woman of the house” toward the younger
immigrant “helper” does not “fit” with the current work force of older careworkers with
more life experience. Italy has had one of the lowest birth rates in the world for decades;
it often has had the oldest population when compared to other countries; and yet it has maintained an ongoing ethic of family-based care for elders. The in-home support that careworkers provide is not officially considered a delivery of healthcare services, but it does keep the elder living in a private family household and maintains the ideal (for many families) that their elderly family member is being cared for “at home,” even if the bulk of that care is done by a non-family member (Lyon 2006:221). The relationships negotiated among employer household members and careworkers are discussed in chapter 5. While female immigrants from South America have dominated the domestic work sector in Genoa for many years, there are other patterns of work and immigration in the literature, especially by Italian scholars, that have informed my work.

**Genoa, Immigrants, and Social Science**

Recent social science scholarship on Genoa has focused on the influence of immigration and immigrant-citizen relationships on life in the city, including the phenomenon of immigration in this place where many Italian family histories include stories of *emigration*. This research has addressed transnational family formation and the history of immigration from South America to Genoa, which has shaped my understanding of the transnational fields inhabited by the carework immigrant participants in my research. Topics include: the main patterns of immigration, e.g., young solo Moroccan men followed by wives and children (Alzetta 2006; Zontini 2010); the issues involved in the arrival of family members who have moved to Italy to reunify families, i.e., middle-aged solo South American women followed by their children, husbands, parents, in-laws, and/or grandchildren (Ambrosini and Palmas 2007); and, women migrating to Genoa for low-wage domestic worker positions and engaged in transnational family formation (Lagomarsino 2006a).

Examining other ethnicized, gendered work enclaves in Genoa provides insight into the way the careworkers from Latin America are characterized by Italians as suitable
for domestic-based work only. This is especially evident in chapter 6 in my analysis of Suor Carmen, a nun who represents the Catholic Church as the patron/broker who essentializes the immigrant women in her careworker training course. The ethnographies organized by ethnic work enclaves include those focused on South Americans in domestic work (Erminio 2007a; Lagomarsino 2005), male Ecuadorian flower sellers (Lagomarsino and Torre 2007a), and Chinese retailers (Erminio 2007a; Fravega and Bonatti 2005). Much of this work has been done by Italian sociologists and political scientists (for examples, see Ambrosini and Palmas 2007; Boccagni and Lagomarsino 2011; Dal Lago 2005; Torre 2001; Vento 2004). My work fits into this portion of the canon in that I am studying the situation of a group of workers clustered by profession, nation/ethnic identity, and gender – South American women caring for elders in their homes in Genoa. Others doing research based in Genoa have looked at domestic workers generally (Lagomarsino 2005), or at South American women in relation to their families (Esparragoza 2004). Besides the specificity of this work group, that is, only low-wage workers caring for elders in private homes, this dissertation research also is uniquely situated in that this particular work, because it is done in the intimate space of the home, leading to much more citizen-immigrant interaction. This interaction is different in degree and in kind from other typical immigrant work contexts.

In the following chapter, the discussion focuses on the history of immigration between Italy and South America and situates the current immigration policies affecting female careworkers in Genoa within the political and legal history of Italy. The immigrants in the carework force are supporting the everyday quality of life and general well-being of elders by their low-wage work and their steady presence in communities all over Italy. In this way the state is relieved of the responsibility for elder care, by naming the family as responsible and then not supporting the family members who might provide day-to-day care of elders. The low-wage immigrant careworkers currently working in
Italy immigrated to take these jobs, which meant that the Italian state did not contribute to the maintenance or renewal of this portion of the labor force. For those that remain in Italy undocumented, there is little to no contribution from the state toward sustaining their labor power in Italy. However, as Michael Burawoy noted in his early important work on reproductive labor and immigrants, “domestic work simultaneously provides for both maintenance and renewal of the labor force” (Burawoy 1976:1052). When low-wage immigrants provide the care, “a proportion of the costs of renewal (of the labor force) is externalized to an alternate economy and/or state” (Burawoy 1976:1053). There are consequences for individuals, families, and communities in both Genoa and the immigrant’s country of origin.
Chapter Four: Italy in the European Union, 
Immigration in Italy and South American Careworkers in Genoa

For this research, most relevant to the discussion of current Italian-South American relations is the historical trajectory of transnationalism, defined here as the circulation of ideas, people, and goods among and between places (Appadurai 1991; Appadurai 2000). This chapter begins with an analysis of the transnational ties between Italy and South American countries, with an emphasis on Ecuador. The discussion focuses on Guayaquil, a coastal city from which large numbers of Ecuadorians have immigrated to Genoa (Lagomarsino 2005). It also considers Genoa in the context of Italy and the European Union (EU). The analysis then shifts to consider the historical context of immigration in Italy, leading to the climate that produced a recent wave of anti-immigrant legislation.

When the Italian state crafted contemporary immigration policy that focused on security (discussed later in this chapter and considered in detail in chapter 7) and the perceived threats of “the immigrant” to the safety of Italians, they conjured up the image of a dark-skinned, non-Catholic person from Northern Africa who arrived on the coast of Italy via boat (Baldwin-Edwards 2004:3). The many immigrants in Italy who hail from countries that have in the past been destinations for Italians were generally perceived as people more familiar and less threatening to Italians, especially if they were from a “Catholic” country (such as Peru), or a neighboring country (such as a France). In this way the transnational ties and movements over the past seven centuries have shaped current approaches to immigration by the Italian state (Silverstein 2005).

The History of Immigration among Italy and South American Countries

The movement of people between South American countries and Italy since the mid-19th century (both directions) was important in this research for understanding the unique situation in Genoa, where Ecuadorians and Peruvians dominated the population
of immigrants, and the labor sector of carework (Dossa 2002; Lagomarsino 2006b). Italy was not directly involved in the colonization of South America. However, even as early as the first half of the sixteenth century, there was a link as the great banking houses of Europe, including those in Genoa, were involved in financing the activities of the conquistadors of Spain (Elliott 1987:30).

While immigrants from many different countries were working as careworkers in 2009 in the private homes of elders in Genoa, the group that dominated this workforce, and has for 15 years, were Ecuadorian women (Lagomarsino 2006b:145-146; Vento 2004:53, 82). This project reflects this fact – most of the worker-participants in my research were from Ecuador, and all of them were from South American countries, including Bolivia, Brazil, and Peru.

Early in this research I learned that many Ecuadorians were from Guayaquil. This chapter also addresses the specific reasons why a large number of immigrants from the coastal metropolitan area of Guayaquil have migrated to the port city of Genoa. More than one interviewee quipped, “We have here in Liguria, in the city (meaning Genoa) a little Guayaquil,” or “This is the Guayaquil of the Northern hemisphere.”

**The History of Italians Moving to Ecuador**

Soon after Italy became a republic in 1861, when trade was in full swing with some South American countries, the migration of people from Italy to South America began in earnest, driven by declining economic conditions in Italy (Devoto 2006; Devoto and Míguez 1992; Lucassen 2002). In addition to the 19th century waves of migration out of Italy, following each of the World Wars, Italians emigrated to many other countries and continents, looking for increased economic opportunities. Italians moved to the Americas, including countries in South America (Clark 1996; Devoto and Míguez 1992; Villamil and Sapriza 1982). For example, those seeking a livelihood familiar to their experience landed in port cities all over the world to work in the shipping or fishing
industries, including destinations such as San Francisco in the United States (Gabaccia 1998; Gumina 1978) and Guayaquil in Ecuador (Carducci 2001; Estrada 1994). In South America, there were also tens of thousands of Italians who immigrated to Argentina, Brazil, and Chile; in comparison, a much smaller population moved to Ecuador (Di Sciullo, et al. 2009b:15).

The Catholic Church played an important role in Italians moving from Italy to Ecuador. Catholicism has dominated religious life in Ecuador for the last five centuries, starting with the emphasis on carrying Catholicism to colonial lands, a priority of Queen Isabella and King Ferdinand for the conquistadors in the 1500s (Elliott 1987:9) and the arrival of Italians in the mid-nineteenth century continued this tradition. The Church served as a familiar important community and cultural institution for the wave of Italian immigrants who arrived in Ecuador in greater numbers starting in the mid-19th century. Thus, in considering the transnational relationships among Italians and Ecuadorians over time, it was important to consider the role of the Catholic Church in Ecuador.

Of course, the reason Ecuador became predominantly Catholic was due to the deliberate effort made by Spanish colonists to destroy other traditions and impose Catholicism as a means of domination (Guerra Bravo 1987; Wolf, et al. 1991). Starting in 1523, Catholic missionaries played an important role in the colonization by Spain of what is now Ecuador and Peru, when other religions, notably those of various indigenous groups, were suppressed (Elliott 1987; Klaiber 1995:24). The Catholic Church and colonial states in Latin America were intertwined from the 16th through the 19th centuries, but several scholars (e.g., Herrera 2006; Williams 2001) considered the 19th century to be the time period “when the Church most directly influenced Ecuador’s society and politics” (Ayala Mora 1994:91-92).

The first Italians seen in Ecuador following Italian unification (1861) were Catholic missionaries – the Dominicans and then the Salesians (Carducci 2001:9-10). Both the
Jesuit and Dominican Catholic orders started in France but had an established presence in Rome by the 16th century (Puca 2003); the Franciscan and Salesian orders both started in Italy (Viller, et al. 1995). In 1888 Ecuador’s President Antonio Flores Jijóñ, in coordination with the Vatican, divided up the Amazonian region among the Dominican, Salesian, Jesuit, and Franciscan missionaries. (Spindler 1987:135).

Catholicism was named as the official religion of Ecuador in 1862 due in part to the efforts of President Gabriel Garcia Moreno (Carducci 2001:19) who maintained a direct relationship with the pope (the head of the Catholic Church, located within Italy in Vatican City)(Garelli, et al. 2003). In 1897 President Alfaro officially separated the Catholic Church from the Ecuadorian state (Spindler 1987:135). Ecuador and Italy continue to be two of the most “Catholic” countries today in terms of large percentages of the population self-identifying as Catholic. In both countries national identity is aligned with Catholic identity (Garau 2010; Ospina 1996).

The relationship between the Church and the government of Ecuador has undergone changes since the Ecuadorian constitution of 1897 separated church and state, and, as the scholar Aguilar-Monsalve observed, “after Vatican II [the Church has] even become a force for social change”(1984:205). This same scholar described the relationship between the Ecuadorian state and the Church in as interdependent, describing the state as needing “the Church to exert social influence” and the Church as “split between conservatives and liberation theologians and dependent upon government stability” (Aguilar-Monsalve 1988:236). One example of the liberal side of the Catholic Church in Ecuador in action was the community-based initiatives of religious community workers from the Salesian order who have worked with the indigenous movement in the past 15 years to develop “an anti-neoliberal nation” (Martinez Novo 2009). The Salesians are an order of Catholic missionaries focused on education, founded by “Don” John Bosco in 1845 as a boys’ school near Turin in northern Italy. As the work
continued, Don Bosco wrote rules for community members and named the community after a saint, the Rule of the Society of St. Francis de Sales approved by the pope in 1873 (Marsh 1912). The Salesians have a strong presence in both Italy and Ecuador today.

**Uneven and Nonreciprocal “Flows”**

These initial waves of migration to South American countries resulted in substantial numbers of Italian immigrants remaining there, establishing families and businesses, and investing in civic life. A look at the Italian immigrant population of some South American countries today illustrates the relatively small number of Italians who arrived (and remained) in Ecuador when compared to other South American countries.

**Table 4.1. Number of Italians living in South American Countries (2009)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Argentina</th>
<th>Brazil</th>
<th>Venezuela</th>
<th>Uruguay</th>
<th>Chile</th>
<th>Peru</th>
<th>Ecuador</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>544,037</td>
<td>234,815</td>
<td>97,159</td>
<td>72,778</td>
<td>40,225</td>
<td>26,231</td>
<td>10,983</td>
</tr>
</tbody>
</table>


It is interesting to note that 544,037 Italian citizens registered as living in Argentina make up just over half of all Italians living in Latin American countries. In Ecuador the 10,983 Italian citizens registered make up 1% of all Italians living in Latin America as of 2009 (Di Sciullo, et al. 2009b:407-409). Yet, in Genoa one was very likely to meet Ecuadorians but might never meet a person from Argentina.

Once the immigration flows from Italy to South American countries were started and transnational relationships were established, a next step could have been for some South Americans to emigrate from their home countries to Italy. With this idea and the numbers from the table in mind, it would have been logical to expect many Argentinean and Brazilian immigrants in Italy. These countries, however, did not experience the extreme economic collapse that the Ecuadorian economy sustained in 1998 (UNFPA...
Italian immigrants and their families remaining in South American countries could have set up the next “wave” of migration the other direction, i.e., to Italy. However, the numbers are not sufficient to account for the massive influx of Ecuadorians into European countries, and specifically, the city of Genoa\textsuperscript{22}. The rapid decline of the Ecuadorian economy was the overwhelming force in this remarkable transnational phenomenon (Bertoli, et al. 2011). Before discussing this decline, however, tracing the specific historical ties between Genoa and Guayaquil is a necessary next step.

**From Genoa to Guayaquil: a History of Immigration**

People from Genoa and other states of pre-unification Italy emigrated to Guayaquil and other parts of Ecuador in the early 19\textsuperscript{th} century (Carducci 2001:7; Estrada 1994; Lagomarsino and Torre 2007a). Many of these early immigrants were from southern pre-unification states (Sicily, Sardinia, Naples-area) and, notably, the more northern Liguria (Carducci 2001; Estrada 1994). Those who arrived in this coastal city during the first half of the 19\textsuperscript{th} century were merchants and businessmen, many from Genoa, associated with shipping and trade. The next wave of Italian immigrants (from approximately 1860-1910) to the city of Guayaquil worked for grocers in Ecuador, and many eventually set up their own grocery businesses in Guayaquil (Carducci 2001:18). Friends and family ties continued this chain of migration. For the second half of the nineteenth century immigration to Ecuador was almost exclusively Ligurian (Carducci 2001:7; Estrada 1994; Lagomarsino and Torre 2007a).

One example of the steady presence of Ligurian immigrants in Ecuador, specifically the coastal city of Guayaquil, was the existence of the Garibaldi Society of Guayaquil, which was established June 24, 1882 in Guayaquil and continues to this day (Carducci 2001:83). Its membership includes descendants of Genovese who emigrated

\textsuperscript{22} For instance, while in Genoa, I did not meet anyone from Ecuador who claimed any Italian heritage from grandparents or earlier generations. On the other hand, I met Brazilians and Argentineans in Italy who named relatives as Italians who had lived in Brazil or Argentina.
to Guayaquil, including some who have returned to Italy. The official name of the group was The Society of Beneficence for the Italians “Garibaldi” (La società di Beneficenza per gli Italiani “Garibaldi”). It was formed after Garibaldi, considered a key figure for facilitating the unification of Italy into a kingdom in the years 1860-61 (Killinger 2002:189), had only been dead for a few weeks.

Ecuadorian Migration Patterns

Migration out of the country has varied by region within Ecuador, and by industry, gender, and destination. Immigrants (predominantly male) from the highland region of Ecuador started emigrating to the United States in significant numbers in the 1950s and this migration stream increased after the Panama hat industry collapsed in Ecuador and restarted in New York (Gratton 2007). The hat industry connections led the migrants, mostly young men, to the New York metropolitan area. Though these migrants followed the hat industry connections, they most often worked in low-wage restaurant, cleaning or construction jobs (Miles 2004). In the 1980s a larger variety of immigrants, from places other than the highlands, left Ecuador for Spain.

The historical colonial ties between Ecuador, Peru, and other South American countries and Spain have resulted in recent migration agreements that have facilitated migration to Spain (Gratton 2007; Jokisch 1997). Until 2003, when the agreement...

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23 One of the community leaders who helped me conduct a focus group in a Catholic Church careworker support group in an outlying neighborhood from the Genoa city center, Rosa, started her own Garibaldi society of Genoa. She named it the Garibaldi Rosa Barrera Society and invited me to join. She said, “We have many Italians, people from the Guayaquil area, Peruvians, a Moroccan woman who is a friend of mine, and people from other countries—why not an American?” Rosa and her Italian male partner started this society, in a serious imitation of the beneficial society with a long tradition in Guayaquil. She viewed it as both a playful and serious way to acknowledge the power of women in Genoa, the way women operate now as opposed to when the male-only society was started. It continues the tradition of meeting the need for opportunities to develop community relationships, and provides a way to facilitate communication and integration in the multi-ethnic society that is Genoa today.

24 Giuseppe Garibaldi (1807-1882), a major historical figure in Italy’s history, had a minor tie to South America. Based in Genoa, this political leader was instrumental in using military force and diplomacy to unite the many provinces of Italy (Killinger 2002:116-117; Ridley 1976). Between activities in Italy that made him a revered patriot, he was in exile in South America aiding the revolts for independence from colonial powers in Brazil and Uruguay (Killinger 2002:189).
between Spain and Ecuador changed, individuals from Peru and Ecuador needed only a passport to travel to Spain for tourism. The typical South American immigrant in Spain simply overstayed their tourist stay and entered the informal economy. After 2003, a visa was required for travel to Spain from Ecuador, but it was still possible to obtain a tourist visa, and many simply stayed beyond the 90 day limit of the visa, often to find work in the domestic service or construction sector in Spain’s informal economy (Baldwin-Edwards 2004; Padilla and Peixoto 2007).

**Neoliberal Policies on Two Continents**

The agreements Ecuador made with the International Monetary Fund and the World Bank in the 1980s drastically changed household economies in the 1990s in Ecuador, largely due to the effect of privatizing previously government-managed and subsidized industries for basic needs such as electricity (Ramírez Gallegos and Ramírez 2005). Once the effects from structural adjustments were felt in everyday life, many Ecuadorians emigrated, a substantial number to the United States and many to Southern European countries (Gratton 2007; Winslow 1997). After the 1998 economic collapse in Ecuador and until 9/11, women and men emigrated to the United States in ever-increasing numbers. After the terrorist attacks in the United States on September 11th, 2001 (9/11), the rules changed for those seeking entry into the United States from another country (Mittelstadt, et al. 2011). It became much more difficult and costly for immigrants from Ecuador (and many other countries) to enter the United States (Jokisch and Pribilsky 2002). After 2001 Ecuadorians increasingly looked to countries such as Spain for opportunities to work and maintain a quality standard of living for their family back home (Jokisch and Pribilsky 2002).

The overwhelming force of the economic downturn in Ecuador can be seen in the rapid exodus of its citizenry who have left the country out of economic necessity, especially in the years following the financial collapse of 1998 (Jokisch and Pribilsky
2002). As Lagomarsino and Torre state, “keep in mind that a small country of only 12 million people expelled nearly a third of its active population in…7 years” (Lagomarsino and Torre 2007b:9). Here the reference is to the years 1997-2003, a time period when the results of neoliberal adjustments were felt sharply by households, that saw their everyday living expenses for items such as food, electricity, water, and fuel rising as government regulations and supports were removed. At the same time, paychecks were shrinking and the value of the sucre, the currency at the time, was diminishing (Ramírez Gallegos and Ramírez 2005; Whitten and Whitten 2011). The U.S. dollar became the currency for Ecuador in 2001 (Lagomarsino 2006c).

The largest most diverse group of migrants left after the collapse of the Ecuadorian economy in 1998 (Bates 2007; Jokisch and Kyle 2008). At this time, women of all ages, couples, young men and women, Ecuadorians of all education levels and economic classes migrated for economic reasons. It was at this time that many women between the ages of 20 and 40 migrated alone to Spain or Italy, usually to find low-wage domestic work. This post-1998 migration was notable for the number of women in households who became the “migration pioneers” (Herrera 2005).

Neoliberal policies unfolded differently in Italy than in other countries in Europe such as Germany and France, in part because Italy has never had a robust social safety net (Zaslove 2003). In Italy, the scant resources set aside to serve a tiny percentage of the population had been reduced during the 1990s in anticipation of adopting the Euro in 1999, as EU countries were subject to tight controls on budget deficits as a condition of entering the Euro zone (Newell 2009:21). The then Berlusconi-led government maintained these cuts and did not reintroduce a “national minimum income scheme” which had served the poorest households with monthly payments in the 1970s,1980s, and into the early 1990s (Ferrera 2005; Newell 2009:22). Instead non-profit agencies, many linked to the Catholic Church, have served as the social safety net for low-income
households in Italy for a century (Menz 2006:410-413). Italy has a tradition of looking to the family, rather than the state, to provide support for its citizens in need; and this philosophy still guides policy today (Naldini and Saraceno 2008), even as the availability of family members to provide support is greatly diminished. The Italian government, as represented at the nation-state, the region, and the comune (city-county) levels, has been interested in maintaining the current situation in which immigrants perform family carework, and consequently the informal economy has flourished.

**Ecuadorians Move to Italy, Especially Genoa**

A review of the detailed migration data provided by Caritas (Caritas di Roma 2006; Caritas di Roma 2007; Caritas di Roma 2008; Caritas di Roma 2009) and of the scholarship on South American outmigration confirmed that Ecuadorian and Peruvian women began arriving in Genoa at higher rates in the late 1990s. There were several reasons why Ecuadorians were the largest group of immigrants in Genoa, and one of the largest groups of immigrants in Italy. These included: the changes in destination countries’ immigration laws that made it more difficult for Ecuadorians to enter other “desirable” countries such as the United States and Spain (Jokisch and Pribilsky 2002); the availability of jobs in Italy, primarily due to the aging population (Vento 2004); and, the perceived cultural similarities between Ecuadorian and Italian culture (Lagomarsino 2006b). Though there were historical transnational links between Italy and Ecuador, especially between Guayaquil and Genoa, the choice of migrants from Ecuador to live in Italy was viewed by economists and political scientists as migration done for entirely economic reasons (Di Sciullo, et al. 2009b; Jokisch and Pribilsky 2002; Padilla and Peixoto 2007). This was especially true for the huge numbers that left Ecuador in the 1990s (Ambrosini and Palmas 2007; Ramírez Gallegos and Ramírez 2005).

After the jobs were filled in certain work sectors in Spain, Ecuadorians turned toward Italy. Beyond the job opportunities in Italy, “the so-called great cultural, religious,
and linguistic proximity” (Lagomarsino and Torre 2007b:1) between the Ecuadorian and Italian cultures is another reason why Ecuadorians came to Italy, rather than another European country, such as Germany or Norway. The Mediterranean climate, and the related food and other cultural practices are quite different from life in the highlands of Ecuador, and are distinct from but more similar to coastal Ecuador. Specifically, Guayaquil and Genoa are both port cities, with large fishing and shipping industries and similar daily practices associated with urban working ports. One worker, Maria, said, “I am from near Guayaquil, and we have the most wonderful seafood, as here in Liguria. We also have huge ships, just like you see here. Ours have been full of bananas. These are shipping other goods.” The Italian and Spanish languages share many cognates and similar verb forms, and some pronunciation rules (Wilkinson 1973). Ecuador is a country that today is overwhelmingly Catholic, 89% (Cheney 2005c), as is Italy at 96% (Cheney 2005a)\(^25\). The specific use of the Catholic Church as a bridging institution is detailed in chapter 6.

It was very easy for immigrants to enter Italy, especially when compared to the more restrictive entry policies of the United States post 9/11. For example, up until 2003, Ecuadorian citizens could enter Italy with nothing but a passport, with no need for a visa (Ambrosini and Palmas 2007). Other researchers have noted that people from Bolivia, Ecuador, and Peru all reported that they entered easily as tourists, with permission to stay for 90 days, and then stayed after the tourist period had expired (Lagomarsino 2006b; Lagomarsino and Torre 2007b). During the period of my research, approximately $3,000 was required to enter with or without a visa, to cover costs related to the required roundtrip plane ticket, a hotel reservation, cash available to cover daily

\(^{25}\) The numbers published by Cheney are from Catholic Church records, which may include undocumented immigrants who regularly participate in Church activities.
expenses for the duration of the stay, and proof of insurance (Ministero degli Affari Esteri [Minister of Foreign Affairs] 2012).

**Genoa and Liguria in Italy, Italy in the EU, the Anthropology of the EU and Europe**

The context for this research included the importance of three institutional entities as mutually constitutive of one another: the nation-state of Italy, the more local regional and *comune* (local city or county) government agencies, and the European Union. My research on all three of these governmental institutions, especially regarding migrants and healthcare, led me to the conclusion that the nation-state will continue in its importance for these low-wage migrant careworkers and the lives and households which they influence. There were three reasons for this perspective: (1) the work of granting citizenship or even temporary legal migrant “guest worker” status was done by the nation-state; (2) the nation-state influenced local regulatory and service delivery practices via budgets, infrastructure, and federal legislation; and (3) the concept of Italy, the idea of being Italian, was embedded in the rhetoric that accompanied Italian politics at the nation-state level. The third reason drove the activities of anti-immigrant groups such as *Lega Nord*, the conservative Northern League in Italy, one akin to similar groups in Austria (Gingrich and Banks 2006).

Meanwhile, the European Union continued to rely on the nation-states to do the gate-keeping to determine who was a citizen or a legal immigrant worker. In Italy, it was very rare to find an immigrant from Ecuador who aspired to be an Italian citizen and by extension an EU citizen. Technically, the law allows for citizenship, but it was extremely difficult to attain and the most that immigrants in carework were hoping to gain is a legal work arrangement with a contract, and then, a permission to stay, also referred to as “being documented.” As Nic Craith stated so clearly “the emergence of EU citizenship might appear to herald the development of a post-national form of citizenship, but this is not the case as nationality of an EU member state is a precondition of EU citizenship”
The first step toward “EU citizenship” was for the country in which you were a citizen to be included in the EU, then for that country to clearly name you as one of their own citizens, allowing you to cross boundaries easily and enjoy other benefits of citizenship that were being negotiated by EU bureaucrats regarding such citizenship (Holmes 2000b; Shore 2000). So, in fact the work of naming and sorting citizens still fell to the nation-state, with the possibility for nation-state citizenship to open the door to broader citizenship opportunities and responsibilities tied to the European Union, rights and responsibilities which were not yet fully determined by the “Eurocrats.”

Interrelated to the strength of the nation-state of Italy was the influence of regional and comune agencies as important mediators for how services were delivered and laws regarding immigration were enforced (Ammendola, et al. 2005). Specifically, the regions of Italy used their authority to decide how to enforce laws regarding immigration control (detailed in chapter 7) and the delivery of healthcare services (discussed in chapter 2). Some migrants and native Genovese have noted that in a city like Genoa, the authorities avoided rounding up immigrants, looking for undocumented individuals to send back home, in part because the immigrants were seen as essential to care for the large number of home-dwelling elderly in the city. Interestingly, the local institutions also have had an interlocking relationship with the EU, the subject of an edited volume (Goddard, et al. 1994) in which anthropologists concluded that the European Union and local settings (such as regional governments) directly influenced one another. This was possible due to the malleability of the EU, which was viewed as “a project, its present obscure and its future open”(Ruane 1994:132). The funding of non-governmental organizations (NGOs), which served migrants in Genoa, with European Union and Ligurian (regional) government monies was one example on the ground of this relationship. In Summer 2008, I observed EU logos at Città Aperta (Open City), a NGO health clinic providing specialized outpatient care to nondocumented
immigrants. In my 2010 interview with the clinic director I confirmed that EU monies were used to fund the operation of the clinic and the Ligurian government paid for its promotional materials. In summary, both the EU and the regional governments influenced local *practices*, including healthcare resource availability, but the nation-state influenced the categorization of *people*. The nation-state exerted a large gate-keeping influence on the legality of migrant workers and their ability to remain in Italy.

The conceptual idea of Europe was of some importance in Genoa today, as was the process and entity of the European Union. The construction of the EU and the EU/European citizen has occupied anthropologists studying Europe. One important concept from this literature was the idea that for a citizen to exist there must be an outsider, an “other” as a counter identity (Silverstein 2005). The immigrant provided this identity. The economic vision for the EU (under discussion in 2012) was that it would be modeled on the economic policies of Germany. In the 2011 discussion of EU financial concerns, the recent aid to Italy’s economy and the “bailout” of Greece’s failing economy there was a subtext that some of the Mediterranean nation-states were “unruly” or “less than genuine” in their commitment to the EU, and perhaps were “polluting” the body-politic of the EU (Fraser 2011; Godoy 2011). What could be implied was that the citizens of the Mediterranean EU nation-states (Italy, Greece, Spain, Portugal) may not fit the ideal of European-ness (Borneman and Fowler 1997; Triandafyllidou and Ambrosini 2011). The “European” citizen was still an ideal, and may not have included individuals with dark skin, or Muslim Turks, even when in fact these were citizens or legal workers in EU nation-states (Salih 2003; Sniderman and Hagendoorn 2007; Zontini 2010).

The EU mattered in that it set the context in which the nation-states operate and named expectations that they must respond to when designing and legislating policy. The nation-state of Italy has attended to immigration regulation because the economic
and demographic shifts in the population in Italy increased the need for labor; but it also had to adhere to the expectations of the EU. First, the Union’s Schengen agreement prompted attention to immigration policy. By the year 1990, Italy had signed on to the Schengen and by 1997 all of the countries participating in the Schengen had to have laws consistent enough that the agreement enabling a single visa for all of the European Union countries could function (Europa: Summaries of EU Legislation 2012b). With this agreement individuals visiting from certain non-European countries could travel freely in Europe without the need for a visa for each individual country (Gelatt 2005). Second, Italy had not developed a long-term, comprehensive system for dealing with immigration, and this was required of all EU member nation-states, starting with the Tampere program, which laid out expectations of member-states for the years 1999-2004 (Europa: Summaries of EU Legislation 2012a).

Nation-states wielded power in that they decided who got documentation, a work permit, and this affected access to public resources and the ability of undocumented immigrants to circulate freely. The regions in Italy both represented the nation-state and exerted the most influence over state resources as they used INHS resources and policies to deliver healthcare at the local level. It was the decision-makers at the regional level who had the most power to influence access to healthcare for immigrant women laboring as careworkers in Genoa.

**Immigration Policy and Female Careworkers in Italy**

In the 1980s global-level restructuring in economic and labor markets affected all of Southern Europe (Padilla and Peixoto 2007), at a time when changing political leadership moved to a more neoliberal economic stance (Gill 1998). In most of the EU countries the public monies that had provided funds for a safety net for those most in need were severely cut, resulting in changes in the quality of life for many people (Gori and Pasini 2001; Lewis 1997). In Italy, this was not felt so severely, as the threshold for
an individual to qualify for services was already very high. In Genoa, the high need for care of elders and the lack of state-supported care initiatives led to a rapid increase of informal economic activity. Families directly hired low-wage immigrants, most often women, to care for elders in their homes.

Legal and political science scholars have criticized the Italian state for delaying the development of a comprehensive realistic policy on immigration (Di Stefano 2003; Triandafyllidou and Ambrosini 2011; Watts 1999). This delay had been attributed to a variety of factors, including the slowness of Italy to recognize it had become a destination country for immigrants. By the mid-1970s Italy was a destination of choice for migrants from many developing countries (Capacci, et al. 2005:65), including some Latin American countries, and received more immigrants than it sent Italians to other countries (Gabaccia 1998:74-75). According to the Italian government census (ISTAT 2011), the foreign resident population of Italy was made up of immigrants from all over the world. The following two tables (4.2. and 4.3.) include only information on documented immigrants.

Table 4.2. Foreign Resident Population of Italy, January 1, 2010

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Number</th>
<th>Percent of FRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romania</td>
<td>887,763</td>
<td>21.0%</td>
</tr>
<tr>
<td>Albania</td>
<td>466,684</td>
<td>11.0%</td>
</tr>
<tr>
<td>Morocco</td>
<td>431,529</td>
<td>10.2%</td>
</tr>
<tr>
<td>China</td>
<td>188,352</td>
<td>4.4%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>174,129</td>
<td>4.1%</td>
</tr>
<tr>
<td>Philippines</td>
<td>123,584</td>
<td>2.9%</td>
</tr>
<tr>
<td>Moldova</td>
<td>105,863</td>
<td>22.5%</td>
</tr>
<tr>
<td>India</td>
<td>105,608</td>
<td>2.5%</td>
</tr>
<tr>
<td>Poland</td>
<td>105,600</td>
<td>2.5%</td>
</tr>
<tr>
<td>Tunisia</td>
<td>103,678</td>
<td>2.4%</td>
</tr>
<tr>
<td>Peru</td>
<td>92,847</td>
<td>2.2%</td>
</tr>
<tr>
<td>Ecuador</td>
<td>87,747</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Source: ISTAT 2011
As seen in the above table, Ecuador was number twelve in the list of countries of origin for Italy. In Genoa, however, as seen in Table 4.3., the leading contributor to the foreign population was Ecuador.

Table 4.3. Foreign Resident Population of Genoa, January 1, 2010

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Number</th>
<th>Percent of FRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ecuador</td>
<td>15,553</td>
<td>33.9%</td>
</tr>
<tr>
<td>Albania</td>
<td>4,885</td>
<td>10.7%</td>
</tr>
<tr>
<td>Morocco</td>
<td>3,559</td>
<td>7.8%</td>
</tr>
<tr>
<td>Romania</td>
<td>3,316</td>
<td>7.2%</td>
</tr>
<tr>
<td>Peru</td>
<td>2,433</td>
<td>5.3%</td>
</tr>
<tr>
<td>China</td>
<td>1,420</td>
<td>3.1%</td>
</tr>
<tr>
<td>Senegal</td>
<td>1,200</td>
<td>2.6%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>1,113</td>
<td>2.4%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1,007</td>
<td>2.2%</td>
</tr>
<tr>
<td>Tunisia</td>
<td>734</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Source: ISTAT 2011

Although Ecuadorians make up only 2.1% of the foreign resident population of Italy, they constitute 33.9% of the foreign resident population of Genoa. The next section analyzes immigration laws in Italy, beginning with a macro-view of the policies and structures associated with immigration in Italy, focusing on immigrant female domestic workers in general and the situation of informal sector careworkers in particular.

Policy versus Practice

Because Italy is a member-state in the European Union, two sets of policies influenced the lives of migrant workers. EU policy statements were often viewed as guidelines for goal setting, with the Italian government, at various levels, enacting policy that may only sometimes be enforced. Several scholars have noted the gap that exists between the protections named in the EU and Italian policies and the way such protections are implemented in day-to-day situations (Campani 2009:12; Cholewinski 2004; Cholewinski 2005; Menz 2006; Trinci 2006). In Italy, for example, many families hired workers without following the laws regarding household employment, taxation of
wages, and social security for employees. The women working in these arrangements outside of the formal economy were citizens, documented migrants, and undocumented migrants. The terms “irregular,” “undocumented,” and “illegal” are used to refer to immigrants who are in Italy without documentation that gives them state permission to remain and work. I use the term “undocumented” or “without papers” to describe immigrants without a work permit. In Italy, “irregular” and “illegal” also are used to label employers who are operating outside of the law and regulations.

Italians who would not consider entering into “undeclared” or “off the books” transactions in their own place of employment embraced the use of the informal economy in order to hire care assistance in a private residence for the lowest possible price. For this discussion, the “informal economy” or “informal sector” refers to economic exchanges that take place outside of institutional regulation, based on employment activities that are also part of the formal regulated sector. Under this distinction, selling stolen property or drugs would not be considered part of the informal economy.

Employers violated multiple laws by hiring undocumented migrants and avoiding regulations that bring revenue to the regional or Italian government. Employers often would not enter into a legal contract with the workers hired to care for an adult in the private home (Lamura, et al. 2006); and they did this with little concern for the employment laws they were violating (Trinci 2006). This was due in part to how the non-public nature of the workplace is rendered invisible to authorities and the public gaze. It was also related to the general lack of enforcement of the rights and safety of legal careworkers in the home (Lyon 2006), the lack of human rights protections for undocumented immigrants, and the cultural history of laws not being enforced in Italy, for instance, as when taxes were not collected according to the law (Holmes

26 Italy is not a signatory to the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW). http://europe.ohchr.org/Documents/Publications/
2000a). Both the European Union and Italy have laws, guidelines, and systems to ensure that the home care industry has protections in place for both clients and workers (Capacci, et al. 2005; Laitner 2006a), but the enforcement of such laws is minimal to nonexistent (Favello 2011).

In Genoa, due to the high numbers of elders requiring care, there was a high level of motivation by a variety of stakeholders to keep the workforce of low-wage immigrants healthy and laboring in the homes of aging elders. As outlined in chapter 7 in greater detail, regional and comune officials wanted to maintain the status quo, which meant not enforcing the laws that limit public services to immigrants who fill low-wage jobs caring for elders. The effectiveness of informal networks to locate workers and the ease with which all parties entered into these non-official arrangements maintained the non-contract informal arrangement as the normal care arrangement, in Italy and many other countries (Bryceson and Vuorela 2002; Degiuli 2007a).

Differences between the ideal named in European Union documents, Italian law, and the opportunities and constraints within which individuals operated existed for three reasons (Cholewinski 2004; Cholewinski 2005). These were: (1) the need for a labor force in Italy at this time in its demographic history; (2) the way Italians view the informal economy in their communities; and (3) recent changes in the political and social climate of Italy at the regional and national level. The need for carework in Genoa has already been established; the role of the informal economy is discussed in the next section; and the outcome of political and social climate changes are discussed in chapter 7, which focuses on the relevant details of Italy’s anti-immigrant Security Package legislation.

Acceptance of the Informal Economy

The informal economy, broadly defined, has flourished in many forms, at various moments in history, over a long period of time in Italy (Reyneri 2003). Italian officials and everyday citizens were comfortable with the idea of unregulated or informal
economic activity, and generations of Italian citizens have engaged in such work arrangements. The unregulated economy has a strong foothold in many industrialized nations, in the forms of sub-contracting, small family enterprises, and locally developed services in response to locally developed needs (Andall 2003:39-41). The informal economy was necessary at various moments in the history of Europe. For example, during and following World War II, food and other essentials for everyday existence circulated largely via the informal economy. This was especially true in the cities of Italy (including Genoa) and France that sustained extensive infrastructure damage and subsequent loss of population (Killinger 2002:154-155).

In analyzing networks of migrants as they enter the informal economy, Trinci viewed the informal economy in Italy as affected by the taken-for-granted nature of such economic exchanges (2006:390-392). He pointed out that the informal sector activity for irregular migrants included “relationships of reciprocal convenience and complicity …just like the rest of the informal economy” (Trinci 2006:392). This was not unique to Italy, and was the situation in many countries in activities that take place in the domestic sphere (Boris and Parreñas 2010; Nare 2009), especially in direct payments to house cleaners, painters, gardeners, babysitters and careworkers. Estimates of economic activity that was unregulated can be difficult to determine, by the very nature of the category, but one source estimated the informal sector activity as encompassing 30% of the total national product of Italy (Campani 2009). This figure included the production and activity of Italian nationals, legal migrants, and illegal migrants, laboring “off the books.” As with many transnational processes involving actors with different levels of investment, both official and unofficial processes shaped the practices of individuals.

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27 Italy is not the lone example of a country with a history and present involvement in the informal sector. The informal economy has been present, but not acknowledged, in a variety of guises throughout history. For an excellent review of the development and recognition of the informal economy, see the chapter by Alejandro Portes and William Haller in the Handbook of Economic Sociology, (2005), Smelser and Swedberg, Eds. New York: Russell Sage Foundation.
Shifting Political and Social Views on Immigration

Identity linked to social movements and to the organizing principles of the supranational idea of the European Union was central to the shifting political landscape on immigration in Italy. Schneider and Schneider (2003) traced an important social anti-mafia movement in Sicily, by using history as part of their anthropological analysis to demonstrate that there was in fact not a deep-rooted historical linkage between mafia structures, power, and Sicilian histories (Schneider and Schneider 2003:22-48). Holmes (2000a) and Cole (1997) both examined the constructions of national identity that developed into social movements in response to la bomba (the bomb), the massive wave of migration into European countries such as Italy in the early 1990s. Holmes talked with working class anti-immigrant nationalists in Italy and Great Britain in his attempt to learn about the negotiations around the idea of a multicultural and integrated Europe (Holmes 2000a:8-9). As a modern state in the developing EU, Italy has experienced a rise in neo-national groups (Cole 1997; Gingrich 2006; Holmes 2000a), at approximately the same time as the boom in migration, i.e., since the 1990s. The most powerful political party in Italy associated with a nationalistic ideology is Lega Nord (the Northern League), which is analogous to the Le Pen political party in France or the Tea Party in the United States. The name Lega Nord builds on the traditional class and “racial” divide between the richer, more prosperous Northern half of Italy and citizens who are from Southern Italy and who have faced a great deal of discrimination and name-calling ever since the mid-nineteenth century when Italy’s south-to-north/rural-to-urban migrations began (Bull and Baudner 2004; Mangano 2010; Schneider 1998).

The recent social and political history of Italy has included changes in laws to benefit irregular migrants, though these were implemented erratically (Campani 2009; Suo 2007). Below is a table which summarizes the legislation on immigration to Italy, with explanations focused on how the law affects undocumented migrant careworkers.
Table 4.4. Summary of Italian Laws related to Immigrant Careworkers in Genoa

<table>
<thead>
<tr>
<th>Year</th>
<th>Law Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1931</td>
<td>Public Safety Laws (Royal Decree 733, by Mussolini)</td>
<td>Required registration of foreigners designed to authorize police tracking of the relatively small number of foreigners entering Italy—not fully repealed until 1989.</td>
</tr>
<tr>
<td>1979</td>
<td>Amnesty (Decree by Ministry of Labor)</td>
<td>Applied only to immigrants employed illegally as domestic workers and to those seeking domestic work.</td>
</tr>
<tr>
<td>1982</td>
<td>Amnesty (Decree by Ministry of Labor)</td>
<td>Regularization to immigrants who were working for an Italian in any sector and had entered Italy before December 31, 1981.</td>
</tr>
<tr>
<td>1986</td>
<td>Law no. 943, 30/12 (renewed via Act no. 81, 1988)</td>
<td>Regularization for undocumented immigrants living in Italy. First comprehensive Italian law on Immigration. Named sanctions to punish illegal employers. Named legal immigrant workers and their families to have the same rights as Italian workers. Family reunification laws for legal immigrant workers introduced for the first time. Named the labor market as the determining factor for immigration decisions.</td>
</tr>
<tr>
<td>1990</td>
<td>“Martelli Law” (Law no. 39, 28/2 (from Decree 30/12 of 1989))</td>
<td>Regularization for illegal immigrants already employed. Provided amnesty for employers (no back taxes or fines to be paid). Well-publicized Regularization resulted in 250,000 formerly non-documenteds receiving work permits. Quota concept introduced based on labor market needs. Immigrant with permit to stay can renew permit when certain conditions are met. Expanded the kinds of crimes that trigger deportation.</td>
</tr>
</tbody>
</table>
### Table 4.4. Summary of Italian Laws related to Immigrant Careworkers in Genoa, continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Law Description</th>
<th>Key Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998 “Immigration Act” Law no. 40, 6/4</td>
<td>No regularization plan.(^{28}) Created at this time to ensure inclusion in the Schengen open border agreement of the EU. Decentralized by moving responsibility for immigration controls and social services to the local (regional and comune level). Introduced permanent residency concept for immigrants, after five years of legal residency, application can be made. Imposed heavier fines on employers who hire and those who traffic illegal immigrant workers. Expanded quota policy.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{28}\) However, soon after this passed and the Schengen requirements were met, the Italian government set aside 38,000 work permits for those who were employed and had arrived in Italy prior to March 1998. 280,000 immigrants applied.
Table 4.4. Summary of Italian Laws related to Immigrant Careworkers in Genoa, continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Law Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>&quot;Immigration Act&quot; Law no. 40, 6/4</td>
<td>No regularization plan. Created at this time to ensure inclusion in the Schengen open border agreement of the EU. Decentralized by moving responsibility for immigration controls and social services to the local (regional and comune level). Introduced permanent residency concept for immigrants, after five years of legal residency, application can be made. Imposed heavier fines on employers who hire and those who traffic illegal immigrant workers. Expanded quota policy.</td>
</tr>
<tr>
<td>2002</td>
<td>&quot;Bossi-Fini Law&quot; Law no. 189, 30/7 (and September 2002 Amnesty Decree)</td>
<td>Regularization for those employed as domestic workers and home-helpers who have not received a deportation order. Amended the 1998 Immigration Act and introduced new clauses. Some of the most significant changes included: immigrant quotas, mandatory employer-immigrant contracts, stricter illegal immigration deportation practices, and new provincial immigration offices to help manage immigrant worker and family reunification cases.</td>
</tr>
<tr>
<td></td>
<td>Amnesty Decree associated with Bossi-Fini Law, September 2002</td>
<td>Italy's immigrant legalization program of 2003 had a surprising 705,000 approved applicants (the second-largest legalization ever in the world), of which 20 percent were Romanian, 15 percent Ukrainian, eight percent Albanian, and eight percent Moroccan.</td>
</tr>
</tbody>
</table>

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29 However, soon after this passed and the Schengen requirements were met, the Italian government set aside 38,000 work permits for those who were employed and had arrived in Italy prior to March 1998. 280,000 immigrants applied.
Table 4.4. Summary of Italian Laws related to Immigrant Careworkers in Genoa, continued

| 2009 Pacchetto Sicurezza (Security Package) | Prior to implementation of the Pacchetto, March 2009-September 2009, a “mini-regularization” program only for domestic helpers and careworkers was passed. Careworkers were specifically named as exempt from any quotas in the Pacchetto itself. The Pacchetto focused on three main goals: to govern regular migration, to promote integration and to discourage illegal immigration. |

Source: Elaboration of the author from material provided by various authors

As recently as 2007 a proposal was under consideration to change the requirements so any child born in Italy would be a citizen; currently children born to immigrants must wait until they reach the age of 18, and only then may they petition for Italian citizenship (Forti 2009). Since the 2007 proposal, the political shift has been to an anti-immigrant stance and a number of other proposals that would severely restrict immigrant minors have been introduced (Düvell 2011; Hackman 2009).

Ten to fifteen years ago, Italian government officials made the decisions leading to the sanitoria or regularization rule changes that took place five times between 1986 and 2003. To a degree the situation of in home immigrant careworkers being

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31 A move was made in the late 1990s to establish a plan for the integration of irregular migrants into Italian communities, culminating in Law 40 “the 1998 Immigration Act” and policy recommendations from the National Commission for Policies of Integration of Immigrants. With a shift in national political leadership in 2001, the law and recommendations regarding it were never fully implemented (Campani 2009:12). For example, one proposed recommendation would have increased funding for teaching the Italian language to both adults and children who have migrated to Italy (Campani 2009:9, 15-18). As of 2009, this had not been implemented.

32 Also notable was the Bossi-Fini Law of July 30, 2002, that distinguished “useful” labor migrants from undesirable refugees (Suo 2007). Bossi-Fini, in effect, established gatekeeping guidelines for immigrants, and standards to be used by Italian authorities making decisions about whom to deport. Italy has been reactive in much of its policy, but proactively negotiates bilateral labor contracts with “those countries that have proved particularly cooperative either in preventing outward migration and/or accepting deported nationals” (Menz 2006:212). These countries included Albania, Tunisia, Morocco, and Romania, but not any Latin American countries.
regularized was “institutionalized” in 2002, when almost 350,000 home careworkers were legalized by a change in the Italian law. As seen in the table above, approximately every five years there have been regularization or “amnesty” laws enacted to move undocumented migrants already working in Italy into documented status, and these sometimes allowed for limited family reunification. The pre-Security Package reality of ad hoc laws that allowed for regularization for undocumented workers and for family reunification factored into the decisions of some migrants who considered a stay in Italy or remaining in Italy as part of their overall “migration project”  

Documented workers are not headed toward Italian citizenship, but have work permits, documents that allow them to remain as workers in Italy.

Uncertain immigration policies, uneven enforcement, and a large permeable border made Italy an “easy” destination for some migrants (Chell-Robinson 2000). For instance, arriving on Italy’s southern coast by boat from Tunisia or Morocco was a common way to enter. In another example, since Romania joined the EU, its citizens can enter Italy unquestioned at the border and remain legally for six months. The recent rise in national pride by some Italians and active anti-immigrant behavior by others has influenced the political context for immigration in Italy.

The Security Package

Lega Nord formed an alliance with Prime Minister Berlusconi’s party and administration, which resulted in the 2008 passage of the controversial, massive, and diverse Pacchetto Sicurezza (Security Package), referred to by the term Pacchetto for the remainder of this document. This set of laws included many initiatives grouped

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33 This term describes the overall plan that some migrants named in Andall’s research. For instance, one father’s project was to establish an economic base in a country with “easy” entry, such as Italy. He planned to then gain EU citizenship status, so that he could educate his children in the United Kingdom.
together in the name of “security” (DiPascale 2010). For instance, it included provisions that made it easier for crimes of human trafficking to be addressed in and out of the European Union and in cooperation with more governments and agencies in the world (Marchetto 2009; Merlino 2009). There were also provisions to deal exclusively with refugees and family reunification for these immigrant populations, a system that, according both to non-profit agency workers with whom I spoke and to legal scholars (Maccanico 2009; Margiotta 2010) had long been in need of revision. However, this project examined laws in the Pacchetto that potentially affected careworkers, their quality of life, and, by extension, their health status. These included the parts that criminalize being an undocumented immigrant, that limit access to public services for undocumented immigrants, and that apply harsher consequences to those who rent housing to undocumented immigrants (Camera e Senato d'Italia 2009). These portions of the Pacchetto are discussed in detail in chapter 6. Overall, though, legal scholars agreed that the wide variety of proposed laws and political maneuverings seemed a long overdue overreaction to the lack of a cohesive immigration policy for Italy (Suo 2007; Totah 2003).

Beyond the political landscape, the rise in nationalism and the acceptance of the informal economy contributed to a climate that led to the passage of the Pacchetto, which was widely denounced by international human rights groups, such as Doctors Without Borders (Merlino 2009:13). The informal economy assumed that even if immigrants were kept out of full participation in civic and economic life, an underclass of immigrant worker could be maintained, and the work would still get done. Under this viewpoint, an Ecuadorian woman, a very “typical” immigrant profile in Genoa, was considered to be: a) only fit for cleaning or caring work in the home; b) not deserving of protections such as social security under the law; and/or c) the fortunate recipient of a job. Thus, it was easier to view her (the Ecuadorian woman) as “less than” an Italian
citizen, “less than” a fully-actualized human being, and someone who was not appropriate to be a fully participating community member (Ammendola, et al. 2005; Lyon and Glucksmann 2008). This thought process was revealed in data collected in all types of interviews when participants reflected on how employers and other Italian citizens in Genoa viewed immigrants, and it was apparent from my own observations as a day to day resident of Genoa.

Summary

Italy’s history of sending migrants abroad created transnational ties with several South American countries. Specific historical ties developed between the coastal city of Guayaquil, Ecuador and Italy’s port city of Genoa, which in 2008 had an immigrant population dominated by immigrants from Guayaquil. The reasons South Americans migrated to Genoa in such significant numbers included: the collapse of the Ecuadorian economy and the problems with the economy in Peru; the ease with which people from South American countries could enter Italy and overstay their visa; the strong possibility of employment in Genoa due to the large aging population; the track record of regularization programs for undocumented immigrants in Italy; and the difficulty of immigrating to the U.S. or Spain after changes in the entry laws of each of these attractive destination countries.

As migration to Italy increased, significant shifts have occurred in immigration laws and regularization programs, especially as they influenced the lives of female immigrants from non-EU countries, who dominated the domestic service work sector. Also notable was how the acceptance of the informal economy has combined with formal policy to create an environment in which the de facto policy for care of elders was that an immigrant (documented or undocumented) labored in the home of the elder supervised by a family member or the elder him- or herself. The debate within the anthropology of Europe and the EU regarding the importance of the nation-state in the
emerging concept of the European Union was used here to investigate the interplay between the powers of local (seen here in the region of Liguria and the \textit{comune} of Genoa), national (the Italian state) and supra-national (the European Union) institutions. These interstitial relationships, resistances, and collaborations have led to the rise of Italian national sentiment, which set the stage for the anti-immigrant \textit{Pacchetto} (Security Package).
Chapter Five: Working Conditions and Carework

The first step towards understanding the relationship between the employment of the immigrant women and their own health and healthcare strategies was to learn about their daily work life. It was important to examine job responsibilities, the marketplace of this work sector, and the environment for carework and issues related to the quasi-public/quasi-private space of the home-workplace. Before providing data on the conditions of work for the careworkers interviewed, I describe the context of this work in Genoa by addressing the relationship between careworkers and labor unions in Italy.

The Relationship between Labor Unions and Careworkers in Italy

Labor unions are important to Italian politics and policy-making. These institutions influence the lives of careworkers in several ways. In 1974 they engaged in national collective bargaining to secure rights of domestic workers and to create regulations for conditions of domestic work, and ever since that time have been involved in crafting policy as it affects home-based workers (Barkan 1984). Since the 1940s when domestic workers were typically Southern Italian women, labor unions have been involved in providing cultural and educational training; today this continues with language and job training programs aimed at immigrant careworkers (Angelini and Casciola 2005). Labor unions also provide employment contract information to both household employers and home-based workers and sometimes help to connect employers with workers, often in conjunction with municipal and regional organizations or non-profits such as Caritas (Di Santo and Ceruzzi 2010:21-22).

The two most prominent labor unions for domestic workers in Italy are the Italian General Confederation of Labour (La Confederazi Generale Italiana del Lavoro, CGIL) and the Italian Christian Workers’ Association (Associazioni Cristiane dei Lavoratori Italiani, ACLI). CGIL is an Italian trade union confederation with about 5 million
subscribers, making it the largest labor union in Italy, representing workers in many sectors. It was established with the Pact of Rome, in 1944, replacing the disbanded General Confederation of Labour, which had originated in 1906 (2012) which is generally aligned with the communist political party (CGIL 2011; Maraviglia 1996).

ACLI-COLF is the domestic labor sector-focused part of the larger labor union ACLI34 (ACLI-COLF 1979; Di Nicola 1994) and has 6,000 subscribers (Patronato Acli 2007). COLF is an abbreviation for collaboratrice familiar (family collaborator, thus the acronym ACLI-COLF); the women I interviewed who have work contracts to provide care to home-based elders have the term colf as the occupation category in their paperwork, as the term was defined in Italian law in 1958 (ACLI-COLF 1979) to include: “babysitters, waiters, cooks, caretakers, governesses, gardeners, tutors, teachers, nannies, butlers, ladies in waiting, etc., who carry out their activities in… an employer’s home” (World News 2011). In general conversation today, the word colf refers to a person who does cleaning in a private home; assistente anziana (elderly person’s assistant) refers to the person who cares for an elder in the elder’s home.35 Both colf and assistente are used interchangeably in Genoa by immigrant workers, labor union representatives, and employers, but without a distinct wage difference.

Generally, immigrant women working as low-wage careworkers are not official dues-paying members of a labor union. However, in Genoa and throughout Italy, labor

34 ACLI is an important organization for “workers aiming to promote Christian values” participating in a variety of work sectors that has existed since the end of the second World War (Maraviglia, 1996).
35 The more pejorative term badante was often used by the workers themselves, and by Italians of many walks of life. It was in the law adopted by the center-right government, law n. 189 art. 33, July 30, 2002 to define “an immigrant person from a non-EEC country, who offers assistance to a person whose self-sufficiency is limited by pathologies or handicaps.” As Degiuli (2007) pointed out “the term has been contested by many because it was originally used to define, in the 1900s, people who would take care of animals.” This of course is demeaning to both the person doing the caring and the person cared for. Italian scholars and many labor union workers tend to avoid this word, which has negative connotations analogous to the term slave as in saying, “I hired a new slave to work in my home.” Badante has been compared to the use of the “n” word in the United States, but is not understood to be as degrading and inflammatory in degree. Assistente, in Italian, or careworker, in English, are the terms I, and many other scholars, use.
unions have a strong presence and an important history (Lyon 2006; Watts 1999:23-25). Almost half of the worker participants in this project have used the services of a *sportello* (information service counter), which may be operated by an “immigrant membership organization” aligned with a labor union. This model of parallel organizations as a stepping stone to union membership is unique to Italy, and these immigrant membership organizations are open to assisting and enrolling illegal and unemployed immigrants (Watts 1999:14). Italian household employers and immigrant careworkers (with or without documents) are likely to seek advice from a local union office or *sportello* when seeking to learn how to make an undocumented immigrant worker “regular,” when there is a change to be made in the work contract, and/or when the worker is learning how to legally bring a family member to Italy (Bettio, et al. 2006; Pojmann 2006:41-43).

Since 1986, a work contract is required for anyone from another country to remain in Italy *con permesso* (with permission, i.e., legal documents for an immigrant working in Italy) (Chell-Robinson 2000:106-108). The work contract must be initiated and filed by the employer at the local government office. The major labor unions provide community service offices to aid employers and employees in this process. The union offices, throughout Genoa, are busy every time there is an amnesty or regularization program, as many illegal household employers scramble to get a legal work contract for the immigrant careworker in the family elder’s home. The steps involved in obtaining a *permesso* are also discussed below.

One reason for such a strong pro-immigrant stance in a country where the national attitude leans occasionally toward being anti-immigrant is that gaining rights for immigrants could keep the informal economy from growing even larger in Italy, and could keep wages higher for all workers, as immigrants being paid outside of the formal wage structure would not undercut the standard wages for union member workers (Bedani 1995; Watts 1999; Wever 1998:5-6). Some labor unions discuss international
sisterhood/brotherhood and invoke the ideal of workers of the world, invoking communist traditions (Giammanco 1989; Pojmann 2008; Watts 1999:4, 14-15). Others emphasize the Catholic/Christian value of respect for human rights when lobbying at the national parliament for workers’ rights and organizing protests in response to the Security Package of laws enacted in 2009 (Calandri 2009). With every change in the law regarding immigration and/or domestic labor such as the amnesties that have brought many illegal employment arrangements into compliance by making the workers “documented,” the unions have been where Italian employers go for advice (Watts 1999:14-15, 125-126).

Careworkers Describe their Work

The remainder of this chapter builds directly on the data from the careworker interviews to provide a work situation context for the data chapters which follow. I did not conduct any formal interviews with employers or clients for this research; rather, I chose to focus on the women workers and begin with their insights.36 All fifty-five interviews with careworkers were conducted by me in Italian.37 For this project, I chose to analyze the data from fifty of these interviews; all were with women from South American countries who had worked in Italy in domestic work for at least four years. I was

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36 As described in chapter 2, regarding methods, later interviews were conducted with those who served immigrants (servers) and the decision makers in various systems that influenced the lives of immigrant women (administrators). I met many of the women who eventually consented to interviews during my participation at Catholic Spanish-language church services, careworker classes, and other immigrant events which took place in and out of the church setting. I did not interview any women in their workplace or within sight of their employer. The interviews most often occurred in cafés, parks, and plazas as I was interested in interviewing the women in settings both comfortable and convenient for them. In some cases the women preferred to be interviewed locations near group activities, such as: the choir room at Don Bosco following the Spanish-language service, the confirmation room near the carework class at the immigrant center, in the kitchen following the big lunch associated with cleaning the immigrant center and sanctuary every Saturday. Nine of the fifty-five interviews were conducted in the careworker’s home; these women had live-out positions or were currently unemployed.

37 In fifteen of the fifty interviews, I made notes during the interview and immediately following, as the tape recorder was not used. Thirty-five of the fifty interviews were recorded, then translated and transcribed by me.
interested in women who had a work history in Italy, who spoke Italian, and had spent enough time in country to experience a variety of health conditions.

When prompted to describe a typical work day, the careworker being interviewed usually focused on one or two aspects of the daily routine of the job and, unless prompted, rarely named all of the activities of the day. During every individual careworker interview, the woman was quick to point out how the capability of the elder client made a substantial difference in what exactly was needed from the careworker. An example of a client with high need is that of a woman who could only move her head and one arm, and spent most of her time in bed, where most of her care was provided by the worker. An example of the other extreme is the careworker who provided companionship to an 80 year old woman, did not provide any help with personal care such as bathing, dressing or toileting, but did aid the elder with daily shopping, cleaned the house, and occasionally helped with cooking. Most often the level of need of the client was somewhere in between these two extremes, and the exact list of tasks performed could change from day to day, and over time. The workers acknowledged that they were expected to adjust to do whatever was needed to keep the elder functioning to maximum capacity, and that what the client was capable of would likely change. Maintaining elders in their homes by assisting with everyday life was a certain type of health maintenance, one critical in a city like Genoa, with such a large percentage of the population over 70 years of age (20.49% as of January 2010) (ISTAT 2012b), a group that often required some sort of assistance. To reveal the range of tasks involved in a typical day of in-home care (Colombo 2007), I summarize the daily and weekly job responsibilities, as they emerged in my analysis of the interviews conducted.
with 50 individual careworkers, 7 women in a group interview, 5 women in another group interview, and 9 women in a focus group.38

**Daily and Weekly Job Responsibilities**

The workers who cared for elders in their homes in Genoa were almost always immigrants and female (Lamura, et al. 2008). The typical work week for a full-time careworker who did not live in was 8-9 hours per day, Monday through Friday, and 6 hours on Saturday. By law, these workers were to work only 8 hours per workday, and have one hour off every afternoon, plus time for meals and coffee breaks. When the workers lived in, by law they were expected to work a maximum of 10 hours per day, Monday through Friday and 6 hours on Saturday, sleeping in the home of the elder client Monday through Friday nights. The live-in worker was allowed, by law, two hours off every workday, and one afternoon and evening off during each week, typically one of the days Monday through Friday (Gallotti 2009:19-22). As seen in Table 5.1. below I have categorized the tasks of carework from my research data into three categories: physical, relational, and decision-making.

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38 The difference between a group interview and a focus group interview is the intention of the group (Bernard 2006: 232-239). The focus group convenes to discuss a more particular topic. In the group interviews, one which occurred spontaneously after a class, the participants knew that my research focused on carework and their health, in a general way. The people who arrived for the focus group had been invited by a careworker community leader and/or me to discuss their situation in Italy as immigrants, workers, and patients in the healthcare system in light of the Security Package. All of these research participants (N=67) had held at least two positions caring for elders in the private home; all except two women who participated in the groups had worked in Italy for four years or more.
Table 5.1. Categories of Tasks Based on Careworker-Participant Interviews

<table>
<thead>
<tr>
<th>PHYSICAL TASKS</th>
<th>RELATIONAL TASKS</th>
<th>DECISION-MAKING TASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with ADLs</td>
<td>Persuading</td>
<td>Anticipating needs</td>
</tr>
<tr>
<td>Lifting</td>
<td>Listening</td>
<td>Monitoring general health and illness episodes,</td>
</tr>
<tr>
<td>Carrying</td>
<td>Comforting</td>
<td>Choosing foods, herbs, pharmaceuticals,</td>
</tr>
<tr>
<td>Cleaning</td>
<td>Relaying information to family</td>
<td>Deciding when to get assistance to contact doctor, family, ambulance for ER,</td>
</tr>
<tr>
<td>Diapering</td>
<td>Reminding</td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td>Communicating with physician, grocer, pharmacist, others</td>
<td></td>
</tr>
</tbody>
</table>

Physical Tasks of Carework

The main goal of having a caregiver (often untrained, unlicensed, and not linked to any particular medical training) was to assist with Activities of Daily Living (ADLs). This assistance often involved physical effort. ADL is a concept that health scholars developed as they considered the continuum of care and services for individuals recovering from acute health events, those living with chronic illness, and people with temporary or permanent disabilities. ADL has moved from being a concept to being operationalized as an evaluative tool. After first appearing in the literature in 1935 in a theoretical article by Sheldon in the Journal of Health and Physical Education (Feinstein, et al. 1986), it was first used for practical purposes in a checklist by the physiotherapist Edith Buchwald in 1949 (Law 1993). Today several ADL tools are used by occupational therapists, gerontologists, managed care companies, insurance companies, physical therapists, nurses, doctors, and other healthcare workers. For instance, most long term care insurance policies in the United States require a professional’s certification that the
person needs assistance with a certain number of basic ADLs before the insurance can be used (Fricke 2012).

Assistance with shopping, meal preparation, toileting or diapering, bathing, and walking are all types of ADLs that support physical wellness and require physical effort and strength of the careworker.\textsuperscript{39} Having a careworker present to assist with these basic activities is key to accident prevention (Li 2006), which avoids acute health episodes (Cesaroni, et al. 2009; Rozzini, et al. 2003). Many of the tasks done as part of carework required some physical effort. Here I describe the tasks; in a later chapter I address the consequences of the physicality of the work for careworkers in Genoa.

The physical tasks of carework were emphasized by many women I spoke with for this research. The following is a typical description, emphasizing that physical effort was involved in giving care. Patrizia cared for a 79 year old man who broke his hip, then suffered a stroke while rehabilitating, leaving him unable to support his own weight. Her remark is typical of statements made by careworkers to me in interviews regarding the physical exertion required in the job,

\textit{“Che brutto! (It is ugly!) the amount of strain on my body. Everything takes me moving his body. Out of bed to the chair, from the chair to the toilet, from the toilet to the wheelchair again, out to breakfast, then to the big chair where he sits for most of the day. Back to the toilet again before lunch, and on and on.”}

This woman was describing all of the transfers that take place during her ten hour workday. Another physical task was manipulating a bed-confined client’s body to deliver care. In interviews I learned of the physical effort involved in moving the client’s body into position to: empty catheters, change diapers, move and remove bedpans, administer enemas, bathe, massage, adjust pillows so the patient could sit up to eat, and reposition the patient to prevent bedsores. At least one-third of the careworkers

\textsuperscript{39} See Katz (1983) for the ADL scale and Lawton and Brody (1969) for a complete list of Basic ADLs and Instrumental ADLs, the two lists which are the basis for most of the evaluation tools currently in use (Fricke 2012).
mentioned assistive devices when asked about the physical effort involved in the job.

Lupe said,

Listen, if they make a special mechanical machine to help move a person that should tell people that this is a job that takes lots of strength and movement. If you get a fat person for your nonno\textsuperscript{40}, that is really hard. Some of these places are so small and with a bad arrangement for moving a person into a wheelchair, especially in some bathrooms.

In follow-up interviews with careworkers, and with servers I learned that such devices were generally available, and that NGOs and government agencies were working to make certain that caregivers helped educate the families of disabled elders about the possibility of getting assistive devices at low or no cost. Some workers had heard about them from friends, or learned about them at a training session, others had already used them on the job.

Relational Tasks: Meeting the Emotional Needs of Elderly Clients

In Italy, due to the demographic described earlier in this document, there are many people over 70 who live alone, or with one other person, most often a spouse. The ratio of elders to younger family members is especially off balance in Genoa, so that many elders are living solo in a household. Research has shown that elders who live alone suffer more often from depression (Almeida-Filho, et al. 2004), and are at higher risk for other health problems (Saiani, et al. 2008). The presence of another person in the house can improve day-to-day quality of the emotional life of the elder. Many careworkers, when asked about their tasks, made remarks categorized in a theme I titled “the need to be emotionally generous.” The relational work of the careworker, i.e., the communication done to establish and maintain an emotional relationship with the client, can take up a great deal of the energy expended during a work day (Parks 2003; Stacey

\textsuperscript{40} Many careworkers referred to their elderly client as their nonna (grandma) or nonno (grandpa) or used the Spanish language abuelita or abuelito. Another often-used term was the Italian vecchiata mia (feminine) or vecchiato mio (masculine) another term of affection, best translated as “my little old one.”
The relational work tasks described by careworkers included: providing companionship, listening, having conversations, telling stories, persuading the elderly to tell stories, playing cards, singing, letting the client help with the careworker’s Italian language learning, praying together, and providing comfort via voice, gesture, and touch.

The important much-discussed idea of emotional labor (described in more detail in chapter 1) is distinct from the relational tasks that meet emotional needs, although in some situations these overlap. The examples in this section highlight the relational tasks performed by the careworker. None of the ADLs named by researchers point to the emotional or mental well-being of elders, but in fact careworkers complete relational tasks with their clients throughout the day, sometimes in service of meeting the basic needs of the elder. One day a client may need persuasion to eat adequately or to continue a regime of medication, another time the same person may need a calming conversation in order to relax enough to drift off to sleep; here the interaction with the careworker directly influences the well-being of the elder (Lyons, et al. 2007; Saiani, et al. 2008). During some of these interchanges, the careworker is managing her own emotional display, i.e., performing emotional labor, to meet the expectations of the job.

When asked about the specifics of her careworker job Aracely started with the relational work done to meet the emotional needs of the client:

I am telling you, you are being paid to be caring, to show loving. And some of these people can no longer understand anything except love and feeling, their brain may not work anymore in the same way. But they can feel…and my job is to make them feel as happy as possible.

Here, she is specifically describing a client with severe dementia who may miss some environmental and communication cues, but does respond to the relational cues that

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41 Mignon Duffy (2005) uses the term relational job to describe work done directly with a person. It is distinguished from nonrelational jobs which are done on or with objects. Changing an adult diaper is a relational task; doing laundry is a nonrelational job. For more examples of scholars studying work tasks and distinguishing relational from nonrelational see Chang (2000), Hondagneu-Sotelo (2001), and Stacey (2011).
communicate feeling. Aracely’s words point out the high level of communication skill and personal energy required to do carework well.

An analysis of home-based low-wage careworkers in Genoa benefits from Claire Stacey’s (Stacey 2011) extension of Hochschild’s concept of emotional labor, an important concept from labor studies discussed with more detail in chapter 2 (Hochschild 1983). For many of my research participants the knowledge that their caring is being done to help an elderly person “to live out their last years or months” (according to Patrizia) is something they have learned to live with. Some viewed this as a difficult side effect of being in a work situation in which they start to “really care,” i.e., to develop a positive emotional connection with their client. This directly supports Stacey’s findings, described in chapter 1, that when the real feelings of the careworker match the performed emotions (deep acting), there was increased stress when the client suffered and/or died in the careworker’s presence (Stacey 2011:70-72). For others, while they may have experienced stress, they also felt a certain job satisfaction. For instance, Nury reflected on what was, in her words, “a spiritual experience”:

I mean it is a privilege to help someone die. I am Catholic and so was my first client, a sweet old man, I told his kids too, I was happy to be at his side when he died. This is not the job I trained for in university (accountant), but it is a wonderful experience to help someone through their last days.

In my analysis, Nury may have engaged in surface acting when she started the carework position, but had developed real affection for her client, and her deep acting influenced the ways in which she experienced the death of her client.

A particular emotion, care, was expressed (or acted out) as part of the work and was involved in this market exchange. This has been found in research on other caring professions (Duffy 2005b), e.g., nursing (Reverby 1990; Tucker, et al. 2012), occupational therapy (Denny, et al. 2011), clinical social work (Glomb, et al. 2004). Another worker, Marjorie, directly named the paid job of caring:
Look, her (the elder client’s) family is busy and she is proud of them but they live away, in Torino, in France, one in the United States sometimes for work. They love her but cannot be here with her in Genoa, so they pay me to love her in person (laughs)...it is the same of me, my mother is starting to need help and thanks to God in heaven my sister is there but she (my sister) also cares for my two children, so I pay for a person to help clean and cook. I love my family in Guayaquil but cannot be there to love them in person all the time.

In this statement, the multiple, interlocking markets for carework are visible. In Genoa Marjorie was paid to care for a woman who needs companionship more than physical care (revealed in the follow up interview). Marjorie, based in Italy, employs a housecleaner in Guayaquil to do some of the labor to maintain the home so that her sister can coordinate care for both her children and their mother, ostensibly helping the sister in Ecuador have energy for the emotional work of caring for others. The international reproductive labor “chain of care” (Parreñas 2006) described in chapter 3 is apparent in this example.

Following up on the well-established idea that carework leads to mental exhaustion, especially in caring for a person with dementia (Coon, et al. 2003; McConaghy and Caltabiano 2005; Romero-Moreno, et al. 2011), I asked careworkers how they managed their own energy and maintained a level of mental balance while still attending to the emotions of another person in the private home. This prompt led many women to discuss the need to give emotionally, and how, for some of them it was a role they could fill once they figured out what worked with their client. As Anabel reported,

Listen, I found out that routine is most important, but she needed to get out of the house, she was in gamba42(with it) and I think a little depressed. I checked with her son and her doctor – “Can she go out of the house if I help her walk? Is there a reason she sits at home? Who are her friends?” Her son was delighted, her doctor said, “No problem.” I called her friend, she came by, we had a coffee at home, and then her friend said, “Now next time you come to my house.” We went shopping for the first time, together, and another woman, her friend, was so happy to see her (my nonna) that she had tears in her eyes.

42 This term was used in many interviews and careworker trainings and means literally “with legs,” referring to an elderly client who is functional. One equivalent meaning in English is “with it.”
This worker saw her own ability to read a situation and respond with compassion as part
of the job she excelled at performing. She also pointed out this was a strategy to aid her
own quality of life in the job. “Listen, in that job, I worked fissa (live-in) and I did not want
to live with a depressed person, so I needed to reach out and help. Not just for her
(laughs), for me!”

Decision-Making Tasks

The third characteristic found in my data was one I labeled “tasks of
responsibility,” but later changed to represent the importance of decisions to carry out
this work. This is the set of work tasks perhaps most often not valorized or undervalued
by clients and employers. In fact carework as described in interviews to me required a
set of skills that often involved making decisions. The situations requiring these skills, as
I noted from my data, include but are not limited to: monitoring both acute and chronic
illness episodes, remaining alert for changes in general health, deciding when to involve
other resources (pharmacist, family members, health professionals, emergency room),
choosing foods, herbs, and pharmaceuticals. I have ample ethnographic examples. In
one, Nury noted during our interview, “You see this ‘take as needed’ – on the pill bottle. I
have to figure out ‘is this needed?’ And when she (the client) gets constipated from this
pill, who has to do the enemas to help her? – me!” Anticipating the needs of their
clients was one way that careworkers used their abilities to analyze situations, learn from
recent history, and consider resources available when making decisions for the care of
the client.

Iris recalled a situation in which she found help in the pharmacist when she did
not know what else to do.

I had called the son, he lives in Berlin, in Germany, you know? And he
said “my father exaggerates, his headache is not that bad, he has never
had migraines. Just wait.” But I felt so terrible for my nonno, who was not
a complainer and I could tell by his eyes that he was still in pain, but he
(the elder) refused to call his doctor and would not let me! So I was shopping and stopped by the pharmacist and told him the situation. He said, “listen I have some ideas, I know your client, I will call him and then call his doctor.” So, thank God! the pharmacist made all of the calls and we went to the doctor who prescribed something and in the meantime I got a few (over-the-counter) drugs to relieve the suffering for my nonno.

This situation is an example of the careworker acting as a proxy for the client and perhaps the client’s family, who may have acted more aggressively on the client’s behalf had they seen his demeanor in person. Iris assessed and described symptoms to report to the pharmacist. The careworker here also acted as an advocate on behalf of her elderly client, in that she enlisted the help of an ally with more power in the health care seeking situation (the pharmacist) to speak in expert terms to the doctor and to apply pressure on the elder. Iris’ moment-to-moment decisions made a positive difference for her client. A failure to exercise decision-making skills could have created an acute health event or unneeded discomfort for her client.

Physicians, nurses and clinic administrators confirmed the decision-making skills of careworkers in their discussions regarding their strong preference that careworkers accompany elders to appointments. One geriatric physician noted, “Even if the adult son or daughter is there with my patient, I want the careworker, because she knows what is really going on and reads the situation closely.” The medical professionals interviewed also noted that for elderly patients with communication problems or cognitive issues it was necessary that someone accompany them to appointments, and one nurse said,

Why not the assistant? That is what she is being paid to do. And the women doing this work (careworkers) may have a job where they do not have enough to occupy their mind and time, so this is something that is an interesting challenge, and part of their responsibility.

This nurse administered a program to educate INHS users and practitioners about safe pharmaceutical use.
The Carework Marketplace

The eldercare labor market was saturated during the time I was conducting fieldwork in Genoa. Also, fewer jobs were available as the global financial crisis entered the Euro zone. In one example, a lower-middle class Italian family had hired immigrant women to clean or care in their elder’s home since 2002; in 2010 a newly unemployed family member was providing care to the elder.43 This labor sector is inherently precarious for workers due to the likelihood that an elderly client’s health status and subsequent care needs may change quickly. The immigrant’s status, documented or undocumented, also contributes to the precariousness of this work sector. Thus, while this section discusses the terms of work covered in the collective bargaining agreement (Gallotti 2009:16-20), it is important to emphasize that a variety of working conditions exist, especially for those who are undocumented.

Legal/illegal work arrangements

The most an immigrant can hope to gain is a permesso di soggiorno (permit to stay), which can only be given to persons over 18 years of age who have documentation of a work contract and proof of a legal residence. After the work contract is in hand, the immigrant worker then gets the permesso packet at the post office, completes the forms in the packet, and gathers other materials which must accompany the application. In addition to the work contract, the worker submits passport, proof of residence, and proof of payment of application tax (total cost of permesso application in 2010 was 72.12 Euro, 95.92 USD). Then the employer and the employee wait, generally for three to six months. During this time, the proof of application offers protection to both the undocumented worker and the illegal employer (Minister of the Interior: Italy 2012).

43 Everyone I talked with told me it would have been difficult to get project interviews in 2001 or 2002 as every immigrant from South America was working at that time, often in two homes, as the need was so great.
Though I did not include questions about documentation status in my interviews with careworkers, it was often volunteered by the interviewee. Most of the women I interviewed had worked in illegal arrangements and had become documented due to the regularization schemes provided in the past decade, detailed in chapter 4. The modest amount of data from this study and the large set of longitudinal data on undocumented immigrants based in Milan (Devillanova and Frattini 2006) has revealed that the longer an undocumented immigrant did “off-the-books” carework in Italy, the more likely she was to become documented. Being “with documents” or “documented” means that the worker has acquired a permesso. Undocumented immigrants from South American countries generally have been women who arrived on a tourist visa and overstayed the visa to work and send remittances to their families who have remained in their country of origin (Vento 2004). Generally, there were references from friends or family connections from “back home” that provide information about how and where to begin. Unlike some migration streams, transnational coyotes (Spanish for immigration brokers) are not involved in the transportation and migration of women to Genoa from South America to find careworker jobs (Lagomarsino and Torre 2007a)44.

Documented immigrants have the permesso, and this status lasts as long as the work contract is in effect, plus six months following the final date on the contract. For immigrants who arrive alone, without refugee status or for a family reunification situation, the most stable form of legal documented status is to have an “indefinite” work contract. The influence of documentation status on access to healthcare resources since the Security Package laws is discussed in detail in chapters 7 and 8.

The work of caring for an elder at home is part of the general category of “domestic work” in Italy. The work agreement between the employer (often the adult

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44 I met only one woman who signed a contract or had a secure job offer before departing South America. In this case she signed a one year contract to work as an assistant for an elderly man; the cousin coordinating the elderly man’s care advertised with an agency in Guayaquil (Ecuador).
daughter or other relative of the elder or the elder him- or herself) is sometimes “off the books” and therefore illegal, in that the employer is not making the required payments to the government for unemployment insurance, government pension (equivalent to social security in the U.S.), and healthcare for the employee. The illegal work arrangement also means that the worker does not have the opportunity to ask that her rights, such as daily/weekly breaks, equitable pay, and paid holiday and vacations (all described below) be respected. Many of the women I interviewed had started their life in Italy working in an illegal arrangement. A typical next step was that they obtained their permesso during one of the regularization programs created by the Italian government to legalize the many domestic workers already laboring in (illegal) arrangements in homes in Italy. Sometimes the permesso was obtained with their original employer, or as they started their second job in the country.

The legal work arrangement most desired is an “indefinite” work contract which makes the immigrant worker “legal” as long as she is employed. Of the 50 workers interviewed, 40 women had obtained this “indefinite” status. Some with “indefinite” work permits were concerned for the first time during their life in Italy that they may not be able to find a new job so that they could maintain their documented status. As noted above, immigrants “with papers” have six months after one job ends to find another before their status changes. The legal arrangement with the employer requires that the contributions for the worker are paid to the Italian government, making this arrangement more expensive for the household employing the eldercare worker. During some of the amnesty periods, see in table 4.2., the Italian government did not require employers to pay fines or taxes that should have been paid in the past, an arrangement designed to

45 If the illegal arrangement was discovered, the employer was required to pay the government the described fees for the duration of the work arrangement. If the worker was documented, because of a previous work arrangement or an “indefinite” documentation status, the employer could be required to pay back fees and a penalty fee. More often than not the worker was not documented and so did not want to call attention to the illegal arrangement.
move many households from illegal to legal and to move workers from undocumented status to being someone “with papers.”

Occasionally I met a woman who was “with papers” who was working “off the books” for the time being because she needed to keep some money coming in while she continued to look for a job with a legal contract. Sometimes an illegal employer would change an informal arrangement into a legal contract, often because the client had become emotionally attached to the current careworker. In this situation, the worker with papers may have secured a new “legal” position, and then given notice to the current illegal employer. Sometimes, this employer then scrambled to get a legal contract in place so that s/he could keep the worker in her family elder’s home. At other times, the illegal employer would simply find another woman from the steady supply of unemployed immigrants, especially available at the time of my research, and hire her in an equally illegal arrangement.

Exploitation of New Immigrants in Carework

The point was made during one group interview (N=7) that new immigrants more often have lower salaries, fewer breaks, less time off, and less information on rights and resources for workers. Thirty-eight of the fifty women who participated in individual interviews discussed having an experience of being tested and exploited in their first job(s), and then learning about their rights and how to care for themselves. New immigrant careworkers were also more vulnerable to exploitation in the workplace of the home in that they were made to work longer hours than agreed upon and/or to do tasks beyond the job description, all in the name of “care.”

More than two-thirds of the women I interviewed (N=50) offered reflections on their naïveté and terrible vulnerability in their first months in Italy. Many of the women arrived alone, without any Italian language skills or knowledge of carework, and most worked in a live-in job early in their work history in Genoa. Most overstayed their tourist
visa, and worked undocumented and without a legal contract in their early jobs. Many received their permesso during one of the Italian government’s regularization schemes. When I asked them to reflect upon their first few months in Genoa, and their first carework position, many women laughed ruefully or looked sad and thoughtful as they recalled how difficult it was to cope with a new culture, climate and language. The general view of the way each handled her first careworker job is summed up in this reflection from Valentina:

Listen, I did not know anything – about my rights, salary, breaks, what was a good paycheck, how many hours. And now looking back I see that the family I worked for took advantage of me. The elderly lady used to be a schoolteacher and she seemed to like to teach me the language. And it was the two of us all day, but she slept a lot, and I was so lonely. But she did help me. But her son probably knew better, that he should pay me more, and make sure I got the time off according to the law….now I know that I can leave every afternoon, and it is better if I do, for everyone, for my client, too.”

This is a very typical recollection of a worker’s early days in Genoa, working so many hours in a private home, often living in the same home where she worked.

Hours, Salaries, Benefits

A careworker may begin the day as early as 7:00 a.m., even as a live-out worker, and may not leave their client for the day until 12 hours later. In between she accompanied the elder through the activities of the day, depending on the functional capacity of the client. She was often present when the elder awoke, changing clothing, toileting or diapering, bathing, brushing teeth, transferring from bed to chair to toilet to chair as needed. By 9:00 a.m. the client was eating breakfast, by 10:00 a.m. the careworker had the elder settled for a rest so that she could shop, clean, launder, cook, check in with the elder’s family members, write notes on health and household concerns, and make appointments with health providers for the elder. In some cases the elderly client expected the assistant to accompany her to do neighborhood shopping or attend mass. By 1:00 p.m. the shops and churches were closed and the elder was preparing to
eat a lunch at home, most often prepared by the careworker and often consisting of two courses.

During the afternoon *riposo* (rest, nap) of the elder, the careworker cleaned up from lunch and finished any other duties to maintain the household and/or the elderly client, perhaps with toilet or transfer assistance before the nap. The worker might have gotten an hour’s rest in or out of the home-workplace during the afternoon. At 4:00 p.m. the stores reopened and last minute purchases could be made in preparation for the evening meal. The careworker then had an evening full of jobs to complete, perhaps assisting with feeding of the elder, then toileting, transferring, washing, brushing teeth, and dressing for bed. Throughout the work day the careworker was responsible for reminding or cajoling the elder into taking prescribed medication and vitamins, and in some cases administering enemas or taking tests for diabetes and administering related shots. Usually a family member asked that the worker document the day or week’s activity – in a written log or by placing a phone call to the family member coordinating the care.

As detailed above, ever since 1975, standards for domestic workers have been set in a national collective bargaining agreement, last updated in 2007 (Gallotti 2009:17-20). While the provisions of this agreement are discussed here, it is important to note that many immigrants in my study were caring for elders in their homes, laboring in informal, illegal working arrangements (Di Santo and Ceruzzi 2010:13). Some of the women I interviewed emphasized that in illegal arrangements they worked under the same terms, especially regarding hours and time off, as they did when they were employed via a legal contract. Others emphasized the legal work contract and how they
and the employer adhered to the terms, and the quality of their work life was much better than when they were in illegal arrangements\textsuperscript{46}.

The hours interviewees reported often were stated in reference to the standard work week allowed by law, available to those who were documented or “regular” and who were employed by a person who understood and followed the rules in a work contract. The hours for live-in workers were to be no more than 10 hours per day, with a maximum of 54 hours per week. For live-out workers, the hours allowed by law were 8 hours per day, with a maximum of 40 hours per week. For a live-in careworker in a household complying with the law, there was a mandated two hour break from work every afternoon, Monday through Friday, as well as one entire afternoon off each week; and the live-in careworker was to leave work Saturday at 2 pm and not be expected in the home again until 8am on Monday morning (Di Santo and Ceruzzi 2010).

Although live-out workers were to be given an hour break for every eight hours that they work, to end their work week at 2pm on Saturday, and to have Sundays off, this was not always the reality. Some women worked two part-time positions, and so had a 12 hour work day, but without a substantial break within or between their two 6 hour shifts. Some women arranged to have long afternoons off two days a week, as Laura says, “To attend a careworker support group or just have time to be away, to go shopping, to have a coffee.”

\textsuperscript{46} Because I did not interview clients or employers, I did not learn about the variation in the quality of the work done by careworkers. In some interviews, careworkers commented on how the quality of their client’s life improved when the careworker participating in the research interview arrived. Other careworkers mentioned what they had heard about lazy careworkers who “took advantage” of a situation by not keeping the elder’s home clean or providing high quality meals or lying to the elder’s family.
The Money: the Commodity of Care

There were two important areas to consider when situating carework in the economy of Genoa. First, the salary for this work has shifted over time as geopolitical changes have taken place, supplying more immigrant workers to fill jobs caring for elders in their homes. Second, it was important to understand how, due to a combination of xenophobia and the economic downturn, the job prospects for immigrant women from South American countries were limited (Bettio, et al. 2006; Degiuli 2011:7-9; Delacourt 1998). Equally important was to understand how the salary and working conditions of the careworker position fit into other employment available to these women. The table below shows how monthly salaries have changed for an immigrant working a live-in position caring for an elder in a private home in Genoa.

Table 5.2. Monthly Salary for Careworker in Genoa, Italy

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<tr>
<td>1999</td>
<td>700 Euro (749 USD)</td>
<td>950 Euro (902.50 USD)</td>
<td>1100 Euro (1364 USD)</td>
<td>750-850 Euro (997.50-1130.50 USD)</td>
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</tbody>
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When the subject of salary was broached it often involved a discussion of how the number of women willing to do carework had increased in Genoa. Money was usually introduced into the interview soon after a discussion of the long hours involved in the carework job. For most workers “the hours seemed long” even if they were in what they considered an ideal situation. This ideal may have included: an employer who follows the laws protecting workers; one who provides a “by the book” work contract that is indefinite (ongoing); and a situation in which it is easy for workers to take daily/weekly breaks and time off for holidays and trips back home to their families. Forty of the fifty

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47 These amounts are not adjusted for inflation, between 1999 and 2010 the value of the Euro increased overall with fluctuations along the way. The 1999 average exchange rate was $1.07 per Euro; in 2010, the average exchange rate was $1.33 per Euro (Board of Governors of the (USA) Federal Reserve Bank 2012). These data were gathered in interviews with 50 careworkers and 20 servers, then “checked” in a careworker group interview.
research participants had been irregularly employed at some time during their work history in Genoa; the remaining ten had only been in legal contractual arrangements. In or out of a legal working situation, the workers reported tremendous variability in the working conditions, such as days off, daily breaks, mandated holidays and vacation time.

The Changing Labor Market of Care in Genoa

In the discussion of salaries, the workers often discussed how wages had decreased during the past four years and attributed the reduction to two factors. These include: (1) new immigrant groups entering this work sector and accepting less than standard working conditions and salaries; and (2) the general global economic crisis. The crisis was especially visible in the housing situation in the U.S. during my time in Italy (October 2009-November 2010), and a more frequent topic of discussion with each month I lived in Genoa. Immigrant careworkers and servers all referred to the new immigrant groups entering carework jobs as “from the East” and women desperate to make money and care for their families. These immigrants were described to me as being so desperate for money to sustain their families that they were willing to take live-in jobs in nero (literally “in the black” meaning irregular, for cash and without a contract) for low salaries and in unsuitable working conditions. South Americans, Ecuadorians in particular, had dominated the carework labor force in Genoa for more than a decade, starting in 1998; but they were starting to feel the effects of other immigrant groups establishing a toehold in the market.

Generally, in referring to workers from the “East,” interviewees and others were referring to women from Albania, Belarus, Poland, Romania, and Ukraine (Culic 2008; Turai 2010). The workers from European Union (EU) countries such as Poland and Romania were utilizing the EU border crossing policy which allows EU citizens, that is, a citizen of any EU country, to move freely into other EU countries and reside there for up to six months without, for example, a work contract or formal living arrangement. In Italy,
such residency included access to the national health system. Women from Albania, Belarus, and Ukraine generally were coming to Italy in the same way undocumented immigrants had for decades, arriving on a tourist visa and staying beyond the time limit, with some seeking refugee status, which was difficult to obtain in Italy (Fasani 2008 (2009)). Economic downturns related to political changes in the post-Soviet countries (Belarus and Ukraine) had led to migration into Italy within the last 5 years in significantly increasing numbers (Chaloff 2008). One scholar referred to the “Ukrainisation” of female migration to Italy, first visible during the regularization of 2004 (Gallotti 2009:27-28). All of these workers from poorer European continent countries were more likely to work in precarious conditions for lower wages (Culic 2008; Turai 2010).

Changes in the economic and political structure of Albania stimulated a mass migration to Italy beginning in 1991 (Barrell, et al. 2006). Albanians had been present in the carework market in Genoa for some time, but originally were regarded as “less desirable” than, for example, Ecuadorians. Other researchers in Italy have reported this hierarchy within this work sector (for examples see Andall 2000b; Chell 1997; Merrill 2006). The recent arrival of women from other Eastern countries had highlighted the possibility of the lower-cost of wages for an Eastern European worker, and so Albanians were noticed as participants in the carework market. One social worker pointed out,

They (meaning the Eastern Europeans) have always been here, as long as the Ecuadorians, but were not seen as suitable for this work in the same way that a Latin American….Now an elder’s friend may brag about the low cost of her Polish careworker and so hiring an Albanian may be more acceptable now, and they do generally accept lower wages.
The number of Albanian documented immigrants in Italy doubled from 2002 to 2008; during this same time period the number of Ukrainian documented immigrants in Italy increased more than tenfold (ISTAT 2008).48

For South American women seeking work in Italy, employment options were limited. The unemployment rate for Italians in 2009 was 8%, at that time the unemployment rate for documented immigrants was 11% (Martin 2010). Of the South American women employed in Italy more than two-thirds were in the domestic work sector (Degiuli 2007b; Fravega and Bonatti 2005; Vento 2004). More specifically, for Genoa, research by Salvatore Vento (2004:34) in January 2004, using Genoa immigration office data, showed that 71% of the documented Ecuadorian immigrants in Genoa held positions as domestic workers.

My study was of immigrant women from South American countries, and some observers (i.e., my neighbors, the servers and administrators who participated in my interviews) would place them at a higher tier in the racialized hierarchy of immigrants deemed to be capable and trustworthy by Italians.49 Generally, the South American immigrant women above 35 years of age were employed as careworkers, babysitters, nannies, cleaners of private homes, hotel maids, and cleaners of public areas of an apartment building. For those younger female immigrants, between the ages of 18 and 35, there were all of these options, and a few more job prospects. The ones most often

48 The perceptions of careworkers that women from the East would work for lower wages and in poor working conditions matched the perceptions of labor union officials and Church workers participating in this project.
49 Ecuadorians generally had more options, than, for instance, women from Cape Verde or Morocco. I learned this from labor union workers, church workers, and immigrants from South America and Cape Verde and Morocco. What was implied in these conversations was that Italian elders did not want people with dark skin and/or non-Catholics in their homes.
mentioned were: *barista* (bartender, for both cafés and bars serving alcohol), waitress, cook, travel-ticket agent, and hotel clerk.  

Table 5.3. Characteristics of Employment Typical for South American Immigrants in Genoa

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Monthly Salary</th>
<th>Work Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bartender (Barista)</td>
<td>900-1000 Euro (1197-1330 USD)</td>
<td>6-7 hours/day, 6 days/week</td>
</tr>
<tr>
<td>Waitress</td>
<td>900-1000 Euro (1197-1330 USD)</td>
<td>6 hours/day, 6 days/week</td>
</tr>
<tr>
<td>Live-in careworker</td>
<td>750-950 Euro (998-1264 USD)</td>
<td>12 hours/day M-F with two hour rest period and one afternoon off; from 2pm on Saturday until Monday morning every weekend off</td>
</tr>
<tr>
<td>Live-out careworker</td>
<td>750-950 Euro (998-1264 USD)</td>
<td>7-9 hours/day, 6 days a week</td>
</tr>
<tr>
<td>Babysitter</td>
<td>600-850 Euro (798-1131 USD)</td>
<td>6 hours/day, 6 days a week</td>
</tr>
<tr>
<td>Cleaner and/or administrator for semi-public areas of an apartment building (or two)</td>
<td>950 Euro (1264 USD)</td>
<td>6 hours/day, 6 days a week</td>
</tr>
<tr>
<td>Colf (housecleaner in a private home)</td>
<td>950-1250 Euro (1264-1663 USD)</td>
<td>7-8 hours/day, 6 days/week</td>
</tr>
</tbody>
</table>

The information on wages and working conditions was collected in several ways: (1) via fieldnotes taken in the careworker training and placement classes I attended every week; (2) in the support group I attended three times and the focus group conducted at its site with the cooperation of its leaders; (3) from individual follow-up interviews conducted with immigrant careworkers; and, (4) with some of the servers who were aware of the average salary of careworkers at various points in time, usually because they were advising immigrants applying for these jobs. Conversions from Euro to US Dollar are done using the 2010 average derived from the daily rate reported by the U.S. Federal Reserve System.
A position as a cleaner-administrator for an apartment building was seen as a desirable job for women who have the physical stamina. However it was rare to get six-hours a day for the entire six day work week at one apartment building. I interviewed ten women who now or at one time had a job cleaning/administering an apartment building for half of their workweek, and cared for an elder, or did after school babysitting or cleaned a private home the other half of the workday/workweek.

The downward mobility experienced by immigrants who had been educated and worked in their home countries as chemical engineers, advanced practice nurses, government agency administrators, supermarket chain regional managers, small retail business owners, city administrators, educators, and counselors was an unhappy surprise for most of the women I met. Because they were educated and/or experienced, they expected to “start over” because of the need to master a new language, but these women also expected to be able to build on their past life in Ecuador. Those who discussed their “old” life would point out, as Luzmila stated,

I really thought I could find something in my industry, perhaps as an assistant to the professional (graphic artist) I used to be. I studied the language so hard, I even got a certificate of Italian, but they (the Italians) really only think of us as servants.

This downward mobility, endured for the sake of economic improvement, was a source of the stress linked to social location (discussed in chapter 8). Limited job opportunities for immigrants were attributed to the economic/employment situation for native workers in Italy, the language and cultural barriers, the xenophobia linked to a cultural belief of belonging as linked to blood, and the high motivation for immigrants to take any work in order to survive and aid their sending household (Gallotti 2009). After so many years away from their profession, these women gradually lost their progressive competencies and remained in the domestic work sector even after mastering the language and moving with confidence in the culture(Gallotti 2009:48).
The precarious nature of carework

The tenuous condition of elders with chronic illnesses or disabilities or frail elders meant that circumstances for care changed quickly. Clients died or needed care beyond the scope of an arrangement that included the low-wage immigrant careworker. When a situation changed, the worker was out of a job. Several careworkers reflected on the trajectory that began when the elderly client first visits the emergency room. As Valentina noted, “The first trip to the emergency room with the elder is the first step towards not eating or drinking or stopping walking altogether or needing to go into the hospital. Elvira, another woman in the group interview interjected at this point, “You should make a note in your agenda the day you come back from your weekend or day off and learn that your nonna has been to the ER—‘start to look for new job’ (laughter from the group).” These women were reflecting on their own observations and experiences with the high rate of mortality for elders associated with a condition that prompts an emergency room visit. Problems with breathing, chest pain, and falling are some of the main reasons that elders seek care in the emergency room (Newton 1999; Samaras, et al. 2010). The breathing problems and chest pain are often associated with pneumonia, stroke (Di Carlo 2009), chronic obstructive lung disease (COPD), and heart disease, which are among the most frequent causes of death for individuals over 65, in Italy and elsewhere (Cesaroni, et al. 2009; Gorina, et al. 2006; Lopez AD, et al. 2001). Medical researchers have found the fractured hip or limb that is the outcome of the fall is not often the cause of death, but contributes to an increased risk of death, especially for women over 80 years of age (Kannus 1999; Launer and Hofman 2000). The decline is attributed to a condition that is exacerbated by the trauma of the fall and the break (LeBlanc, et al. 2011).

The precarious nature of the work and the inevitable change in condition made elder care less attractive for some women than other home-based work, such as
childcare or cleaning work.\textsuperscript{51} The low wages, the negative aspects of living in, the sometimes unreliable or unreasonable hours and the lack of benefits—all were reasons why a worker, especially a new immigrant, may have moved on to live-out eldercare, childcare or cleaning work when she had the opportunity (Degiuli 2007a; Gallotti 2009). New immigrants were the primary labor force for careworkers living with elders in their homes (Lamura, et al. 2006).

The Home as the Working Environment

Health and social science scholars have used the term \textit{intimate} to describe care that involves crossing body boundaries usually reserved for the individual and an intimate other; i.e., bathing, toileting, diapering, dressing, applying substances to the body of the client (Twigg 1999). Along these same lines \textit{intimate space} has emerged in discussions of home care to refer to places in the living space typically limited to an individual and an intimate other; i.e., bathroom and bedroom. \textit{Intimate space} may also refer to the space surrounding an individual body (Wiles 2003). For example, a person who must be assisted (or lifted) from wheelchair to toilet has a careworker touching her, with the worker very close to the client’s body, in her intimate space, and this work is being performed in the typically privatized intimate space of the bathroom (Twigg 1999; Williams 2002). The term \textit{domestic} is used to describe the home as a worksite. Thus, \textit{domestic workers} is the encompassing term for cleaners, gardeners, nannies,

\textsuperscript{51} However, several women in one focus group talked about how they had tried cleaning-only jobs, and babysitter jobs, but were happy to return to eldercare work. They described the more peaceful pace of working with an older person. When Elena pointed out, “Those of us who arrived here from Ecuador or Peru more than 10 years ago were a young 40 then, but now we do not have the knees to chase someone’s children around…,” the group responded with laughter and head nodding. The group talked about how although the time spent inside can be difficult, it was better than being exhausted by caring for children or constantly cleaning. They explained that the downside of childcare was that the parents expected you to do other tasks while you were caring for the children, such as laundry or meal preparation. However, with some elders, your job was to provide companionship and to set your pace to that of the elder in your care, which led to a less physical and frantic day. The consensus in this focus group was that for some workers, with personalities that embraced being patient and ready for change, with the right family, elder carework could provide a pleasant work pace.
babysitters, cooks, careworkers to elderly and/or disabled adults, and home managers.

All of these terms are defined in service of the following discussion of power in the home workplace and the examination of the implications of doing intimate care for wages.

The power of the Padrona

Sometimes the employer, the person supervising the work, is also the client and this person is referred to as employer-client in this document. Other times, the employer is a family member of the elder client, especially if there is a communication disorder or dementia affecting the elder client. In my careworker interviews I heard of daughters, daughters-in-law, sons, cousins, nephews and spouses who were employers. Most often the person coordinating care was a female relative, thus the term Padrona (female boss). The most prevalent arrangement, specified in the literature, is when a female relative of the client is coordinating care (Anderson 2000; Degiuli 2007b); another common arrangement reported is when the employer-client directs care (Sarti 2005; Timonen and Doyle 2010). My own analysis is consistent with these findings, as 80% of the care situations described by careworkers in interviews referred to a female relative of the elder as the work supervisor. Women I interviewed described a range of employer supervisory behaviors. For example, Elvira reported that the daughter of the elder client said,

I will come by three days a week to have a coffee with you and father, and to make sure he gives you enough money for the shopping. We trust you and some days he functions well – go spend time with your friends, take a break, use your own judgment. You know best.

Another type of supervision is seen in the following from Anabel,

I suppose these people, who are not rich, had never had a helper in the home before, but my god, treat a person with a little respect! She (the elder client-employer) followed me around and did not want me to sit – ever! Only during the required breaks – I had a contract – and I lived there and she would make me stay home during the afternoon nap break when I had plans to go out. She had me re-clean things to get her money’s worth? Maybe. I am not sure why.
Many women described their live-in experience as flexible, depending on the level of client need. Some women had learned to work with the flexibility and viewed it as an opportunity. Bianca recounted the following:

My nana’s son, my capo (boss) says, “Go out when you need to, just make sure my mother is comfortable, has food in the house, and is resting comfortably. She is in good health because of you, take care of your own business.” He is not kidding, he wants me to leave the house so that I am kind to his mother and fresh when I am here.

Others, like Mari, said the flexibility can be a double-edged sword: “She (the client) has been kind about letting me leave to attend choir practice or events at the church, but then she hurt her ankle and said, ‘All of those times I let you have more time off, now you owe me…” In this case it seemed that the client-employer was flexible in her demands of the careworker’s time, but then expected a certain amount of flexibility in return. Also important to remember was that the ultimate power remained with the Padrona, as the employer was required to aid an immigrant in obtaining a permesso.

During interviews, I asked “What factors make a good work situation?” and “What would you change about your current job?” In three-fourths of the individual interviews (33 of 50), the careworkers reported that the relationship with individuals in the workplace-home had the most influence on the quality of life of the careworker. Alba recounted,

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52 There are many examples. For instance, Iris said she had a client in gamba who recommended she take on another (part-time) job since he knew she needed the money. She worked fulltime in the live-out position, meaning 8-10 hours a day Monday thru Friday, and 8:00 a.m. until 1:00 p.m. on Saturdays. She reported her fulltime employer said, “Go ahead, clean my neighbor’s house, and use your mandated break time and a little more if you need it. You and I know that you need the money for your children back in Peru and that I am out in the park with my friends most afternoons and do not need you. My daughter will not care.” Iris did in fact do some cleaning at the rate of ten Euro (13.30 USD) an hour for her client’s neighbor, and when she cooked a meal in her main employer’s home, she sometimes prepared double portions, and took the rest to the neighbor. The neighbor paid her for her time preparing and delivering the meals, sometimes while she was “on the clock” for her main employer. Her main employer worked out the cost of the groceries with the neighbor. “He (the elderly male client) wanted me to succeed and not worry so much about money and to be happy and to…remain in his situation.” Iris said his kindness and flexibility aided her in raising the money needed to bring another of her children to Italy, and eventually her sister found a full-time job caring for the neighbor.
Listen, this person, her moods are your moods, and you must respond. If the person you spend 12 hours a day with, or wow, even live with, I mean 24/7. If this person does not treat you with respect like a person equal to her, you could start to see yourself as less than a person.

The power of the client (in this case, also the work supervisor) is apparent here. The power emanates from the psychosocial status of the elderly client/Padrona and her ability to set the mood of the home, the place where Alba spends so many of her waking hours. Some careworkers introduced the topic of the relationship with the client/family without prompting; this also occurred in interviews with those who serve immigrants. In one-third (8 of 25) of my interviews with those who serve immigrants the participants spoke of how much this relationship affected the quality of life for the immigrant careworker. Social workers, church workers, counselors, and medical personnel all commented on this topic. As a counselor at a labor union office for immigrants noted,

Listen, I have heard about truly wonderful Italian families, who are respectful, who regard this worker with their nonno as a complete person, and recognize her accomplishments in her own country and care, follow the rules, and maybe even better than that…but I have also heard, and you have too, of some really crazy and really…naughty old people here in Genoa, or their son or daughter-in-law is the mean one. They really regard these people as slaves.

Because this counselor works with the rights of workers, she has been exposed to many situations involving families needing care and the worker being paid to provide such care. Her “slaves” remark points to the xenophobia and racism that is sometimes so overt that it has been displayed in the neutral environment of her labor union information office by an Italian employer and recounted in stories that she and her co-workers heard in the workplace. I interviewed this woman and two of her co-workers at their busy office, where they were specifically charged with addressing issues around immigrant labor, including contracts for workers in home care.

The presence of this labor union worker points out the limits of the power of the Padrona in home-based work in Genoa. The pervasiveness of labor unions in the fabric
of Italian life (Pojmann 2009; Watts 1999), and the importance of the Church as a moral authority in Italian household behavior (Degiuli 2007b) results in limits being placed on the power of the employer in the hidden workplace of the home. The Church- and non-profit-based careworker classes I attended included information on working conditions, as in the following from Suor Carmen, who facilitated a careworker training:

I have heard of an Italian family I know, I thought a good family! Asking that the Romanian worker sleep in the same bed as the elder with Alzheimer’s that she cares for. This is a shame, a sin! Do not ever accept a situation like this. Go talk to the union. Ask us questions.

The work of the Church, discussed in detail in chapter 6, included an interest in humane treatment of immigrants and the moral integrity of the careworkers, which placed a set of expectations on Italian families to treat workers with dignity (Magat 2004). The Church has been protecting the moral integrity, including the sexual purity, of female immigrant servants for decades (Magat 2003). This included the internal Italian migration of large waves of single poor rural Southern women who migrated to Northern cities (Andall 1998; Pojmann 2008; Sarti 2005). Because the workers who care for elders are in the home, they are in a space that is at the nexus of private family space and public paid work space (Martin-Matthews 2007). This nexus is an ideal site for what Hochschild (2003) characterized as “marketized private life” and Stacey described as existing “awkwardly between the realms of family and work” (2011:62-63).

Implications of Doing Intimate Work in the Intimate Space of the Private Home

While earlier in this chapter I addressed the daily work tasks involved in carework, here I address the work setting – the intimate space of the home where personal care takes place. U.S. and European scholars from nursing, geography, healthcare economics, sociology and anthropology have explored the implications of in-home carework, and this research highlights the home as a site of care for improving or maintaining health (Dyck 2005; Kadushin 2004; Tung 2000; Twigg 1999; Wiles 2003).
The home differs in a variety of ways from the institution as a place to do the work of care and experience the health effects of this work.

In addition, recent research points out that the private home has become more important as a site for care. Now more types and levels of care are provided in the home, and not the hospital or rehabilitative facility (Tung 2000). In a variety of healthcare systems, including in Italy (Anessi Pessina 2010), the United States (Norton 2000), and Japan (Fujiwara, et al. 2003:313) hospital stays have shortened following surgeries, injury, or acute health episodes (Aronson and Neysmith 1996). For instance, patients used to remain in the hospital for five days for post-operative care following a “routine” surgery such as gall bladder removal. Now, the patient without apparent complications may be sent home the evening of the day of surgery. This requires that a person be available to assist with post-operative care. In Genoa, this person is often an immigrant careworker supervised by a female family member of the elder client.

Work done in a family home is work done in a space hidden from oversight. The research on home-based care, including agency workers in private homes, points out the risks associated with the lack of public access to the home. Though a public workplace under the jurisdiction of a regulatory agency for enforcing standards of working conditions does not guarantee an ideally safe workplace, it can improve conditions because of the possible threat of inspection and consequences for violation by the workplace owners (Pitidis, et al. 2005:42). In the private home, the complete lack of public institutionalized oversight of work conditions means that workers may not have,

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53 For instance, researchers from the U.S. National Institute for Occupational Safety and Health highlight the need to utilize ergonomics concepts to ensure worker and client safety in home-based carework (Galinsky, et al. 2001). While the recommendations are well-documented, urgent, and reasonable, the reality is that there are not structures in place for most of those women providing care in the homes of their elder clients to find one another, learn about such opportunities or have time to attend such a training. Indeed, many of the women participating in individual and group interviews expressed interest in information sessions regarding the new immigration laws in the Security Package, but half of those wanting to attend found it difficult to make arrangements to attend without losing wages.
for example, regular breaks, safe spaces in which to work, and/or appropriate equipment for physical tasks to cut down on work-related injuries (De Marco, et al. 1998; Denny, et al. 2011; Maso, et al. 2007).54

Another implication of work by my interviewees in the private home was that the physical arrangement of the home often increased the risk of physical injury for home health workers. The fact that specialized equipment and/or second careworker often were not available during times when a patient transfer took place (for example from bed to wheelchair) made a notable difference in the physical health of the careworker. For example, Vilma, who had worked in both a rest home and a private home noted,

> In the rest home, I called someone when I had a really big person or a person who could not help with the moving. If I am just starting to feel a little pain in my lower back, I would do this. But when I was alone with the client in her home, that was not even an option.

The comparative OSHA study by Galinsky, et al.(2001) found that the careworker in an institutional work environment, such as a hospital or rest home, often had more room in which to maneuver, and more control over the arrangement of furnishings and the timing of activities. In home care situations, the rooms were described as “often small and/or crowded, with furniture arranged in ways that make their tasks more, rather than less, difficult” (Galinsky, et al. 2001:60). However, these findings were based on occupational research done in private homes in the United States, where the average room size in private homes is much larger in comparison to Italy (Gallent, et al. 2010).55 A 1993

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54 There are other personal safety concerns linked to home-based carework, separate from ergonomic issues and physical strain. These risks included, “assault while traveling/working in high-crime areas…attacks by dogs…allergic reactions to pets in the homes; and second hand smoke” (Galinsky, et al. 2001:69).

55 The bedrooms and bathrooms in European apartments typically do not have any built in storage cabinets or closets and so precious floor space is taken up by wardrobes and portable closets. I observed many apartments in Italy with bathrooms 4 feet by 6 feet, with much of the square footage filled with toilet, sink and tub, leaving little room for maneuvering, with or without a wheelchair. The bedrooms generally were 14 feet by 16 feet, with the space taken up by the wardrobe(s) and a double bed. Several careworkers said it was always a great help to them when a (single) hospital bed would be delivered to replace the double bed, so they could move...
study found that the median Italian home had approximately 39% less square footage when compared to the median home in the United States, and usually had freestanding storage units, which use up room and floor space (Bates and Peacock 1993:76). One-third (N= 17/50) of the careworker participants in my research discussed the crowded rooms of the home-workplace as a negative working condition.

While in Genoa, I visited the homes of many (~45) elderly neighbors and acquaintances. In many of these apartments a wheelchair would not fit into the tiny space of the bathroom even if it fit through the threshold. Often, the bedroom could not accommodate a wheelchair, due to floor space used up by the bed, the wardrobe, and other furniture. Some of the women I interviewed had learned to request that changes in the home-workplace be made to accommodate their employment. Norma recalled,

It was 10 years ago, my second job, and this apartment was stuffed full of furniture, these old Genovese do not like to part with their belongings, and I said, “Listen let us try each other for 30 days, but a few things need to change...you find a place to store at least half of the big wooden pieces of furniture in these two rooms, I cannot live and work in a place like this.” Norma believed that the daughter was looking for an excuse to move some items out and eventually the family responded to her request. Norma worked there for five years.

Some of the research participants reflected on how working in a home is a good situation for a new, undocumented immigrant. Forty of 50 careworkers interviewed said that they seldom felt anxious that immigration authorities or government officials would come looking for them, asking them about their papers. As Lutz and Schwalgin found in their research with households employing immigrants in Germany, “private households offer more protection against police controls” (2004:297). A few women (all now documented) in my study went so far as to say that working live-in helped them to feel safe and remain relaxed, especially about housing and money. Elvira, who has worked more easily around the client to perform tasks sometimes based on the bed such as bathing, changing diapers, and dressing.
in Genoa for 14 years said “Yes…if you get the right situation.” And another worker, Carmen Maria, who had done live-out work, noted:

I would rather work live-in and just earn money and feel safe, have a roof over my head, and food on the table. I don’t want to be bothered with the details of keeping my own home, especially when I work so much. I actually think I relax more when I work live-in, as I am not worried about having enough money to pay all of the bills here and still send some home.

Working and Living in the Same Place

Most of the 50 interviewees had experienced both live-in and live-out work situations, and so there are not discrete groupings of women. Instead, the live-in and live-out work situations are compared within each interviewee’s reflection on her experience with health and work. All but two of the careworkers interviewed reported that their first position upon arrival in Italy was a live-in position.

I focused on careworkers in this project, centered on their lived experiences, and consequently, the perspective on carework from the clients or employers is lacking. Many Italian elders and their family members were watching because they cared about the quality of care and general security of the elder. In fact several careworkers spoke with derision of family members who, in the words of Bella, “did not pay attention, observe, ask questions or care.” A client’s family was expected to keep an eye out for the elder and make certain valuables were not taken. Only infrequently did this concern manifest itself as xenophobia, suspicion, or unreasonable surveillance.

The Structural Violence of Surveillance

Another theme that has emerged in an examination of the interview data is feeling the effects of working and living in a situation in which another person has control over the careworker’s everyday activities. This is especially intense in a live-in work situation. This control can influence the activities that many people engage in every day—for instance, sleeping, resting, washing, eating, and having private time. Stress
caused by employer control over the careworker’s movements was reported by interviewees discussing both live-in and live-out employment. Valentina reported that she stopped carrying her purse with her as the client’s family seemed convinced that she wanted to:

...steal the spoons, the cleaning supplies, the curios from the cabinet. I wanted to bring my own lunch, as they did not give me the food I liked, but it seemed to make them nervous and I did not like having them look in my lunch bag every day, which I insisted they do. I just got a feeling, I did not speak Italian that well at the time, but they seemed suspicious of me

This level of mistrust was not experienced by all of the careworkers I interviewed, but one-third (17 of 50) of them recounted at least one work situation when it was clear the Italian client/employer suspected them of wrongdoing. One type of concern expressed by Italian clients to the workers was that the careworker was wasting household resources. Workers described clients who would show them the water meter or the electric bill, and express dismay that more resources were used than the clients viewed as necessary to maintain the home and/or the careworker.

All interviewees described being “watched” by their elderly client and/or the family member of the client who served as their supervisor. Because most of this surveillance occurred in the home, such scrutiny was intensified. The small size of home dwellings in Genoa, most often apartments, made it almost impossible for the careworker to avoid this scrutiny. These workers were competent adults with many responsibilities that, in fact, they were addressing by doing this work. The careworkers worked long hours and shouldered responsibility for another human being in order to contribute economically to their family households, yet they were under surveillance as if

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56 There is of course the very real concern in Italy and elsewhere that workers in a vulnerable elder’s home have the opportunity to exploit the situation by stealing, embezzling money, coercing the elder into giving items of value to the worker, or abusing the elder (for example, see Maraffino, 2009). According to Melchiorre, et al (2012), this phenomenon has not been widely studied in Italy.
they were children or indentured servants. The following excerpt is from Mari reflecting on her first job (live-in):

The woman (the elder client) had a mirror arranged so that she could see me in my room and demanded that I keep the door open. When she had a nap, I had to take a nap, or do some task she wanted me to do while she napped. When she went to bed for the night, pretty early, I had to go to bed, too.

This physical arrangement of the mirror was not made to accommodate a specific need of the elderly woman, who was physically self-sufficient. The client wanted to control the movements of the worker, and, in this case, to be able to see that she remained in her room on her bed. The use of surveillance to control the movements of the worker becomes a form of violence when power is used with such persistence and with so little respect for the individual adult autonomy of the worker.

**Personal Risk involved with Carework in Genoa**

While some women in my research introduced the usefulness of being away from the scrutiny of government officials, there is another side to such workplace privacy. Lutz and Schwalgin named the home workplace as a space that is simultaneously a "space of protection (from immigration officials or more public harassment) and...a dangerous space (a place away from public oversight)" (2004:297). Similarly, Gallotti found “the private nature of the workplace and the informal and personal character of the employment relationship often confine them (the immigrant careworkers in Italy) in what in some extreme cases could be defined as a 'safe hell'” (Gallotti 2009:31). While Gallotti’s study for the International Labour Organization examined the case of migrant domestic workers and the ability of government organizations to enforce labor laws (or not), she learned that an undocumented immigrant safe from officials may in fact be in an abusive situation (a sort of hell) if the employer was controlling and isolating the worker in the home.
My interviews included discussions of the dangers of working in a “hidden” workplace. The lack of oversight also means that there are no other factors to counter an employer who is tyrannical, unfair or abusive in the workplace (Chang 2006; Di Santo and Ceruzzi 2010; Gallotti 2009). Several careworkers in my research offered their own experiences with personal violence in the home-workplace. Three of the 50 interviewees talked about feeling physically threatened by a client or employer in the past. Four others recounted sexual assaults. In one case the husband of the client, a 50-year old disabled woman, hinted (to the careworker, Rubi) that one reason he hired her, an Afro-Ecuadorian, was because he assumed she would be “available.” In Italy it is immigrant women with dark skin who enter jobs in sex work (Cole 1993), in Genoa many of these women were from Nigeria. Rubi’s client’s husband followed up his hint with several attempts to grab her breasts or buttocks, or to restrain her in a room far away from his wife. Rubi recalls:

I said, “Listen to me, Sir. I like this job, I like your wife. But if you do not stop this, I will not only tell her, I will call your parents, her parents, your sister (the one who likes me so much), the physical therapist, your wife’s doctor, the priest who visits, and my priest at Don Bosco.”

Rubi continued to work for this family for over two years following this incident, and planned to do so indefinitely. She was convinced that her threat to expose him was enough to keep him at bay. She said, “I showed him all of the phone numbers and I have relationships with all of those people. Most of them like me more than they like him. They trust me.” Several studies on domestic workers have found an increased risk of their being assaulted while isolated in virtual strangers’ homes (Di Santo and Ceruzzi 2010; Galinsky, et al. 2001) and that “immigrant women are more likely than Italian women to be the victims of sexual harassment by their employers” (Pojmann 2006:41). However, Rubi derived social authority from her relationships, and exercised this power to prevent further assaults.
Relationships and “Public Transcripts” in a Private Space

In chapter 8, I address specific strategies used by careworkers to attend health appointments. Here I discuss how careworkers took steps to “stay sane, healthy enough and employed,” according to Germania, one group interview participant. The sphere of the household, generally conceptualized as a feminine space (Exley and Allen 2007; Lan 2003), is also the site where relationships, strategies, creative responses, and acts of resistance are developed by the careworkers to improve their own health and well-being (Parreñas 2001a). What careworkers have described as “doing what you must to keep a job,” or staying “healthy enough” to show up to work every day, is discussed by Aihwa Ong (2006) as “self-engineering” to become employable workers in this carework economy. It is helpful, then, to consider specific examples of: (1) the use of relationships (with or without strategic intent); and, (2) acts of resistance (Foner 1993; Scott 1990) embedded in the social relations that extend from the work household and the social ties of the careworker.

The use of strategic relationships, often obscured by genuine friendships and relational aspects of the work done in a household led to alliances and connections that extended beyond the work functions and workplace. For instance, eight of the twenty-four follow-up interviews included recollections of past employer relationships that were important to careworkers’ opportunities and positive experiences in Genoa. The

57 There are many illuminating examples from the data. For instance, another woman recalled how she was “too nice” in her first job and let them treat her “like a slave.” When she found her second position following the death of the first client, Josephina actively worked to influence the employer-employee relationship. From the beginning, Josephina sensed that the daughter of her client, “Just seemed negative, there was tension, she did not like me, she did not like someone in the house, it was not clear but it was bad. I was very kind, always, they expect you to be, but I sat her down (the daughter) and said, ‘Listen, we both want your mother to have good care, and be as happy as possible—the grandma had an Alzheimer’s-like problem—and so what would make you happy? How can we make this more positive?’ ...I mean it was so hard for me, to have her sort of...angry all the time with me. And it was bad for everyone’s health if you ask me, or read in a magazine,... the stress.”

In the end this careworker was able to develop a positive working relationship that even turned into a close friendship with this Padrona, the daughter of her client. Josephina felt that the
women often had a particular affection for the family of their first elder client, especially if 
they saw that work situation as facilitating a positive introduction to aspects of life in 
Italy. Vilma remained good friends with the extended family of her first client. She 
worked for one elder, and, after her death, was retained to care for the client’s sister, 
who also lived in the family’s small “compound” in a suburb of Genoa. The careworker 
became pregnant, and the client’s family was very interested and involved in supporting 
her during her pregnancy. They helped to bring her husband to Genoa so that her family 
could all be together. The couple and their child lived in the family home after the death 
of the elder. When they insisted on paying rent after they secured new jobs, the family 
of the elder collected a nominal amount and insisted on paying for music lessons for the 
child.

When women resisted working conditions they exemplified one version of James 
Scott’s idea of “everyday acts of resistance” (Scott 1985; Scott 1990), which he 
considered as embedded in a web of relations in a workplace. These acts of resistance 
unfolded in a way peculiar to the private nature of the social relations extending from the 
home-workplace. The arrangement of carework bears analysis using Scott’s work 
because it represents “an institutional arrangement for appropriating labor, goods, and 
services from a subordinate population” (Scott 1990:x-xi). In his initial ethnographic work 
done to develop his concept, he observed different discourses the poorer class used 
when around the richer class than the ways of interacting when they were with others 
from their class (Scott 1985:284-285). Scott defined hidden transcripts as “the open 

daughter focused her frustration regarding changes in her mother onto her as careworker. 
Josephina shrugged, “Maybe she just felt bad about her mother, and so was negative with me, 
because I was nearby.” In the end, Josephina saw her Padrona as having changed to be a more 
open-minded person who saw them as friends and allies. This case illustrates the creative 
strategy of one worker to mitigate a difficult situation and develop a useful relationship in the 
intense setting of the home-workplace.

58 These relationships were often sources of employment. In one of many examples from my data is 
this reflection from a careworker, Veronica, regarding an earlier employer, “I would have 
worked for them without so much money, what a wonderful family, even though the old ones 
are gone, we still see one another and she (the daughter-in-law) helped me to find a new good job.”
interaction between subordinates and those who dominate” (Scott 1990:2) and public transcripts as “discourse that takes place ‘offstage,’ beyond direct observation by powerholders (Scott 1990:4).  

In one example among many, Livia, an experienced careworker, often used her communication skills and a flair for drama to make her point. In the process she utilized relationships as she pushed back against the forces of xenophobia and poor communication within the family that she worked for:

“Listen,” I said, “Mr. Calonico, I cannot work for your family any more. Your mother is sweet, poor thing, and does her best and we (there were other careworkers) make her comfortable, but your father, every time I do the shopping he accuses me of stealing money or food, and he says bad things about foreigners. I cannot be disrespected in this way anymore.” (laughs). I actually think I stamped my foot before starting to cry. I was at the end, the end…

After the immigrant worker described the frustrating situation to him, the son of this couple requiring care begged her not to leave, and was surprised to learn about the remarks made by his father. This conversation the worker moved the hidden transcript of her frustration, which had been discussed with only her family members and one trusted Italian co-worker, into the public realm (Scott 1990:6.203-204).

All of the other workers (a visiting nurse, masseuse, cook, and housecleaner), who were Italians, corroborated this Peruvian careworker’s account of the negative and racist comments by the elderly man who was the recipient of their care. Livia reported that her Italian co workers said to her, “Listen, we would have gone a long time ago; if it does not change, you (the immigrant careworker) should go.” According to Livia, one of these Italian co-workers spoke directly to the son-employer, saying, “If she (the immigrant careworker) goes, I have a foot out the door. You should do the right thing.” I had the opportunity to meet some of the Italians who were Livia’s coworkers, and one of

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59 In part James’ concept interrogated Gramsci’s notion of cultural hegemony, which established that the richer elite class held the power to establish values of society for all classes (Gramsci, et al 2000).
them introduced the topic of xenophobia and racism and told the story Livia had related to me, from her point of view. I also met the son-employer from Livia’s story, who today is a fit 70 year old who does not require care. After the death of his elderly parents eight years ago, he continuously employed Livia with a regular contract to work 30 hours a week. As of November 2010, she remained employed at the higher level of salary associated with carework, even though she did the tasks generally associated with a lower wage: shopping, cooking and cleaning.

Using Scott’s idea, it was useful to consider how careworkers are expected to display “caring” for so many hours of the day, in a particular public transcript. Among my participants, there were not many opportunities for the “subordinates”, the careworkers, to be alone together during the work week to act out hidden transcripts. Even those who lived out were working daily in private homes 7-10 hours/day for 6 days each week. The semi-regular opportunities for careworkers to gather on a regular basis often developed at a church in the form of bible studies, in groups gathered informally before and after official events, and at the careworker support groups. However, these gatherings were technically under the supervision of yet another authority, the Catholic Church.60 Also notable is that the public transcripts which were displayed by the careworker for the employer were in fact taking place in the private home, which could have changed the dynamic of these interactions. Even with these differences, though, the concept of hidden transcripts helped to underscore the relations involved in carework.

The careworkers in this study reported during interviews that they did play roles that included feigning deference to their employers, and there was sometimes a rueful and mocking tenor to their “offstage” discussions of their work and their

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60 One visible exception was the March 1st, 2010 “strike” march discussed in chapter 7. Many of the employed careworkers I knew of were working and could not attend; the March 1st march happened again in 2011, with many fewer participants. The march was abandoned and not repeated in 2012.
employers/clients. I had the opportunity to observe this in the group interviews and casual group conversations I participated in, many over long lunches on Sunday after mass. Humor, general discussion of feelings about their situation, and recollections of good and bad employers and elders from their work history dominated these “off-stage” hidden transcript discussions. After one group interview, Aracely remarked to me, “Listen, do not thank us (for participating in the research discussion), we should be paying you, this is group therapy!”

Sometimes the careworker and the elder client in collusion were mocking or vengeful in their discussion of the family member supervising the care, in a particular form of the hidden transcript. For example, Alba recalled,

Oh, after the daughter leaves we laugh together at all of her questions! “Are you eating, mama? Do you open the windows so she gets enough fresh air? Is her color looking bad? Why do you have to go to mass every day in this weather with your bad leg, mama?” And on and on and on. My nonna and I are fine, we have an understanding and we just tell her (the daughter) what she must know and what she wants to hear. It is gentle laughter, but we are laughing at her, because otherwise she would make us crazy!

I heard of these colluding relationships from one-third of the individual interviewees. In this instance both the elder and the careworker were under the power of the daughter coordinating the care, and had formed an alliance around their common position of vulnerability as both had to allow the daughter to maintain her power. In the case of the elder, the daughter may control the elder’s money, make decisions about her care, and oversee her private life. In the case of the worker, the daughter as employer has the power to control many factors that contribute to quality of life for the worker: ability to take breaks and days off, salary, opportunities to take vacation, and, in the case of an undocumented worker, the chance to gain a work contract and a permesso. These colluding conversations were an excellent example of Scott’s idea that “the frontier
between the public and hidden transcripts is a zone of constant struggle” and that hidden transcripts are not only speech but a whole range of practices (Scott 1990:14).

Summary

This chapter outlines some general working conditions and discusses how the daily life of a careworker can vary for many different reasons. The physical and emotional demands of the work, the personality and attitude of the client and/or Padrona, the personality and attitude of the worker, and the worker’s felt need to provide for herself and for her family back home—all of these contribute to how each careworker survives from day to day in the city of Genoa. The isolation of health workers from the structure of the medical institution as a familiar and useful resource to support care decisions is an important difference for health work done in the home. The risk of assault, harassment, or exploitation is associated with isolation. Being alone with the responsibility, mental stress, and physical work of caring for another person altered the work experience. The data from this research show that this isolation was increased for the immigrant careworkers laboring in a “live-in” situation.

In interviews, workers often gravitated toward one or two aspects of the daily routine they felt exemplified the everyday working conditions of home-based carework. These aspects included: the social isolation; the burden of being responsible for a medically-fragile person; the pleasant pace of the job; the surveillance of the worker; the long hours; the need to be emotionally generous; and the physical exertion required for the tasks of care. The consequences of living with these working conditions and strategies to address such consequences are considered in chapter 8. These factors specific to carework, combined with contextual factors – the broader economic downturn, the competition with workers from the East, the power of the employer, the lack of other job opportunities – create a complex situation in which being a careworker simultaneously provides both relative benefits and high levels of stress.
Chapter Six: The Structural Role of the Catholic Church: Supporting Immigrants and Constructing Careworkers

Involving Latin American immigrants in research in Genoa required that I, as the researcher, become familiar with Catholic parish (neighborhood) churches and agencies associated with the Catholic Church. In my pre-dissertation fieldwork in Genoa during summer 2008, I pursued leads to find the people who served immigrant careworkers, and often ended up at a Catholic Church building or organization. When I asked about weekly work schedules, I learned that many immigrant careworkers gathered at parish churches during the day-and-a-half “weekend” most of them had. In speaking with Italian families about eldercare, the resources named were most often associated with the Catholic Church. This research project included an analysis of the Catholic Church because when I followed the immigrants who do the work of caring for elders in Genoa, I was often led to the Catholic Church.61

Using critical medical anthropology required that I examine the Catholic Church as an influential social and political force in Italy at the transnational, national, and local levels. The transnational role of the Church is discussed in chapter 4, the Church involved in recent Italian politics is discussed in chapter 7, and the local influence of the Church is the main focus of this chapter. While the Church functions on a transnational scale, it operates in a very personal way at the parish level, facilitating a sense of belonging for immigrants in Italy even as it disciplines them into their appropriate roles in Italian society. At this level it serves immigrants, and specifically immigrant careworkers, as a source of social support and to integrate people into local networks. Using intersectionality theory required that I examine how various identities combine, and the Church was important for careworkers’ identities as it reinforced ethnic stereotypes and

61 While there is an Evangelical presence in Genoa, including a community focused on Latin American immigrants, the Catholic presence dominates and the term Church refers to the Catholic Church in this document. I chose to focus my time on the Catholic-related communities serving immigrants, which provide many services to Latin American immigrants in Genoa.
gendered roles. The Church positions the immigrant woman as the “natural careworker” while invoking a social justice discourse in support of immigrant rights. The Church literally places immigrant women into their “proper” place in Italian society as workers to support the Italian family, and, by extension, the larger Italian society.

In this chapter I will first discuss the relationship of the Catholic Church to the Italian state, describe the organization of the Church and the way it operates in the context of Genoa, and then examine national holidays as an example of the historically intertwined relationship between the Church and the Italian government. After providing demographic information on immigrants in Genoa, I explain why the Catholic organizations are so important in serving the needs of Italian families and immigrant workers and how these organizations operate. Finally, the discussion focuses on how parish churches at the local level are sources of social support, operate using cultural power-brokers and serve to discipline workers and employers in carework arrangements.

**Political Relationship of Catholic Church to Italian State**

As previously noted, after 1970, the Italian state addressed issues of immigration and dealt directly with immigrants due to the increased numbers of immigrants arriving in Italy from a variety of countries (Ammendola, et al. 2004:5). The Catholic Church worked directly with immigrants, and also with immigration law, as further explored in chapter 7 in the discussion of the *Pacchetto*. The Church has worked with immigrants in Italy as one of its pastoral missions, based on a social justice agenda and its human rights discourse (Caggiano 2005; Garau 2010:161).

The foundation for the Church’s human rights discourse is based in the history of the relationship between the Italian governing structure and the Church. For instance, in the 1960s, Pope John XXIII facilitated many changes via the Second Vatican Council,
which “opened a new phase in the relations between church and society in Italy”62 (Ginsborg 2003:261). The Pope was able to enact the Council’s critical resolutions because of the moves made by his predecessor, Pius XII, away from the Church’s involvement with politics and toward an emphasis on the pastoral and spiritual role of the Church. The term “involvement with politics” refers to the activity of the Church beginning with the crusades of the 11th, 12th and 13th centuries and up to its anti-communist work during the World Wars (Ginsborg 2003:261-262).

The Lateran agreement of 1929 solidified the separation between Italy and the Catholic Church as independent political entities (Coppa 1999; Pollard 1985). The Pope is the head of the official Church, governing at the level of the Vatican, the worldwide level of the Catholic Church. Today the Church at various administrative levels is involved with politics, but it is as a powerful lobbying organization dealing with specific governments of nation-states, such as Italy, and supranational organizations, such as the European Union and the United Nations (Albahari 2006)63. The Church’s current involvement in Italian politics regarding immigration is discussed further in chapter 7.

It is worth noting that it is not uncommon for the Italian government to support activities that in the United States would be considered “religious.” For instance, it is commonplace to see a crucifix hanging in a public school classroom or courtroom. Italian identity is linked to, and unified by, Catholicism as a taken-for-granted part of cultural life due to the proximity of the Vatican and the strong role of the Church in the

62 The Second Vatican Council was, of course, important in any country where there are Catholics, but for current purposes I am remaining focused on Italy. This Council confirmed the large shift away from how the Vatican was involved in Italian-based politics seen over large portions of history to the political statements of the Church vis-à-vis the Vatican today, most of which are based on a human rights agenda.

63 Interesting to note is that the Vatican has the same status in the United Nations as that acquired by Palestine in November 2012, as non-voting, non-member, observer nation (UN News Centre 2012).
pre-republic history of what is now the nation-state of a unified Italy (Black 2004:22-23; Holmes 2000a).64

Administration of the Catholic Church in the Context of Italian Cities

At all of the various increasing levels of its organization—parish churches, the Diocese of Genoa, the Church of Italy, the Vatican—the Catholic Church is involved in the lives of immigrant careworkers and elderly Italians in Genoa. The Catholic Church is organized by parish (neighborhood), and then the many parishes in a particular geographical area constitute a diocese, which is headed by a bishop. There are 157 parish churches within Genoa’s city limits, with approximately one third having one priest, assisted by parishioner volunteers or a lay deacon (a parishioner with some theological training) (Chiesa Cattolica Italiana 2011). In this setting, the Diocese of Genoa is the official regional administrative body of the Catholic Church in Italy for all of the parishes in the city.65 The Diocese itself is one of multiple diocese in the metropolitan area, the head of them being an Archbishop, a position overseeing multiple diocese and with more power than a bishop (Chiesa Cattolica Italiana 2011). The Catholic Church of Italy is one of many national entities worldwide that together operate under the administration of the Pope, also known as the Bishop of Rome. Politically and geographically, the headquarters of the Catholic Church, generally referred to as the Vatican, is a sovereign state that lies within the city limits of Rome, Italy.

The presence of the Catholic Church is overwhelming yet taken-for-granted in Genoa, as it is in many world cities. One rarely has to walk more than a few blocks to find a parish church. On a street filled with halal butchers and shops catering to a

64 The intertwined relationship of the Church and the Italian government is written into the tax code. Since 1984, tax-paying Italians may designate that .8% of each personal income tax dollar be given to a fund that supports religious institutions in Italy. The citizen-donor can specify which denomination will receive his or her donation. The Catholic Church receives the majority of these funds (Governo Italiano: Presidenza del Consiglio dei Ministri 2012).
65 The Diocese of Genoa is one of 225 in the city that together comprise the Church of Italy there (Chiesa Cattolica Italiana 2011).
largely Muslim population, the Virgin Mary and other saints’ icons remain in the wall and corner displays that were established centuries ago, and maintained last week. In addition to the physical reminders of the historical role of the Catholic Church in Italian life, are the reminders woven into the calendar.

**National Religious Holidays**

The Italian state holidays largely follow the Catholic Church holiday schedule. One example is December 8th, the feast day of the Immaculate Conception, a day when Moroccan, Bangladeshi and Somalian construction workers are happy to have an "Italian" holiday. When asked, Italians and immigrants may acknowledge that although this date may have a history in the Church, now it is a "truly Italian" holiday, meaning mandated by the government. Even the term for “state holidays,” festivi, comes from the Church and its feast (or holy) days.\footnote{Festivi is derived from the early Italian/Latin word festa connoting a religious holiday (for explanation in English see Douglas Harper in the Online Etymology Dictionary, 2001-2012; in Italian, see www.etimo.it/?term=fasta&find=cerca).} This word is found in official Italian government communication such as regional bus schedules, national train information, and in the Italian post office. In addition most regions and/or metropolitan areas in Italy have one or two additional days off related to their local saint's feast days (Carroll 1996:20-23).\footnote{For instance, only the cities of Genoa, Turin, and Florence celebrate the feast day of Saint John the Baptist on June 24th every year (www.italylogue.com/festivals). Only Genoa celebrates the feast day Saint Catherine of Genoa on September 15th every year (http://www2.comune.genova.it/).}

When state holidays take place, immigrants and Italians alike purchase foods associated with Catholic feast days. Interestingly, these may often be the savory pie associated with Easter baked by Egyptians. The “pope's hat” sweets for Easter are produced by pastry shops that often employ Moroccans (often religiously Muslim, see table below) as candy artisans (Ammendola, et al. 2004). It is not surprising, then, that many social scientists consider the Catholic Church a deeply Italian cultural institution (Albahari 2006; Macioti 2000). Ricceri, an Italian scholar of religion notes, “Catholicism
goes deeper into the national psyche than a concept of homeland and has become a
cultural glue” (2007:2). This implies that Italians and even some immigrants practicing
their Italian-ness may blur the line between what is a Catholic cultural practice and what
is an Italian cultural practice.

**Demographics and Religion - Immigrants and Italians in Genoa**

There are practical motivations for the Church to be involved with immigrants in
Italy and in Genoa. As can be derived from Tables 6.1. and 6.2. below, large numbers of
immigrants are from countries where Catholicism is the dominant religion in the same
way it is in Italy. The largest group of immigrants in Genoa is from Ecuador.

**Table 6.1. Composition of the Population of Documented Immigrants in Genoa by Country of Origin**

<table>
<thead>
<tr>
<th>Country of Origin (top ten)</th>
<th>Number of documented immigrants in Genoa, 2008</th>
<th>Percentage of the total number of documented immigrants (54,917) in Genoa, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ecuador</td>
<td>16,774</td>
<td>30.54%</td>
</tr>
<tr>
<td>Albania</td>
<td>6,869</td>
<td>12.51%</td>
</tr>
<tr>
<td>Morocco</td>
<td>4,637</td>
<td>8.44%</td>
</tr>
<tr>
<td>Romania</td>
<td>4,303</td>
<td>7.84%</td>
</tr>
<tr>
<td>Peru</td>
<td>2,721</td>
<td>4.95%</td>
</tr>
<tr>
<td>China</td>
<td>1,452</td>
<td>2.64%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>1,452</td>
<td>2.64%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1,323</td>
<td>2.41%</td>
</tr>
<tr>
<td>Senegal</td>
<td>1,163</td>
<td>2.12%</td>
</tr>
<tr>
<td>Tunisia</td>
<td>810</td>
<td>1.47%</td>
</tr>
</tbody>
</table>

Source: ISTAT census on December 31, 2008

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Genoa and Torino have unique immigration patterns when compared to other Italian cities. They are the only two cities where Latin American immigrants are the largest percentage of the immigrant population (ISTAT 2011). Peruvians are the largest group in Torino and Ecuadorians are the largest group in Genoa.
In fact, immigrants from Ecuador comprise only 2.06% of the population of documented immigrants in Italy (ISTAT 2009a), but make up more than 30% of the documented immigrants in Genoa. Female Ecuadorian immigrants have dominated the carework sector in Genoa for more than a decade (Lagomarsino 2005; Vento 2004).

As reported by other researchers (Castellanos 2004), ISTAT, the census-taking arm of the Italian government, does not collect “sensitive” data, which “includes data on religious affiliation of its citizens” (European Monitoring Centre for Racism and Xenophobia 2006:30). Therefore, Italian census information on the religious preferences of immigrants and citizens is not available. To inform an understanding of the religious profile of major immigrant groups to Genoa, the religious profile of the top ten countries of origin for immigrants to Italy in 2008, derived from US Central Intelligence agency data, are gathered below in Table 6.2.

Table 6.2. Religious Preference of Documented Immigrants in Genoa by Country of Origin (top ten)

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Religious preferences in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ecuador</td>
<td>95% Catholic, 5% other</td>
</tr>
<tr>
<td>Albania</td>
<td>70% Muslim, 20% Christian orthodox, 10% catholic,</td>
</tr>
<tr>
<td>Morocco</td>
<td>99% Muslim, 1% Christian, 6,000 Jewish</td>
</tr>
<tr>
<td>Romania</td>
<td>86.8% Eastern Orthodox, 7.5% Protestant, 4.7% Catholic, 1% Muslim/Other</td>
</tr>
<tr>
<td>Peru</td>
<td>81% Catholic, 12.5% Evangelical, 3.3% Other, Unspecified/None 2.9%</td>
</tr>
<tr>
<td>China</td>
<td>Officially Atheist, 3-4% Daoist/Buddhist/Christian, 1-2% Muslim</td>
</tr>
<tr>
<td>Ukraine</td>
<td>76.5% Ukrainian Orthodox, 8% Ukrainian Greek Catholic, 7.2% Ukrainian Autocephalous Orthodox, 2.2% Roman Catholic, 2.2% Protestant, .6% Jewish, 3.2% Other</td>
</tr>
</tbody>
</table>
Table 6.2. Religious Preference of Documented Immigrants in Genoa by Country of Origin (top ten), continued

<table>
<thead>
<tr>
<th>Country</th>
<th>Religious Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>69.1% Buddhist, 7.6% Muslim, 7.1% Hindu, 6.2% Other Christian, 10% Unspecified</td>
</tr>
<tr>
<td>Senegal</td>
<td>94% Muslim, 5% Christian, 1% Indigenous Beliefs</td>
</tr>
<tr>
<td>Tunisia</td>
<td>98% Muslim, 1% Christian, 1% Jewish</td>
</tr>
</tbody>
</table>


Among the careworkers interviewed for this research, all of the women self-identified as Catholic during our time together and/or participated in Catholic worship activities. In Genoa, immigrants are an increasing proportion of the parish church population and sustain the importance of the Catholic Church in daily life in Genoa; this is not unique to this city but it is very visible in Genoa (Macioti 2000). Also it is obvious in Genoa that the immigrant careworkers play an important role in the lives of elders, who are a critical group in parish churches as important everyday participants in parish cultural life.

Throughout Italy, older Italians and immigrants of all ages are the most consistent participants in Church activities (Magister 2010; Ricceri 2007). Demographers in two Italian studies concluded that adult parishioners born after 1981, those now 30 years old or younger, had a significantly lower involvement in Church activities, likelihood of belief in Catholic ideals, and participation in mass, measured by data from in-depth survey work with Catholics and non-Catholics, population data, and information from the Church (EURISPES 2006; Ricceri 2007). EURISPES, a private institute found that 87% of Catholics in 2005 considered themselves to be Catholic believers. In addition the researchers found that 30% of those who considered themselves Catholic participated in Church activities, such as prayer, confession, or mass more than twice a year (EURISPES 2006).
Italy is an overwhelmingly Catholic country, especially when the definition of being Catholic means being baptized in the Catholic Church (Ricceri 2007:4). One statistical analysis based on the diocesan reports in 2006 found that 93% of the population of Liguria was Catholic (Cheney 2005b). My observation was that daily mass in Genoa was attended almost exclusively by elderly Italians and their immigrant caregivers. Weekend masses included children of parish schools and their parents, and more adults of all ages, often accompanying a family elder. Neighborhood church groups—“parishes” or “congregations”—are important sites for the activities that influence immigrant careworkers. In addition, the volunteer and non-profit organizations active in Genoa and associated with the Catholic Church provide important support for many in need (see Appendix F).

In the next sections, I discuss the activities of the Church at the parish and diocese level relevant to elders and immigrants in Genoa. These include: the Catholic organizations serving elders and immigrants with direct services; the parish church activity that serves elders and the activity in Genoa focused on Latin American immigrants; and the Diocese of Genoa’s investment in immigrants in Genoa, most evident in the immigrant center at Santa Lucia. First I will discuss the Catholic Church as a state-like actor that has addressed the needs of elders.

The Catholic Church Provides Care in the Absence of the Italian State

Long before any neoliberal priorities reduced public funding for social support programs, service agencies with ties to the Catholic Church were providing direct services to low-income Italians, elders with needs, and immigrants and refugees. The historical and political trajectories related to this have been discussed in chapter 4. For decades, the Italian system relied on families and non-governmental organizations (NGOs), such as the Catholic Church, to provide services. Immigrants from a variety of countries have entered Italy in significant numbers since 1970 (Triandafyllidou and
Ambrosini 2011:252-253); and the number of refugees entering Italy has also increased significantly in this same time frame. The NGO “system” of services in place prior to 1970, when immigrants and refugees began arriving in significant numbers, simply expanded and adjusted to meet the increased and changing needs (Gori and Pasini 2001; Paniagua 2009).

The Italian state, on the other hand, has not responded to the increased needs of its native-born citizens, but rather has cut back on resources, making it even more difficult for an Italian citizen to qualify to receive payments or services. The immigrant careworkers I interviewed, even those with documents, could sometimes qualify for social service assistance in the form of social worker support, but rarely did they qualify for any payments (Devolder, et al. 2008; Gori and Pasini 2001). Social workers in Genoa referred immigrant clients (with documents) to non-profit agencies for counseling; facilitated situations at school for the child of the immigrant, with a landlord, or in a legal situation.69 See Appendix F, which gives an account of services directed toward elderly Italians and Latin American immigrants in Genoa. The Ligurian (regional) and Genoa (city) governments has often worked with and supported individual parish activities, non-profit agencies, and organizations associated with the Catholic Church, such as Caritas and Sant’Egidio, to meet the needs of immigrants (documented and undocumented), refugees, people living with disabilities, poor and/or homeless people, and elders without family (Ammendola, et al. 2005; Gough 1996; Rossi 2011).

69 In Summer 2008 during predissertation fieldwork I learned about what it meant to have social services support in Genoa during discussions with social workers and academic researchers who had conducted research with immigrants and their social workers. In Fall 2010 Genoa government health and social service administrators confirmed that these same services for immigrants in the form of social worker support still exist.
Sant’Egidio Serves New Immigrants and Refugees

Sant’Egidio is a worldwide organization\textsuperscript{70} that began as a grassroots movement reacting to the death of a refugee in 1968 in Milan and whose direct service provision, prayer services, and peaceful marches are motivated by the ideals of social justice linked to Catholic ideals\textsuperscript{71}. In Genoa, Sant’Egidio has a well-trained and organized team of volunteers working out of two office spaces in the city, providing direct services to new refugees and immigrants in need. There are 110 volunteers and a few paid staff involved in weekly work, and a much larger general membership in Genoa. Their services include: Italian language classes serving 600 students per year\textsuperscript{72}; food distribution and free hot lunches serving 200 lunches per week\textsuperscript{73}; and, assistance with government paperwork and appointments, i.e., for accessing the Italian National Healthcare System and applying to the immigration system (Rossi 2011).

Caritas Provides Ongoing Support for Immigrants via Listening Centers

The second organization discussed here is one of the Catholic Church’s strongest charitable arms, Caritas\textsuperscript{74}. Located in every medium- and large-sized city in Italy, this agency’s caseworkers serve individuals, families, and households access a

\textsuperscript{70} In the United States, for example, there are Sant’Egidio groups in New York, Boston, Washington, DC, South Bend, and St Paul-Minneapolis. One reason these groups started is the large numbers of Italian immigrants that settled in these cities over the past four decades. These are also cities that receive high numbers of immigrants and refugees.

\textsuperscript{71} I attended the four prayer services and processionals for peace based in two large cathedrals near Genoa’s Centro Storico (historical center).

\textsuperscript{72} I participated in and observed the language-learning activities of the Sant’Egidio office in my neighborhood.

\textsuperscript{73} One example of direct service to Italian elders is the Sant’Egidio Christmas lunch, aimed specifically at poor people, refugees, immigrants and the anziana da sola (the elderly person living alone). People are informed of the luncheon via announcements in churches and at language classes, and encouraged to sign up for the meal, which is very popular. As a volunteer server at this Christmas luncheon, I found this event highlighted what some Italian elders and some immigrants have in common—they are poor and isolated and need a little help finding resources to get by day to day. Any time of the year, a neighbor who is worried about an elderly person without visible family may stop by to get a Sant’Egidio food box for the elder.

\textsuperscript{74} This organization is comparable to Catholic Charities in the United States, in that it employs case managers and social workers. For decades, it has provided statistical and demographic information regarding both documented and undocumented immigrants to policy makers and scholars of immigration in Italy.
variety of needed services (2008) described in Appendix F. Latin American immigrants in
Genoa live all over the city, and a variety of neighborhood parishes provide services to
these immigrants. Many parish churches in Genoa have a centro d’ascolto (listening
center) (Caritas 2008) which consists of a small room with a food bank and donated
clothing and household items, staffed by parishioner volunteers (often retirees) and
perhaps a brother or nun from a local religious community or the local Caritas office.
These are places open one or two designated times per week, for 2 hours at a time.
People at the Diocese immigrant center, city/county social workers, the Red Cross, the
caseworker at Don Bosco (a site discussed below), and Italian and immigrant individuals
often refer people to these centers. Food and clothing distribution to people who arrive
with need is the main activity of these centers; the items distributed having been
collected by Caritas.

As implied by the name, listening centers are places where people can talk about
a variety of concerns, such as: personal problems, marginal housing, concerns about
family back home, or the trials of being an immigrant in a new culture. In these centers
those seeking help are sometimes referred to a more appropriate agency for other
needs, such as legal assistance, language classes, housing, job training and placement,
and healthcare. These referrals often involve the listener using his or her personal
contacts, in and out of the network of agencies, to provide help. Most often the
volunteer pulls out a cell phone, finds a number and name to hand along, or makes the
call on the spot. I did not observe fear on the part of the immigrants using these
listening centers. I observed a brother in a religious community listen to a woman
expressing her fears over losing her carework job; and one day older Italian ladies
listened to a new speaker of Italian painstakingly describe her family situation and
concerns for her children’s care back home in Morocco. For over an hour the volunteers
listened as they sorted clothing and encouraged the immigrant woman to take what she needed.

When an immigrant couple at the Don Bosco Latin American community described the “listening centers” to me they said,

Some of the people you will see there are in a bad way, closer to desperate, they are not established and blessed as those of us you see here at mass every week. This is another reality. It can be hard to be a new immigrant.

These two community leaders were ensuring that I understood the breadth of experience of immigrants in Genoa. They understood that I was interested in speaking with careworkers who had both a work history and a health history in Genoa. I had explained about wanting to talk with women from South American countries who had worked in Italy for at least four years. However, the community leaders directed me to the listening centers so that I would understand how the quality of life for immigrants changes over time. Also important to note is that in the Church community I was seeing one particular slice of the immigrant population, one that was generally successful in their immigration goals. Because I chose to interview careworkers from South American countries with at least four years of work experience in Italy, my understanding of the variety of experience of immigrant careworkers was limited to those who had been successful at establishing themselves, i.e., by finding housing and work.

**Services for Elders from the Neighborhood Parish**

At the neighborhood parish church level, elderly Italians receive necessary social support. During summer 2008 and during the 10 months from October 2009 until July 2010, I learned about these social support services when I participated in weekly senior club meetings at one parish, and observed worship participants at a variety of neighborhood Catholic Churches. Staff and volunteers made “weekly rounds” to a number of house-bound Italian elders in every parish. Many participants on active
church committees, such as those in charge of clothing distribution and worship liturgy, consisted of parishioners over 65, and senior-focused activities were offered in most neighborhood churches. For example, senior groups often met weekly to play tombola (bingo) and card games, share conversation and snacks, and occasionally participate in a mass or devotional activity.

My first full day in Genoa, I met a group of elders in front of San Siro, a church in the historical center neighborhood, selling raffle tickets for rummage sale items. During our conversation on the street, they informed me that the proceeds would help to fund one of their day trips to a nearby seaside town. Upon their invitation, I attended weekly meetings, and there learned more about their individual interests, living arrangements, and daily challenges and strategies. For example, one 81-year old woman, Rosetta, told me that she had her son and daughter-in-law to call her every day, “to make sure I am still here.” Rosetta’s family also visited her once a week to help her with heavier household tasks. She said, “I shop every day and my friend cannot see or hear very well and sleeps a lot, so it is easy for me to take care of her, too.” Rosetta was living with her tombola and card table companion, Alma, who required assistance with communication and movement. The ability to get out of the house and shop every day was a symbol of healthy living for Rosetta. When I asked about hiring a careworker to assist in the home, Rosetta gave a contemptuous snort,

To do what? I can take care of what needs to be done. When I hurt my foot, I had everything delivered by the shops near my street. I have been a good customer all of these years. My family helps me, so why can’t I help my friend? It is hard some days, but we get by.

The church volunteer and part-time paid social worker in charge of the senior group and some active elders from the group often called or stopped by to visit other seniors from the parish during the time between weekly (Tuesday) afternoon activities and a weekend mass. If someone who was a regular did not appear for coffee and
pastry, a call was made or a couple of group members would make the short walk to call upon the missing member in person. The volunteer at San Siro said,

    We are a family, and we need to take care—of ourselves, of each other. It is easy for an old person, especially one who cannot walk so well, to spend too much time alone and perhaps become lonely. Depression is a problem that we do not need.

It is often following such a conversation that a parish community member in the “social worker” role would try to connect an elder such as Rosetta (or her family) with parish-based senior support and/or a careworker that the household could afford. This social worker was most often a part-time worker, a person in a religious order working with that parish, or another parishioner-volunteer. These conversations often took place before or after programs held in parish churches. Since most of the participants in activities and daily mass are elderly, and they most often walk or use public transportation, the neighborhood-focused parish, in which parishioners live near the church building, was thriving in Genoa.

**The Catholic Church at the Level of the Diocese Serves Immigrants**

Of the 157 parish churches located in the city of Genoa, ten of them have some level of ongoing engagement with the Latin American immigrant community. This research focuses on two of these parish churches. The Diocese of Genoa has established an immigrant center community, Santa Lucia, specifically for immigrants from Latin American countries and supports the work of this community by providing a prime facility, key church personnel, and payroll for a lay community coordinator.

The Diocese also provides support to the development of a Latin American community within a thriving community parish, Don Bosco. Here, the Diocese is developing a Latin American church community, which brings together South American immigrants from neighborhoods all over Genoa. This development is partially funded by
the Ligurian regional government and the Genoa city government, explained in detail below.

Diocese of Genoa plus Public Monies for Integration Programs

Don Bosco has a great deal of community space, which is used in service of the shared goals of the city/regional government and the Diocese to aid in the integration of immigrants into Italian civic life. The facility was large and user-friendly, likely the most useful space of all parish churches in Genoa. The offices, playgrounds, soccer fields, fellowship hall, and meeting rooms have served as a community center for decades. The community members using the space have changed from only Italians and Italian youth who attend nearby schools to a mix of these same Italians and immigrant adults from a variety of continents, some with children.

It is here that Paola, a community resource worker paid by the Diocese, uses her vast network of informal and formal contacts to serve immigrants. Her tasks range from providing legal services for those working to bring family members from South America to join them in Genoa to developing a careworker support group focused on stress management. She works closely with Father Karim, who coordinates her work and other programs for the wider immigrant community.

During my time in Genoa, activities at Don Bosco, listed in Appendix F, included an after-school program that provided tutoring and activities for children of immigrants (most from Morocco and other North African countries, Ecuador and other South American countries) and Italian citizens. Many of the children in this program had immigrant mothers who worked as careworkers. In addition to Paola and Father

75 My partner volunteered at this after-school program, in part, because of the importance of a similar program in his own family’s history. His father was the oldest child of a young couple that immigrated to San Francisco from southern Italy in 1904. In order to provide for their family, they both worked in low-wage jobs, and their children, including my partner’s father, attended the Don Bosco after-school program at Saints Peter and Paul Catholic Church in North Beach, then the
Karim, there were usually at least two men and one woman (religious brothers and a sister, or nun) from local Catholic religious communities, part-time workers such as tutors for the after-school program, volunteers, and counselors on contract to work at Don Bosco.

The Diocese of Genoa combines its resources with funds from the regional and city governments to support immigrants by offering programs at Don Bosco named in the table which supported an “integration” project at Don Bosco to aid immigrants in participating in work, religious, and civic life in Genoa. The parish church had three priests, one Spanish-speaking deacon, a lay deacon involved with the development of the community, Italian volunteers organized into committees, and a dozen Latin American volunteers.

At Don Bosco, a lay church worker whose salary was paid by the Diocese used the combined funds of the Diocese and the local government for the activities related to the development of the Latin American Community of Don Bosco (an official name). I was not privy to the budget of this enterprise; however I was present at “coordinating meetings” which were held to plan Community activities and establish priorities for using resources. Those with the most influence on how the money was spent were the lay church worker, the Italian priest who conducted the Spanish-speaking Sunday masses, and the ten community members who attended most coordinating meetings.

I celebrated at gatherings such as the Mother’s Day lunch, marched in the processionals such as the one for the patron saint of Lima, El Señor de los Milagros (The Lord of Miracles), and cooked for one of the weekend retreats. Along the way I learned about the short history and current development of the group. The Don Bosco Latin Americans were proud of their participation in the humble beginnings of this

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"Italian" neighborhood in San Francisco. In some histories of San Francisco, it is referred to as the first childcare program in the city (Issel, 2010:34-35).
community. Several community members recounted how just over two years before my arrival, they started in 2007 with one guitar player, two singers, the priest and sometimes only six parishioners at the Sunday Spanish-language mass. Angel, the guitar player, recounted,

We kept coming, every week, huddled together in a little group in that big sanctuary. This was before Renaldo (the lay Church worker who leads this community now). The church workers at Santa Lucia said, “Help us get this (the Latin American community) going,” and we did. Thanks to God.

Angel refers to Santa Lucia, the parish church and diocese immigrant center that has been focused on Latin American immigrants for the past 12 years. Santa Lucia is discussed at length in the next section and plays a continuing role in the lives of immigrant careworkers.

The Diocese establishes a Place for Latin American Immigrants

Over twenty years ago, the Diocese of Genoa decided to convert a space adjacent to an important church building, Santa Lucia, into an immigrant center, near the shopping and government center of Genoa. This investment was made in response to the large influx of immigrants, the availability of the space, and the Diocese’s leaders’ interest in serving this growing group of parishioners. In the early days, it served all types of immigrants, but later focused on only Latin American immigrants in Genoa. During this time programs developed for a variety of ages within this population as the immigrants remained in Genoa, married, and produced children or brought their family members to Genoa from “home.”

At Santa Lucia, three Franciscan priests, all originally from Peru; a part-time community coordinator, an immigrant from Ecuador; a Spanish-speaking Italian nun; mental health professionals; and a cadre of immigrant volunteer leaders served a very active community. Every Saturday the large ornate sanctuary and the immigrant center were bustling with the Latin American immigrants who arrived to clean the spaces,
everything from the showers in the center bathroom to the area in the church sanctuary surrounding the “miraculously preserved” remains of the patron saint, Lucia, of Genoa. After a long morning of work, everyone remained to share a large traditional “South American-Italian” lunch, produced every week in a tiny indoor-outdoor kitchen. The classrooms and storage areas were well utilized throughout the week to serve a variety of age groups in the Latin American community, as described in Appendix F. The events involving the most people were the Friday evening prayer service in Spanish (100 participants), the “standing room only” Sunday Spanish-language mass (400 worshipers); and the bi-weekly careworker classes (90 students on average).

Some women stated in interviews and some general community members discussed that they had not found the Church to be so important in their life back in Peru or Ecuador. Most of the time, they were discussing their spiritual activity and participation in church rituals, such as weekly mass. Padre Gilberto, a priest from Peru serving the Latin American immigrant center at Santa Lucia, coordinated the general parish activities in the church. He confirmed this idea when he described the efforts to serve immigrants, especially careworkers:

We know that these women can get food from other sources. Listen, Italians will never let anyone go hungry, and clothing is from a centro d’ascolto. And they generally can find a place to live to get started, but they come here for help to find a job. We know that they may not be seeking out religious guidance or have an interest in spiritual affairs, but we slip that in as we serve them as we best know how.

The work that Suor Carmen does to train and find jobs for careworkers is the real reason they arrive at Santa Lucia. But we try to provide two other things, a way to feed their spirit, and a community for them to help them remain connected to others when they are in a new place—this is especially important.

These and other programs initiated by the Catholic parish communities, the service organizations, and the Diocese-sponsored Center for Latin American immigrants in Genoa were all important to meeting the emotional, social, religious, and/or practical needs of immigrants. Generally, these were needs defined by the careworkers, and
those who served them, both in and out of Catholic Church organizations in Genoa. The idea of community, especially as a safe place to practice a new language (Italian) and to speak a mother tongue (Spanish), appealed to Latin American immigrants from a variety of socioeconomic classes, and levels of education and experiences.

A place for gathering was important, and this immigrant center at Santa Lucia was the only one of its kind in Genoa. It was busy most nights of the week, and bustling with activity from Friday through Sunday. Most immigrant careworkers had Saturday afternoon and evening and all day Sunday off from work, and spent much of their time here. If a person had a live-in position, she may have had the opportunity to spend two nights a week in a friend’s apartment, often without a bed for sleeping. For most women who were living and working in the same space, it was important to be out and in giro (around, circulating) whenever possible. Different from Parreñas’ findings in Rome with Filipina domestic workers (Parreñas 2001b), Latin American workers in Genoa were generally comfortable in visible, public spaces such as parks, markets, and cafés. Santa Lucia provided a more private space where they were likely to find other native Spanish speaking immigrants. In many interviews, careworkers reflected in a fashion similar to that of Veronica,

I cannot always go to a café and spend money… I do not want to go to a disco… I will not spend my money on a restaurant like a tourist, where can I go? …If they do not have to lock up soon after mass, this (indicating one of the churches with a Spanish-language mass) is a good space.

Many workers and their families remained in the courtyard garden of the Santa Lucia immigrant center or the outdoor areas near the soccer pitch at Don Bosco after the Spanish-language masses on the weekends. During the week I often encountered Latin American immigrants in the classrooms, the kitchen, and the courtyard of Santa Lucia. These were semi-private places where they felt welcome.
The idea of a place was important but trusting relationships within such a place were equally important. The immigrants frequenting the Santa Lucia immigrant center trusted that the Church leaders had their best interests at heart, at least in terms of providing help finding a job. This trust was based on their experiences with church workers in the past, the word-of-mouth reputation in their immigrant community, and because Suor Carmen and others spoke Spanish and offered necessary job search assistance. This is similar to the findings of Solari (2006b) and Caggiano (2005), social scientists who studied the ways that immigrants to Italy interacted with and perceived religious institutions in Italy.

One situation I witnessed exemplified a church worker protecting immigrants and securing their trust, in the tradition of the Church providing sanctuary. Suor Carmen was in a standoff with an officer from the *carabinieri* (state police) who arrived during careworker class. I could not hear what was being said in their conversation at the back of the room. It appeared that the official was interested in information from her and/or in talking with someone in the group of 100 immigrants gathered for the class. Suor Carmen continued listening, shaking her head and index finger, all with a tight smile. She sent the uniformed officer and his clipboard away after a ten minute conversation. To my knowledge he never returned.

I never learned what was said in the intense exchange, or what the officer wanted that Suor Carmen would not give him. I did learn that the arrival of a government official at Santa Lucia was very unusual and the following week two women speculated in their conversation with me that it could have been related to the new laws that had been on the books for six months at the point of the visit by the policeman in January 2010. Ana discussed the incident,

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76 Here the term *sanctuary* is related to but slightly different from the definition in the New Catholic Encyclopedia (2012), which defines sanctuary as, “A consecrated place giving protection to those fleeing from justice or persecution; or, the privilege of taking refuge in such consecrated place.”
So you were there! You could see with your own eyes. She would not let any officials or police or immigrant officers near us. She sent that guy away (Ana laughs). It was so great and so typical of her. She expects a lot of us, but she is also big hearted and will do the right thing for us. She is Italian, but she understands our situation.

Ana was pointing to the dedication of Suor Carmen and the trust that the Latin American parishioners had in her, but her comment also pointed out the power of the Church in relationship to the Italian state, and the Church’s power to protect immigrants. As discussed in chapter 7 the Church has exercised its power with the state to promote more humane immigration policies, pushed back against harsh immigration laws, and has continued to be a safe haven for immigrants. As discussed below, and as mentioned by Ana in the above quote, the Church also expected immigrants, especially Latin American women, to fulfill a particular role in Italian society. The Church worked to keep them in that role as it aided them in achieving their immigrant employment goals.

Careworker Training and Placement at the Immigrant Center

Every Tuesday and Thursday afternoon the sala (classroom) at Santa Lucia served as an essential site for Latin American immigrants seeking carework in Genoa. I first attended these caregiving classes in summer 2008, when there were often 30 women in attendance. During the 10 months I attended the classes from Fall 2009 to Summer 2010, the number of attendees grew steadily, ultimately reaching 170, and often one-quarter of the attendees were men. The increase in attendance was due to the economic downturn occurring at this time in many places on the globe, including the United States. The economic decline meant that more immigrants arrived needing jobs. In spring 2010 it was not only recent female immigrants who crowded the sala. By March 2010 the attendees were more often men and women who had worked and lived in Genoa for many years and were now out of work.

The composition of the class attendees changed due to the way the Diocese chose to serve various immigrant groups. In summer 2008, there were immigrants from
a variety of countries at these classes. My field notes show that I met women from
Albania, Belarus, Ecuador, Peru, Bolivia, Cuba, Haiti, Romania, Morocco, Tunisia, and
Bangladesh. By the fall of 2009 the classes at Santa Lucia were designated for those
from Spanish-speaking countries. Non-Spanish-speaking immigrants were sent down
the street to another parish church, Santa Zita. At Santa Zita immigrants from Eastern
European countries attended carework training and placement classes. I learned this
firsthand, as, due to my appearance (light-colored hair, eyes, skin), women assumed I
was “Eastern” and helpfully tried to redirect me to Santa Zita for resources. I would
explain who I was and that I had permission to watch, listen, and learn by attending the
classes at Santa Lucia.

In these trainings I came to understand that the Catholic Church conceptualizes
care done in elders’ homes in two ways. First is the conceptualization of care as an
obligation that springs from Christian traditions: the notion of Christ’s love in action. This
is care as an ethical obligation (Bubeck 1998; England 2010). The second
conceptualization is of care as work, and the care of an elder at home as a set of tasks
necessary to maintain the ideal Italian family (Lyon 2006; Stack and Provis 2000:210).
These two perspectives on care were visible in how the caregiver classes were
structured at Santa Lucia. The twice weekly afternoon classes consisted of an outside
speaker regarding a resource or skill (care as a set of tasks), and a devotion led by one
of the priests (care as an ethical obligation). Additional presentations at Santa Lucia caregiving courses include but are not limited to the
following: language and job-skill training from Region of Liguria; opportunities to get “careworker certification” at other sites; information on nutrition for the elderly; workers’ rights in the home
information from labor unions; and information about mental health resources for undocumented
workers.

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The skills-based trainings included Italian cooking, diabetes management, adult diaper-changing and bed-based care. In addition, Suor Carmen brought in speakers to provide information on ways for immigrant workers to care for themselves, for example, stress management via guided imagery, talk therapy opportunities in various non-profit agencies, and family reunification information. The breadth of speakers highlighted the network of resources for immigrants in Genoa, the ways in which the Church and governmental organizations cooperated, and the scope of programs presented under the heading of “careworker” preparation.

Each meeting generally lasted for two hours but sometimes as long as three. Afterwards Suor Carmen’s helpers reviewed each careworker’s applicant file. Each file consisted of a photocopy of an identity card photo or a photo supplied by the immigrant along with contact information, usually a cell phone number. The file also named: immigration status, meaning documented or undocumented; work experience in Italy and in home country; family information, including which family members reside in Genoa; and number of months in Italy. The immigrants needed to name a preference for type of work; the types listed on Suor Carmen’s form included: live-in, live-out night work, live-out day work, and hourly work to supplement the services of a live-in careworker.

Suor Carmen had two assistants, both Latin American immigrant men relicensed as nurses in Genoa, who worked with this confidential information. One of these two helpers carried Suor Carmen’s cell phone when she was away from this work. These assistants were trusted with her keys, which opened the two room doors and a cabinet door to get to the storage place of the files containing careworker information. When I talked with one of these men, he made a point of telling me,

Listen I cannot get to those files without the keys that Suor Carmen keeps. Unless she is away and then she hands them to me in front of the priest, so it is clear I must take this seriously, this trust.
The keys represent the power for protecting the individual personal information in a file, and by extension, the individual dignity of each person with a file. Another power contained in the file is the potential for finding a job. For these reasons the handling of the keys was of great importance. By involving the priest, a third party, the assistants and Suor Carmen encouraged and maintained the trust of the immigrants involved in the careworker placement class.78

Suor Carmen’s cell phone was often ringing during these three hour classes, and as she joked, “Not often enough with a job for one of you!” By this she meant that there were more careworkers seeking jobs than there were families seeking employees. Generally, Suor Carmen or one of her assistants was the job placement agent. On occasion, after receiving a call from a prospective employer, Suor Carmen or a helper would call out three names in the middle of a class, and then send the three women to be interviewed immediately. The standard was that Suor Carmen would send three candidates for each job. She decided what sorts of positions were right for which individuals, regardless of what an individual named as a preference and in this gatekeeping work exercised her power as a broker/patron. As she noted one day,

Listen, some of you who now have your children here. I know you may want night work or live-in work for the higher wage, but you need to take care of your family, your children, be with your husband. I will send the worker who is here alone for those interviews.

Some of the women sitting near me softly commented, “Why does she ask us our preference? We have to do things her way.” This comment represented the small, but steady undercurrent of resentment that I learned of from conversations and observation.

78 The two assistants were starting to train two more helpers by January 2010 and all four important volunteers were mobbed at the end of each session by careworkers looking for jobs. This job-information-seeking activity became progressively more intense as the economic crisis started to be felt in Italy and a progressively higher number of immigrants attended these classes every one of the nine months I attended these classes. The number of women grew every week during the 9 months I attended these classes, and men began to attend in greater numbers the last 5 months I was in Genoa.
Complaints about Suor Carmen also punctuated my interviews with women, most of whom had been part of the Santa Lucia class at some point during their time in Genoa. However, these women also pointed out that they believed that Suor Carmen had their best interests in mind at all times, speaking, in my estimation, in deference to her power. Most of the women in the class were concerned with the impression they made on Suor Carmen, in recognition of her power over their economic future.

Suor Carmen’s work involved many Italian and Latin American immigrant volunteers as she served immigrants by providing Italian language classes, caregiver skill classes, and referrals to support services. She epitomized the broker who deals with Italian families needing services, as well as workers in search of jobs, and embodied the “moral” arm of the Catholic Church. The skills building classes, spiritual teaching, and job placement activities together served to control and provide social support to immigrant women in Genoa.

**Brokering Power and Invoking the Moral Authority of the Church**

Because Italians link the Church with the affairs of the Family, the non-believer daughter or the out-of-town nephew assisting a family elder often turns to the Church for help. They find someone at a parish church—an active parishioner, a nun, a priest—and ask this “broker” if they know someone to hire to help out at home (Degiuli 2011). These brokers are mediators between two cultures, in this case Latin American Immigrant worker culture and the culture of the Church linked to Italian family life. Here I call upon Eric Wolf’s definition of the broker\(^{79}\) as someone who serves “both community oriented and nation-oriented groups” (Wolf 1956:1076). In this situation the nation-

\(^{79}\) Wolf also used the terms power-broker and middleman to refer to this person. He originated this in his ethnographic work on the post-revolutionary Mexico political operators (1956) He points out in this important work that “leaders of Indian corporate communities appeared to him to be Janus-faced brokers who must serve some of the interests of groups operating on both the community and the national level, and they must cope with the conflicts raised by the collision of these interests (often acting) as buffers between groups, maintaining the tensions which provide the dynamic of their actions.” (Wolf 1956: 1076).
oriented group is the Catholic Church in service of Italian society. The immigrants seeking work are, in Wolf’s words, “the community-oriented individuals who want to stabilize or improve their life chances, but who lack economic security and political connections” (Wolf 1956:1076-1077). Using Eric Wolf’s important idea of clientelism (Wolf 1966; Wolf 1956) the Church was the patron because it had jobs to offer the immigrant client. These jobs served the - ideal, Italian - Family and in doing so served the Italian state, which has abdicated the care of elders to the Family.

Most parishes in Genoa had some sort of informal system for helping families to find careworkers. The use of churches in Italy for brokering informal labor arrangements for domestic work is a pattern found by researchers working in Italy in the last decade (Degiuli 2007a; Glucksmann and Lyon 2006; Magat 2003). Earlier work reveals that since 1990 Catholic female immigrants have dominated the domestic labor sector as the Church has been involved in these workers’ “recruitment and pastoral care” (King 1993:287).

In Bolzaneto (a neighborhood in the city but far from the center of Genoa), the priest had Italians and a long-term immigrant community leader working together to help match families needing to hire a caregiver with an immigrant careworker seeking a job. In Bolzaneto, jobs were often discussed in the weekly careworker support group as many of these women knew other experienced immigrant careworkers out of work. In a few places, such as Santa Lucia, described above, this was an institutionalized process, namely careworker training and placement courses. In other parish churches, it was a matter of asking around and calling the right person who had become a *de facto* matchmaker or placement service.

These various methods for matching households with needs to careworkers seeking jobs functioned well. As unorganized and diverse as the process to match careworkers to households was in various parishes, this variety was perhaps also a
strength. That is, the system developed in each parish was maintained only if it worked in that situation. Though caring labor is the commodity for sale, I did not hear of any brokers receiving payment or gifts for their efforts. The immigrant careworker parish leader at Bolzaneto summed up the general attitude: “This is a way I can help others, and so many people helped me when I was new. This is an opportunity to serve God and my church community.” The power of the brokers and the problems associated with so much knowledge being held by one or two individuals has a down side. In the more competitive carework marketplace, with higher unemployment in Italy, immigrant women seeking careworker jobs sometimes complained of favoritism and wondered if they were being passed over when jobs became available. If the de facto or casual broker in a church community became unavailable for a time, or had to give up this responsibility altogether, there was often not a plan in place for a new person to fill the broker role.

In contrast to this, at a place with an institutionalized program such as the one at Santa Lucia, there was infrastructure. At least six trained volunteers maintained a system for matching careworkers and jobs, even when the nun in charge, Suor Carmen, was not available. The women who participated in this more organized program sometimes complained about the bureaucracy, but the strong personality and focused communication by Suor Carmen and her volunteers helped make many of the job seekers feel personally connected to the community. Because the Church decided to support individuals who immigrated to Italy, and believed in exercising dignity for all, it aided immigrants in their goals. For South American women those goals included securing employment, so they could care for their family “back home” (Bryceson and Vuorela 2002; Jokisch and Pribilsky 2002).

In some churches, the conversation would lead to a job posting on the bulletin board near the parish office. In others, the person seeking a careworker would be given phone numbers for careworkers who were out of work and had provided their contact information to the priest-broker as one part of their job-seeking strategy.
As described above in the example of Suor Carmen, agents of the Church presented immigrant women as ready to provide reproductive labor in a general sense for Italian society and, in particular, for the Italian elder’s household (De Santis 2011). The Church presented these women, who came from a wide variety of educational and employment backgrounds as “ready-to-go” careworkers (Anderson 2000; Solari 2006a). An important figure at Santa Lucia, then, was Suor Carmen, who served immigrants and elders by making matches between Italian households with care needs and women who needed jobs. As a 70 year old Missionary Sister of the Immaculate Conception, Suor Carmen had previously served in the historical center at a parish with many seniors, at a rest home for retired nuns, and at a mission to two different countries in Africa. A Genoa non-profit webpage described her as responsible for: “Listening Center contact for illegal immigrant women. Moral and spiritual support, accommodation services and opportunities for small jobs related to the immediate livelihood” (Sportello Informativo 2009). Suor Carmen had been with the Latin American community for almost 12 years. Her work was done under the authority of her religious community, the Diocese of Genoa, and the pastor of Santa Lucia. Italians needing a caregiver knew of Suor Carmen, researchers at the University of Genoa knew of Suor Carmen, new immigrants from any country knew of Suor Carmen, and experienced immigrants who needed to find a job looked to Suor Carmen for help. She also appeared every Sunday for the Spanish-speaking mass at Santa Lucia, and at community events such as the procession of the religious icon associated with Peru to celebrate an important holy day. Suor Carmen was constantly engaged for an hour before and after the Spanish-language mass on Sunday mornings. She touched foreheads to bless women, and spoke to every person in comforting, specific terms.

In my research I was privy to Suor Carmen’s contact with the immigrants but she was actively communicating with the Italian families with care needs. The Church valued
support of the Italian family and human rights for immigrants (discussed below). The support of the Italian family vis-à-vis Suor Carmen’s broker work also directly supported the Italian state’s family care policy and was in line with what Jane and Peter Schneider referred to as “resource mobilization…based on religiously-sanctioned feudalism” (Schneider and Schneider 1984:130) in their examination of local capitalist systems, informal economies, and parish priests in southern Italy. Suor Carmen and other broker/patrons connecting immigrants with Italian households were serving the Italian state while utilizing the idea of serving the values of the Church.

Suor Carmen was focused on her task of supporting Latin American immigrants in Genoa and all of her efforts were in service of supporting immigrants and getting to the business of making good matches between Italian households with care needs and women who needed jobs. In Wolf’s analysis, Suor Carmen was positioned as a power-broker, “who operate primarily in terms of the complex cultural forms standardized as national institutions, but whose success in these operations depends on the size and strength of their personal following” (Wolf 2001: 138). The complex processes of immigration dealt with in the familiar and nearly-national institutions of the Catholic Church in Italy fit Wolf’s explanation perfectly, and Suor Carmen’s social capital and charisma ensured the strength of her legitimacy in the immigrant community and in the Italian community. Suor Carmen was most visible in the caregiver classes and placement sessions due to her obvious power to help immigrants find work and her engaging speaking style. She was prominent in the Italian family community as the person to contact if looking to hire a person for caring or cleaning in the home.

Support, Power, and Discourse in the Making of Careworkers

It was in the parish churches all over Genoa that South American immigrants found supportive peer relationships and met with counselors to help them handle the changes that accompanied immigration and the stress that was part of doing carework in
a private home, as detailed in chapter 8. Immigration scholars have long associated acculturation with Christianity in societies where the dominant religion is a form of Christianity (Mona and Joseph 2007). This was true in Genoa, where the Catholic Church was an important bridging institution for these immigrants from countries which are predominantly Catholic (Caggiano 2005; Pineda-Madrid 2006).

At the parish and diocese levels the Church helped to create and perpetuate the idea (and gendered ethnic stereotype) that Latin American immigrant women were well-suited to doing carework, as the agents of the Church worked to support the goals of the immigrants who had arrived to make money to send back to their families in South America (Lyon 2006:222-223). In matching these women eager for work with elders who needed “help at home” they were also serving the elders (Degiuli 2011). The agents of the Church presented immigrant women as ready to provide reproductive labor in a general sense for Italian society and, in particular, for the Italian elder’s household. Vis-à-vis placement services the Church brokered these women as reliable persons to meet the needs of aging citizens. As Degiuli (2007b) and others who study transnational carework have demonstrated in their research, careworkers are constructed as the needs develop in the job market, economic situations push individuals to strategize for income, and employment opportunities emerge from demographic and economic circumstances. Immigrant women worked as careworkers as these were usually the only available positions they could secure in Genoa. It is the Church in the situation I describe at Santa Lucia that constructed them as “ideal” careworkers and “naturally nurturing.” They arrived in Genoa as women with a variety of talents, and left Santa Lucia ready to interview for carework jobs as “ideal, ready-to-go employees.” In this way then, the Church was the patron with a brokering agency to fill an employment niche with women needing wages to support their household.
The discourse used during trainings for careworkers reminded women of their rights, in the tradition of labor organizing in Italy. It also addressed their “natural” calling to give care to those in need, in the tradition of ethnic/gender stereotypes and Christian compassion (Albahari 2006; Garau 2010:161). Suor Carmen made it a point to tell the class attendees at least once each week, “You are precious; each one of you is precious, to God, and to me. We are in this community together, I feel lucky to serve you as I serve my Lord.” This was often linked to a story she would recount from the life of another immigrant who had overcome adversity, perhaps in an example of a mother overwhelmed by missing her children. Her moral for would-be workers was to find both comfort and motivation in their Catholic faith for the hardships of their life in Genoa. The women in these stories had often found solace in their Catholic faith, in being open to learning and loving those around them (relationships with Italians), and in looking to their spiritual community for sustenance.

Suor Carmen often highlighted the “quality” of being a Latin American immigrant as a positive attribute for finding a job in an economic downturn, as seen in these words spoken to a room full of Latin American immigrants, “You come from communities that care for their elders…you are a naturally nurturing people.” This essentializing discourse linked their occupation to their country of origin, and such ethnic stereotyping and racist speech was obviously at odds with the “dignity for all of God’s children” ethic that guides the Church’s mission to provide pastoral care to immigrants and refugees. However, it was in line with the patronizing, maternal attitude described by Bonnie Thornton Dill (1988; 1994) and Judith Rollins (1985) in their important analyses of black housekeepers in United States’ households 20 years ago. Dill and Rollins described gifts of second-hand clothing, discarded housewares, and food from white employers to their domestic servants. Pierette Hondagneu-Sotelo (2001) and Mary Romero (2002) also found “benevolent maternalism” in the household employer-domestic worker
relationship, and a pervasive attitude of benevolence toward the Latina low-wage workers on the part of the white women employers, who viewed the immigrant women as lucky have a job in a nice house. This statement above reveals the Church vis-à-vis the speaker, Suor Carmen, as a patronizing benevolent maternalistic actor.

The “naturally nurturing” remark by Suor Carmen was also a particular form of institutional racism as described by critical race theorists (Crenshaw, et al. 1995) and highlights the ways in which intersectionality theory helps to explain the position of careworkers in Genovese society. Similar to the work on transnationalism using intersectionality theory by Messias (2001) regarding Brazilian immigrant low-wage workers in the U.S., this statement highlights the limited employment and social opportunities for immigrants’ positions in a web of interlocking identities. The intersection of gender, migration status, religion, and ethnicity combine to position Latin American careworkers in Genovese society as suited for domestic service work, erasing other attributes such as professional and educational background. Suor Carmen’s remark highlights xenophobia that differs from that visible in the hateful anti-immigrant speech of the political party Lega Nord, discussed further in chapters 4 and 7. She sometimes talked of employers who preferred Latin American careworkers over others,

This woman… I have known her for many years, she tried but the careworker from the East (meaning an Eastern European country) was too hard, too strong and rough for her sweet mother and father. You (meaning the Latin Americans in the room) fit into our Italian culture more easily, and you are naturally sweet and giving and responsible. After all, you are here out of a responsibility to your family, you already know that this is important, and it shows in your work.

Here she used the preference of the employer to support her ideas about the racial superiority and religious “fit” of South American women for doing carework. These racist views, which position South American immigrants at the top of the racial and ethnic hierarchy of immigrants in Genoa, were sometimes used by the immigrant women themselves to “sell” their labor to prospective employers. One-third of the workers
interviewed for my project referred to their Catholic faith as an important link to and an area of commonality with their clients. Suor Carmen’s declaration also tacitly assumed that women are more suited for carework, in line with gender assumptions in Italian households (Lyon 2006).

At other times she invoked the tradition of equitable and respectful treatment of all people as part of the Italian tradition of labor organizing and the Italian constitution’s emphasis on human rights:

Since more immigrants from the East have arrived and the economic crisis…there are employers, some of my people, these Italians are crazy!, who expect you to work for too little money and in terrible conditions. Do not accept these conditions. You should call me, call any of us (indicating her helpers) and call the labor unions, like the woman who spoke to us last week.

Here she urged careworkers to stand up for their rights, acknowledged the need for employers to behave humanely, and pointed out the enduring importance of labor unions in Italian society. The sentiment expressed here by Suor Carmen was in conflict with her statement that same week to “stay sweet, stay humble, and stay with God.” The role of religious identity in the brokering of Latin American careworkers was important to the social control of the often single female immigrants making their way in a new environment and an opportunity to reinforce “the moral and religious values of their employers’ family” (Scrinzi 2008:37). This is reminiscent of the Catholic church’s deeply ambivalent and ambiguous relationship to colonialism.81

When these women were caring for an elder, it was to earn money, not necessarily to “help another of God’s children in need” (a statement often repeated by Suor Carmen during her motivational speeches). However, many careworkers in Genoa

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81 For example, the clergy missionaries were the eyes of the Queen of Spain and reported on the excesses of the colonizing powers in the new world. See Scrinzi (2008), Lainati (2000), Lagomarsino (2006) and Campani (2000) for work that directly links current Church involvement with female immigrants in Italy as evocative of the ambivalent relationship the Church has had with colonizing, globalizing powers in much of history.
said that they found the work taught them to appreciate the opportunity to demonstrate their Christian love. Some careworkers considered Christian compassion at work in their life when they cared for a severely disabled person or exercised great patience with an elder dealing with dementia. Other research, including my Masters' work (Meyer 2003), found religion to be named by the workers as a motivation for their lives as in-home, low-wage careworkers. Cinzia Solari found a segment of the Christian careworkers from Russia in Rome to be “saints,” that is, motivated by their faith to serve their clients (Solari 2006a); I found Filipinas in San Francisco home care jobs often pointed to their Catholic faith as renewed by their hardships such as living away from children and other family members and working long hours (Meyer 2003:92-93); and Claire Stacy (2011:109-111) has noted that many careworkers describe their affection for their client as genuine, and sometimes motivated by their Christian faith.

Suor Carmen was a very clever and funny speaker, like a stand-up comedienne, and her audience appreciated both her commitment to them and her humor. She covered some very serious subjects in her stories; one was of two young men she met at the large train station on her way home. She recounted that she spoke to them in Spanish82 and learned they had been sleeping at the train station. “E’ peccato! (It is a sin!) – that people should live this way. They are strong and young and speak Italian very well. It is not right!” She used this story to underscore the importance of social justice ideals based on Christian traditions, as in valuing all humans as children and creations of God. This was also her way of criticizing the anti-immigrant rhetoric so prevalent in the media reports of the center-right and right-wing coalition government, led at the time of this research by Silvio Berlusconi and involving the conservative Lega Nord party.

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82 Suor Carmen always spoke in very clearly and slowly enunciated Italian during the twice-weekly training/placement/devotion. She was adamant about the necessity of learning Italian and would frequently say, “You must learn this language to be able to do this work.”
Summary

The work of Suor Carmen described in the preceding section is supported by the Diocese of Genoa, the parish community of Santa Lucia and the religious community where Suor Carmen resides in the historical center of Genoa. These Catholic organizations -- parish churches, religious communities, and immigrant centers supported by the Diocese -- provided infrastructure for building relationships and exemplified how social institutions were important to careworkers. Social institutions of many kinds were identified as important in Genoa for Latin American immigrants; careworkers and those who served immigrants named them as critical for both community health and individual mental health. The Catholic Church parishes that had activities in Spanish, the Catholic parishes that had a large contingent of immigrants attending mass in Italian (such as in the historical center of Genoa), and non-governmental organizations such as Caritas--all were important institutions from the perspective of careworkers and of servers. Based on my interviews with careworkers (N=50) and individuals who serve them (N=25), such as social workers, there are three social institutions that most directly influenced the quality of life of the immigrant women employed as caregivers: (1) Catholic parish communities and Diocese of Genoa immigrant programs; (2) service organizations—many of which are linked to the Catholic Church; and (3) labor unions, which were discussed in chapter 5.
Chapter Seven: Maintaining the Health of Workers: the Mixed Messages of the Italian State

I arrived in Italy to learn about how low-wage immigrant careworkers provide for their own health and well-being, and focused on which resources were utilized, which barriers existed, and what strategies and conditions were specific to the careworkers’ work situation. The 2009 *Pacchetto*, (Security Package) of safety and immigration laws was constantly discussed in every sort of media outlet (for one example, see BBC News 2009). While I acknowledged its existence when I read the newspapers, watched the daily news, and wrote fieldnotes, I was determined to remain focused on my goal of learning from the careworkers about their experiences with healthcare. It was only when I began my interviews with those who serve immigrants and administrators, and read the legal analyses of the *Pacchetto* that I understood how important these laws were for the context of my research. In September 2010, one year after the implementation of the *Pacchetto*, I conducted interviews with elected officials of Liguria and Genoa, INHS administrators, and a non-profit manager, and then examined the data from my research in tandem with the consequences of the *Pacchetto*.

In order to utilize a critical medical anthropology analysis, this chapter examines the macroscale political forces associated with the *Pacchetto*. After an overview of the legislation, I discuss the consequences of the law for different actors, namely documented and undocumented immigrants, and those who serve them including Italian National Healthcare System (INHS) workers. INHS as manifest in Genoa involved a more local, versus a regional, scale of analysis, but the economic power embedded in the region of Liguria was also important to this analysis. In discussing how these forces influenced the availability and usage of INHS healthcare services, how the national healthcare system was available (or not) to immigrants, I am focused on the particular social location of immigrants in Italy in 2008-2010, especially in terms of their
documentation status and their access to Italian state healthcare resources. The large political force of this legislation (the *Pacchetto*) is, in one analysis, in opposition to the economic importance of having workers to hire for care in order to maintain life in Liguria. Maintaining the health of careworkers ensures that a pool of workers will be available to serve the Italian family.

The second part of the chapter details the reactions to the *Pacchetto* by the Church, labor unions, health professionals, and Genovese public officials. Human rights associated with Catholic social justice movements, the historical importance of labor in Italy, the power of professional groups, and the pragmatism of local officials are revealed in this analysis. The discussion ends with a focus on the status of the *Pacchetto* and its implications for immigrants and Italians in Genoa.

**Overview of the Security Package**

The *Pacchetto Sicurezza* (Security Package), consisting of five sets of laws grouped together\(^{83}\) in a broad definition of “security,” was passed in 2008 and enacted in 2009. The name of this law explicitly characterized immigrants as security risks. For the first time, according to Italian legal scholars, legislation regarding immigration was not considered separately, but included “in a collection of laws for public security among regulations against the Mafia or against rapists” (d’Orsi 2010:1). Many of the laws in the *Pacchetto* were universally lauded as useful (Maccanico 2009:1-2). For instance, it included provisions that made it easier for crimes of human trafficking to be addressed in and out of the European Union and in cooperation with more governments and agencies worldwide (Maccanico 2009; Merlino 2009). There were also provisions that dealt exclusively with refugees\(^{84}\) and family reunification for immigrants which were long

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83 The *Pacchetto* covered five broad areas: immigration, organized crime, widespread crime, road safety, and urban décor, gathered together under the theme of security (Di Pascale 2010:4).

84 Under the *Pacchetto*, the criteria for claiming refugee status were explicit and more closely aligned with the standards of the European Union, themselves in line with the recommendations
overdue improvements, according to non-profit agency workers and government officials with whom I spoke (see also, United Nations Human Rights Office of the High Commissioner 2011). Under the Pacchetto, rules for family reunification were clarified, which streamlined the immigration service bureaucracy. Documented immigrants could use the clear guidelines of the Pacchetto to take steps to bring children, siblings, and parents to Italy legally.

The laws discussed in this chapter are those that most directly affected the health and well-being of immigrant careworkers: (1) the law which made the status of being an undocumented immigrant a criminal offense (Law 94/2009, article 10); (2) the decree which lifted the ban on reporting by doctors and hospital staff in charge of public services of irregular immigrants (Legislative Degree 733/2009); (3) the law which stated that undocumented immigrants could receive only emergency and essential medical care from the Italian National Healthcare System (Law 286/1998, article 35); and, (4) the law which proposed jail time and monetary fines for any landlord who entered into a housing agreement with an undocumented immigrant, Law 94/2009, article 12.5 (all laws from the official record of the Italian Parliament, Camera e Senato d'Italia 2009). Other official changes to the law from the Pacchetto are included below in the discussion of Genoa as a de facto amnesty city.

Many of the Pacchetto laws were considered part of the political theatre produced by Lega Nord, and are detailed here to underscore the general xenophobia present in Italy. In my analysis of the view of many Italians, there are two kinds of immigrants in Italy. The immigrant feared by Italians and often presented by the media (BBC News 2009; European Monitoring Centre for Racism and Xenophobia 2006; Margiotta 2010) was “the Other,” who was specifically non-Catholic (and perhaps
Muslim), dark-skinned, marginally-housed, and precariously employed in a place away from his family, e.g., in agriculture. The immigrant of less concern is “the Worker,” a woman worshiping at mass with the elderly neighbor, working in the home of the grandfather, and chatting in Italian at the local cafe. Generally speaking, the Genovese live in a city dominated by immigrants of the second type described above, careworkers from Catholic countries, seen in a variety of spaces. Also, the elected officials in Genoa and Liguria reflect the generally more immigrant-friendly liberal politics, in contrast to the regions in Italy where Lega Nord has proliferated, such as Lombardy and Veneto (Zaslove 2003).

Politicians such as then Prime Minister Berlusconi and Minister of the Interior Maroni of the Lega Nord (BBC News 2009; Castellanos 2004; Zaslove 2003) claimed that a majority of Italians supported immigration law reform. However, the immigrants and Italians I spoke with in my neighborhood in bars, churches, meetings, and interviews had not heard of the laws in the Pacchetto being enforced or supported in Genoa. The careworkers and those who served them, namely Church workers, public officials, non-profit social workers, counselors, INHS workers, were skeptical that any real changes would result from these laws. In addition, the national and local newspapers and television broadcasts were full of editorials and human interest stories centered on the new laws that prevented undocumented immigrants from getting INHS services, as in, “What will happen if all of these people here in our city cannot get healthcare?” (for example, see Mauro 2009).

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85 Jobs associated with having dark skin included agricultural harvester, flower farm worker, or heavy industrial cleaner.
86 There were immigrant men, and Latin American men, who worked in the home. It was difficult to find statistics on the informal market of care and cleaning. Also, some immigrant men had been “regularized” as domestic workers when in fact they did other work, usually via an arrangement with a female relative’s employer. In Italy, officially 10% of the permits given to domestic workers were held by men (Gori, C. 2002). For more on this and other information about men in domestic work, see also Kilkey, M. and D. Perrons (2010), Galotti, M. (2009).
One reason specific laws in the *Pacchetto* regarding healthcare were considered, amended, discarded, and/or repealed before its final application was because article 32 of the Italian constitution names “health as a right for any person in Italy,” a detail often pointed out to me in interviews with Italians and immigrants (Senate of the Republic of Italy 1947). As noted above, under the 2009 law currently in place, undocumented immigrants were to receive only emergency care and “essential” healthcare services from INHS (Maccanico 2009; Porqueddu 2009). At issue was what the Ligurian regional health authority defined as “essential.” Also at stake was the question: Does denying a person in Italy “nonessential” healthcare services violate article 32 of the Italian constitution? This is considered below in more detail. For documented immigrants, according to the law, access to INHS was unchanged compared to access before the *Pacchetto*, and remained equal to that of Italian citizens. Among the countries that are member-states in the European Union, Italy is considered to have laws that provide a generous amount of healthcare support for undocumented immigrants\(^7\). This is in contrast to countries such as Germany where undocumented immigrants can receive only emergency healthcare, that is for an “emergency to prevent death” (Karl-Trummer, et al. 2010; Karl-Trummer, et al. 2009). During my fieldwork, it was the combination of laws and the public discussion regarding them that influenced the conditions under which healthcare was delivered to undocumented immigrants in Italy (or not).

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\(^7\) In the health care policy and legal literature regarding Italy, the term UDM (undocumented migrant) or third party national are often used. Both of these terms refer to immigrants in Italy who are from non-EU countries and do not have a permit to stay in Italy. For example, even though Romanians were EU citizens, they were targeted by anti-immigrant groups.
Consequences of the *Pacchetto* for the Well-being of Immigrant Careworkers

Healthcare in Genoa

In Italy, the familialist welfare regime (as described in chapter 3) best describes the principle that has guided elder care policy (Esping-Andersen 2009). The way INHS were used in Liguria, to support immigrant health and to maintain the health of elders so they could continue to live at home in the community, also supported the “family” care of elders. The word “family” appears in quotes here because it usually was a female family member of the elder who arranged for and supervised care. It was, however, highly likely that it was an immigrant careworker working in the informal economy that actually did the day-to-day work of care in the family home, maintaining the façade that this was care delivered by the family. One important analysis of this situation is Deguili’s important ethnography in Torino regarding home care in Italy that points out how this organization of care “is only apparently based on the national individual unit of the family, but in practice relies on global, social, and economic processes to function” (Degiuli 2007b:4-5). In the situation in Genoa, the reliance was on Italian state processes functioning at regional and *comune* levels to maintain the health of the carework force.

The importance of the economic power in various levels of government as described in chapter 4 came into sharp focus with the way in which the INHS delivers healthcare in the region of Liguria and in the *comune* of Genoa. Eighty percent of the government dollars which entered Liguria for healthcare were controlled by the Ligurian health authority and the Ligurian ministry of health. These Ligurian officials chose to provide healthcare resources to those who reside in Liguria, and continued services which target immigrants (Angelillo, et al. 1996; Lega and Vendramini 2008). INHS as represented in Liguria chose to maintain the health of low-wage immigrants, documented and undocumented, so that they could maintain the state policy of “family” care of elders. All twenty regions in Italy could control 80% of the funds earmarked for
healthcare, and the region of Liguria decided to support the health of immigrants by building a local health clinic (ASL) clinic in a part of Genoa that was easy to get to from many other neighborhoods with large immigrant populations. This ASL specialized in serving immigrant families and elders in Genoa.88

Also, a little more than one year into the existence of these laws, health administrators, those who serve immigrants, Latin American community leaders and front-line emergency room workers were all trying to encourage new immigrants to get a STP card, which enabled an undocumented immigrant to access the INHS without using their real name or presenting a form of identity. The STP card system (detailed below and in chapter 8) had been in effect for many years, and was a standard resource for immigrants who had overstayed their visas and remained in Genoa without documents. Undocumented non-European Union-immigrants accessed INHS using the Codice per Stranieri Temporaneamente Presente (Code for Foreigners Temporarily Present), which is referred to as an STP or STP card. The STP is “an anonymous code enabling (non-EU) foreigners entering or staying in the country without a valid permit of stay to access healthcare services” (PICUM 2010:9).

Even though it contradicted the spirit of the Pacchetto, the STP system continued. Many interviews confirmed this. For example, the woman who ran the non-profit women’s health clinic at San Giacomo, which was aimed at nondocumented immigrant women, said, “We send people every week to get in the system, to get an STP, especially if we think they will need labs or to see a specialist – oh yes, it is all still there for those without papers.” The STP existed before the Pacchetto, and it continued to be used by workers within INHS in Genoa to obtain the care deemed necessary by

88 In another less political example of the autonomy of regions, Liguria invested resources into INHS dental clinics, unlike many other regions which did not provide dental health care. Providing dental care was not mandated by the national laws regarding INHS, but each region could choose to use a portion of their funds on these optional services.
health professionals working with the individual undocumented immigrant. Continued access vis-à-vis use of the STP may have been due, in part, to the difficulty of changing procedures in a bureaucratic organization and the tendency of humans to act out familiar routines rather than make a change.

In the case of Liguria and the city of Genoa and nearby cities, the regional government officials received and, in turn, allocated national healthcare funds, and then the Genoan health administrators decided who could get which healthcare resources and at what cost (Anessi Pessina 2010; Lega and Vendramini 2008). INHS as manifest in Genoa and Liguria decided to provide basically the same services to undocumented immigrants as those before the *Pacchetto*. 89

When deciding what would be essential healthcare services, the Genoa-based INHS administrator-gatekeepers included many chronic conditions and health maintenance situations in addition to acute and emergency health events. I interviewed emergency room supervisors, nursing managers, a program administrator-doctor for an immigrant mother-infant program, and INHS facility managers to gain an understanding of who was in a position to make decisions regarding what is essential. I also reviewed INHS Liguria (Region of Liguria 2011) and INHS Genoa (ASL 2011) web pages and the literature in waiting rooms. I found the main gatekeepers were: the primary physician of each household, the appointment schedulers, and specialty clinic front-desk staff supported by clinic administrators. In my interviews with providers and careworkers I learned of some examples of chronic conditions that INHS in Genoa included as

89 Though I describe the varying life and work conditions of immigrant women in the carework sector in Genoa, it was but one immigrant experience in Italy. There were ample news reports of exploitation of workers i.e., withholding pay, forced 16 hours days to bring in a harvest of fruit (Triandafyllidou and Ambrosini 2011); inhumane living conditions for workers, i.e. undocumented agricultural workers in Sicily (Ammendola, et al. 2005); unsafe working conditions, i.e., fumes in dye and leather factories for Chinese laborers in Tuscany (Cologna 2005; Spaan, et al. 2005); and a severe shortage of health resources and difficulty in accessing those that exist (Gracey 2004; Ravinetto, et al. 2011).
essential to the healthcare of undocumented immigrants. Some of these were: thyroid
conditions requiring regular blood and/or imaging tests; diagnosis and physical therapy
treatment for back problems; EKG and other tests in response to arm and chest pain;
and fibroid tumor surgery. An analysis of the data collected from those who provide
direct services to immigrants (N=25) and those who are administrators of systems which
influence immigrants’ quality of life (N=22) confirms what the immigrant-patients of INHS
told me in individual and group interviews (N=67)90.

I did not conduct interviews with undocumented immigrants new to Italy to
confirm their perceptions of INHS since the Pacchetto laws have become part of life in
Italy. For my project, I only interviewed immigrant workers from South American
countries who had lived and worked in Italy for at least four years, most of whom were
documented at the time of our interview (N=50). However, I did ask some of the
careworkers who participated in my research for their understanding of the experiences
of nondocumented immigrants.

Careworkers’ View of the Pacchetto

Though the careworkers who participated in my research were all rather
confident and savvy about exploiting INHS resources and not concerned about their
access to healthcare resources being limited by the law, it was interesting for me to learn
their views on Italian public healthcare in light of the Pacchetto. In one of the focus
groups the discussion moved to what it would have been like for these (experienced)
careworkers if they were arriving when the Pacchetto was in place. Janet said, “I have
heard of people (new undocumented immigrants) being scared to go to the hospital to
give birth –can you imagine?...but I understand…” These women also acknowledged
they have not heard of anyone they know being turned away from an INHS facility or

90 Twenty-one women participated in group interviews, four of these women also participated in
individual interviews. Data from 50 individual interviews are used in this analysis.
reported to the state police because they did not have a current work permit. They expressed concern that new immigrants are frightened to use the system and thus would endanger the health of everyone because their illnesses would not be treated in a timely fashion.

Some of the women who had been without work for months talked about the worry that their own work permit would expire if they did not find a job soon and then they would not be able to use the system that had served their healthcare needs well. Some pointed out that Berlusconi and his alliance with the Lega Nord party (the driving force behind parts of the Pacchetto laws) were successful at scaring immigrants. In one group interview the point was made that “maybe this will make some people decide to return home or to think twice before arriving here in the first place”. There were also a fair number of workers and community leaders from Latin American countries who had lived in Italy for more than 4 years who would shrug and say as Virginia did, “These laws? They make no sense, we will continue to get care, and do the work that the Italians do not do for their families.” In summary, the experienced immigrants had great confidence in the system of healthcare provision but the messages about the Pacchetto Sicurezza in the media created doubt as to whether an undocumented immigrant could feel safe while receiving care.

These immigrant women noted the importance of having developed a relationship with a health professional. A few of these immigrants had called their INHS connection to see if there would be any problem regarding their next appointment. Lupe reported,

I call up my daughter’s pediatrician all the time, for questions about the health of the adults in the house. We are sort of friends. And she said “do not worry about your husband who is without papers, he can come in for his appointment just like always. These laws are just operating in Rome, not here.”
This word “Rome” here referred to the national government. Lupe’s doctor, like all of INHS in Liguria, was interested in continuing business as usual in serving undocumented immigrants.

The power of community knowledge, sometimes considered gossip or peer information, has been shown to be influential in migrant access to local health enterprises (Devillanova 2008; Manderson and Allotey 2003) and this phenomenon was at work in the South American community in Genoa. Alba said,

My daughter’s friend is new (to Italy) and pregnant, and well, you know it was not planned and she did not know what to do. Without papers! But I told her aunt, “Listen my daughter will go with her, and I will also if you’d like. She will get the same services any young woman should get, no matter what she decides to do (regarding the pregnancy).”

Because Alba had confidence in the usefulness of INHS for undocumented immigrants, she was able to convince new immigrants in need to use the system. Other examples of undocumented immigrants receiving care or using their STP card to access appointments with doctors and subsequent treatments and tests after the Pacchetto went into effect in July 2009 spread throughout the community. Individual careworkers also felt compelled to pass on this message to counter the stories in the media that included some frightening tales from other regions and discussions of possible consequences. One careworker, Lupe, said to me,

I asked the ticket lady (medical appointment scheduler for the INHS) and she said, “Tell your friend without a permesso to go to Hospital Galliera and get an STP card and get an appointment. They do not even need to use their real name.”

The Hospital Galliera91 was one of the INHS facilities heavily used by undocumented immigrants, in part because it was the place where they first entered the INHS system with the STP card, which could be established with a pseudonym.

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91 Pronto Soccorso Ospedale Galliera [Emergency room Hospital Galliera] was widely acclaimed by both immigrants and Italians as a reliable, high-quality, immigrant-friendly health resource. It was widely-acclaimed by health providers interviewed for this project.
Some immigrants I spoke with acknowledged that if you watched TV or read the newspaper “you might think immigrants were being hauled away when they arrived at the health clinic.” However, most experienced immigrants pointed out what Mari did, that it was “business as usual in Genoa and Liguria, thanks to God, my family and I are here.” The workers I interviewed (who had been in Italy for at least four years), and other South American immigrants, who arrived before the Pacchetto’s ideas about restricting services to immigrants began to enter public discourse in late 2007, were generally dismissive of the laws, especially those regarding their access to healthcare.

Health Providers and Administrators Respond to the Pacchetto

With respect to the reaction of health professionals to proposed laws in the Pacchetto, the public debates and discourse surrounding the Pacchetto created moments of uncertainty, and then led INHS official and providers in Genoa to resolve to serve all migrants as they did pre-Pacchetto. As detailed below, the INHS workers also had to address the fear instilled in new immigrants, who may have hesitated about entering the INHS system. Italy, like many EU countries, does “not systematically collect health data by migrant status or ethnic group” (Mladovsky 2007:1) so information on the well-being of migrants after arriving and interacting with the INHS is limited. Providers and administrators for INHS in Genoa, Genoa city social workers and non-profit case managers all were quick to point this out, in contrast to the tendency to use ethnic categories in health research in the United States and some other countries. When I asked about the ways in which immigrants, documented and undocumented, utilized the healthcare system, a typical response was also, “We treat humans, we are not marking them into categories,” implying that they did not have sufficient data to answer this question. This had been changing slowly. In 2007 the European Union chose to “develop a shared (meaning among EU countries) vision on health and migration based on common EU values and principles” (Padilla and Pereira 2007). In interviews with the
Ligurian regional deputy director for Health and Human Services, and several Genoa INHS administrators I learned that this meant that a nominal amount of EU monies had been made available to health researchers, NGO clinics, and INHS services for projects on migrant health, including needs assessments to establish programs.

According to interviews with two public social workers and one caseworker for Caritas, in Fall 2009 Genoa comune social workers were told that they needed to advise their clients whose work permits were about to expire to get as many of their healthcare needs met before they lost their permit. At that point in time, with the Pacchetto highlighting the distinction of being a documented or undocumented immigrant, the social workers and their clients were attempting to understand which conditions or medical needs would be considered “essential” and therefore supported by the INHS in this region once the person moves into undocumented immigrant status. The example of dialysis was given, i.e., in this new anti-immigrant Pacchetto era, could an undocumented woman who was getting low-cost state supported dialysis continue in this same arrangement? In the end this woman was allowed to receive her INHS dialysis, uninterrupted.

However, as early as March 2009 and during fall 2010 a variety of health system workers (N=25) and immigrants (N=50) assured me that nondocumented immigrant workers continued to have access to virtually the same services as those with papers (and Italian citizens). This was the same level of services they received “pre-Pacchetto.” For instance, Charity, a Nigerian-Italian who moved to Genoa as a young woman and is an experienced nursing supervisor in a busy INHS clinic, said (in March 2010),

Nothing will change in Genoa, non-documented immigrants will continue to be served for acute needs at the emergency room and can go to the Galliera hospital to get a card to access the national health system. That is the only place to begin, and then that card will help you access other hospitals and clinics as needed, but the person must begin there, at Galliera.
Galliera is the second-largest public INNS hospital in Genoa, with an excellent general reputation and a high level of credibility with immigrants. The above quote represents the view of most of the providers and health administrators in the INNS in Genoa that I interviewed in Fall 2010 (Appendices C and D).

In the last three months of my research when I focused my efforts on talking with administrators from a variety of systems, including INNS, the Pacchetto had been in effect for more than a year. One Latin American community leader\(^{92}\) I talked to in a follow-up interview crowed, “I told you Patti, the dust has settled and we are all still here. I just sent two new immigrants to the hospital last week.” He was referring to his prediction of one year earlier that the new set of laws would make no difference in the ability of undocumented immigrants to utilize public healthcare, that life would go on as usual. Indeed, undocumented immigrants continued to use the INNS to address their health needs. However, there has been an effect – the data from my interviews with experienced immigrants and health providers show that the biggest influence of the Pacchetto was the chilling effect it had on recent immigrants – “scaring” them away from using the national healthcare system.

Some recent relevant research done in Genoa confirms that the use of one service, the emergency room, by undocumented immigrants decreased after the law came into the public discourse (Oudghough 2009). The nursing administrator of an emergency room provided such evidence in his thesis regarding emergency room use since the news of the Pacchetto became common knowledge. This administrator, Rehhal Oudghough, found that emergency room visits by undocumented workers had fallen in number soon after the initial media coverage of the Security Package. As he ended his data collection, the visits by undocumented workers were rising, but were not

\(^{92}\) Generally I do not use individual pseudonyms for administrators and servers as a way to focus on their functional role.
expected to reach “pre-Security Package” levels (Oudghough 2009:71-72). As Dr. Oudghough summed up when speaking with me, “If the purpose of the Security Package was to scare people without papers away, they have met their goal.” During one interview, he went on to share his concerns as a citizen of Italy and a health professional, expressing serious concerns that levels of public health would be compromised.

When a similar law was passed in 1994 in California (Proposition 187) restricting access to public services to nondocumented immigrants, fewer resources were used by all immigrants (Chavez 2001:174). Leo Chavez, examining the reality of the “immigrant threat” in the United States, found that while public perception was that undocumented immigrants were using social and health services at a higher rate than citizens, this was in fact not true. He also found that even after laws such as Proposition 187 in California were voted in, challenged in court, and repealed, the public message to immigrants changed their perception of public resources and made them hesitant to use facilities such as emergency rooms, even when in need (Chavez 2008:122-124). In a similar way in Italy, the laws in the Pacchetto related to healthcare workers in INHS being obligated to report suspicion of undocumented immigrants were also repealed (discussed in more detail below), but the fear remained, especially for recently-arrived immigrants.

However, many of the providers added that they were concerned that the recently-arrived immigrants will be afraid to enter the system. Their concern was growing, even as they used resources to make healthcare more immigrant-accessible, i.e., by hiring native speakers in a variety of languages or training intake personnel. Over half of the INHS providers commented that undocumented immigrants should have opportunities to exercise their rights to access healthcare, as guaranteed under Italian constitutional law.
It has already been established that the Genoa version of the INHS had chosen to serve nondocumented immigrants, but what I did not expect to see was the overt effort to specifically use INHS resources to target the health needs of immigrants without documents. I noticed this in fall 2010, after the Pacchetto had been in place for one year. Italian National Healthcare System clinics in Genoa were developing more innovations to serve a variety of immigrant patients even as the discussion in the media regarding the new Pacchetto laws discouraged some immigrants from seeking healthcare. For example, two clinic administrators, who had developed a walk-in urgent care clinic, now promoted the service as “help for undocumented immigrants.” When I arrived to begin the interview they displayed brochures in seven different languages with their new health promotion and clinic advertisement campaign. They seemed amused at my line of questioning, apparently unconcerned with the issues I was raising. I clarified that money from federal coffers, funneled through the INHS system and the Ligurian regional health administration was funding this initiative, which appeared to be in violation of the Pacchetto. When I asked about the law that prevents nondocumented immigrants from accessing non-essential healthcare services, one doctor-administrator laughed. Her colleague, a nursing director shrugged and said,

> How can we spend this government money on people that our current government is saying are not ‘Italian enough’ – is that what you are asking? Health (snaps fingers and flings hands in the air) is essential and we are right here, by the Galliera emergency room! – we know the reality.

This is another example of the local gatekeepers in INHS using their power to serve their patient populations and in doing so, to resist the anti-immigrant rhetoric of the national government in Rome while they keep the workforce healthy. Before meeting with these administrators I had heard of this clinic from a Sant'Egidio volunteer, and new undocumented immigrants were filling it every afternoon it was open.
At a small hospital an administrator-pediatrician who had been working with immigrant mothers and newborns for years pointed proudly to the sign for her new clinic. She also pointed out that the staff at the clinic spoke several languages, and that the multilingual materials promoting the clinic were being distributed in a neighborhood where many new immigrants lived upon arrival in Genoa. On a small sign near the official clinic sign there was a logo for a non-profit, so I asked her about funding. She replied, “Oh, of course the INHS, the hospital budget, they pay for it, but we are working to get to more immigrants.” The INHS had partnered with a non-profit to aid in recruiting immigrants to be part of this pilot program. During the course of our interview, she assured me that they did not and would not ask for documents from their patients. “They have their INHS card or their STP, which does not even have to include their real name, and either one is fine. And if they arrive with neither, we take care of the paperwork later.” Even though the large bureaucracy is ever-present, the workers and gatekeepers and users of the system used relationships and their own limited power to keep healthcare services available to patients. It is sometimes because of the large bureaucracy that an action such as “taking care of the paperwork later” can pass unnoticed and patients can be served.

Even with the Pacchetto in place, nondocumented immigrants had the right to use the INHS to receive care for urgent and essential medical needs (Camera e Senato d'Italia 2009:Law 286/1998, article 35). In Genoa, as the law was interpreted (as of November 2010) this meant a non-documentated immigrant has access to practically the same care as an Italian citizen or an immigrant with documents. As reported by one think tank, immigrants usually access the healthcare system via, specific immigrant health offices created inside ASLs (local health enterprises) and through some voluntary centres delivering health services specifically for immigrants (Lo Scalzo, et al. 2009:14).
The “voluntary centres” this report refers to did not exist in Genoa in the same way they did in other cities in the form of large immigrant health clinics sponsored by Caritas. However, the ASLs and other clinics and hospitals in Genoa were serving immigrants. These gatekeepers also made it clear that it was Ligurian and Genovese individuals such as clinic administrators, providers, program managers, and appointment center managers who decided at the regional and comune level what was essential.

Housing for Immigrants, Consequences for Landlords, and the Pacchetto

Another potential effect of the Pacchetto was the possible influence of a provision regarding housing for undocumented immigrants. This could affect the health and well-being of immigrants in that it would be more difficult for them to find a reliable safe place to live. Research shows that workers with stable housing are more likely to make and keep appointments for doctor visits, mammograms, and preventive health activities, such as pap tests (Brockerhoff 1995; Bruce Newbold and Danforth 2003; Wolff, et al. 2005). Workers talk about the need to have someone they can trust to enter into a relationship with to rent a room, bed, or apartment. Many of the workers interviewed entered into these relationships with ease in the past, and during interviews some women expressed concern about how the housing market will function for immigrants without documents in the future.

The climate in Italy that led to the passage of the Pacchetto - the rise of Lega Nord and the coalition of center-right parties in the national government, and the pro-“real” Italian/anti-immigrant sentiment – diminished the willingness of landlords to enter into housing contracts with immigrants. One key service provider agreed with what I learned from most of my follow-up interviews with careworkers, “It is harder, but it has been harder for an immigrant without papers to find a place to live…for at least three years. This was not the case nine years ago.” While it was not impossible to find housing as an undocumented immigrant, it could be very difficult. I learned in interviews
with experienced careworkers that when they were in undocumented status (more than four years ago) and moved to a live-out position after their initial live-in work, it was not difficult to find housing as a single person. These women often rented a room from another migrant who had legal housing. Those with families sometimes also turned to more established members of migrant networks to find housing.

While it is unclear what eventually will happen with the enforcement of this portion of the *Pacchetto*, it did initially create a situation such that if a landlord entered into a housing contract (for rental or sale) with an undocumented immigrant, that landlord could be jailed and fined (Camera e Senato d'Italia 2009:Law 94/2009, article 12.5). This change in the law has received some attention from scholars because the punishments were much more severe than a previous version of the law, and included an “implied confiscation of the property” as a possible consequence (Merlino 2009:6). In Genoa and throughout Italy, there was not any visible pattern of enforcement (Calandri 2009; Maccanico 2009; Mauro 2009). However, the threat of enforcement and the potential loss of money and/or property acted as deterrents to property owners. This in turn made the housing market more difficult for those about to lose their documented status or those working without documents. It could also present challenges for workers who had been working live-in and were moving to work live-out, as there were fewer options for rental rooms or apartments.

**Reactions to the Security Package**

The birth, development, passage and implementation of this set of laws led to reactions by labor unions, medical professionals, the Catholic Church, and the intellectual elite. Following are findings from the data regarding these reactions.

**The Catholic Church**

At every level, the Church “pushed back” against the anti-immigrant rhetoric and legislative activity of the Italian government that passed the *Pacchetto Sicurezza*. As
described in chapter 6, at the most local level of the individual parish, the Church in Genoa supported immigrants in their money-earning work goals and worked to facilitate assimilation into Italian society. The parish church supported the ideal of the Italian family by brokering immigrant women into carework jobs, and called on the Christian ideal of compassion for all to support immigrants (Solari 2006b). This was congruent with the goals of the Diocese of Genoa, and the Catholic Church of Italy. The Vatican set the tone for the Church’s response to the Pacchetto at all of these levels, as a staunch defender of the rights of immigrants, using human rights rhetoric in the face of anti-immigrant discourse and anti-immigrant legislation, most specifically in its lobbying efforts against the passage of the Pacchetto Sicurezza.

At the largest scales of operation (the Vatican and the Catholic Church of Italy), the Church supported immigrants by directly condemning the Italian government officials behind the Pacchetto as disrespecting human rights and issuing a call for these agents of the state and ordinary citizens to use compassion. The Church argued for the human rights of immigrants as it responded, with force, to the laws originally initiated by then Prime Minister Berlusconi and the socially conservative party Lega Nord. For instance, a Vatican spokesman, quoted in the newspaper La Repubblica warned: “The law (referring to the specific law requiring public officials to report any suspected undocumented person to the state police) is another closure to the dialogue between institutions and civil society” (2005). This aligned Christ’s teachings with the ideal of civility in a modern society, echoing the sentiments of those who warn against the “fascist and Italian-only” extreme rhetoric of the law’s originator, Lega Nord (Merlino 2009). At the largest scale, the Church consistently used a human rights discourse and a call for compassion in the name of Christian love. Archbishop Marchetto, an important Vatican official writing an editorial naming specific problems with laws in the Pacchetto, referred repeatedly to the United Nations Convention on the Protection of the Rights of
All Migrant Workers (United Nations Human Rights Office of the High Commissioner 2011). Ecuador has signed this Convention document, but Italy has not (Marchetto 2009). He points out that the Pacchetto is disrespectful of basic human rights, but also goes on to note that those who treat migrant workers poorly should be held responsible. Marchetto (2009) writes,

> It is worth noting that the measures it (the UN Convention on the Protections of the Rights of All Migrant Workers) deems should be taken, within the jurisdiction of each state concerned, are not directed to irregular migrants, but to those who cause the phenomenon.

The Church generally saw irregular immigration as an administrative problem, not as a crime, and an opportunity for the Church to extend its reach. The Vatican, the Church of Italy, and service groups such as Caritas and Sant’Egidio expressed outrage at the idea that being undocumented now equals being a criminal in Italy (Garau 2010; Marchetto 2009).

There were other Diocese-driven programs to support immigrants, including in response to the existence of the Pacchetto. In reaction to the stories in the media about mistreatment of immigrants, and the divisive anti-immigrant and sometimes racist rhetoric of groups like Lega Nord, the Church of Italy developed an “Immigrant Sunday” program. The Diocese of Genoa supported this initiative, which involved having immigrant volunteers from parishes with high concentrations of immigrants give a personal testimony about their life, faith and circumstances to another mostly-Italian parish church in the subdivision of the Diocese.

During one Sunday morning mass soon after the Pacchetto became law, immigrants spoke to congregations at churches at which the immigrants did not typically worship. I attended one of these services, in part to support an immigrant careworker, Fatima, who arrived to meet me at a coffee bar near the church with her four-year old granddaughter in tow. In church, at the appointed time, Isabel walked up to the lectern
in the front of the church to face the congregation full of Italian faces, with her
granddaughter Meredith at her side. Isabel spoke Italian extremely well, had practiced
her speech, and told the story of her own immigration from Peru to Genoa and of her life
in Genoa. Isabel, like me, usually attended the Spanish-language masses at her home
church, and it was interesting to experience a room full of Italians engaged in the same
religious ritual. Meredith charmed the room, the priest, and the admirers who, at the end
of the service, clustered around Isabel, shaking her hand and welcoming her to return.
When we talked it over later, Isabel and I discussed how Meredith could be the Church’s
secret weapon for integration. Isabel’s story of her life as a single mother in a new
country and the importance the Church and her faith played in her immigration
experience in Italy was very compelling.

Another reaction by the Catholic Church at the Diocese level is what participants
referred to as “International Sunday”, which has been part of the Church of Italy calendar
for at least the past three years. On “International Sunday,” every June and October,
Italians and immigrants from a variety of countries and of various religious faiths have
traveled in parish church groups to a destination. One year it was held in Assisi as an
international peace march, and another year in Recco and the next year in a seaside
town near Genoa for a mass to celebrate global brotherhood.

One parish church, represented by a parish priest, took a step to support
undocumented immigrants’ health in a direct way as I entered the field in 2009. In
September 2009 a 20-year old secular women’s cooperative set up at San Giacomo, a
mostly Italian, upper-income parish. This women’s health clinic focused on
undocumented immigrants, and was busy with patients every week. Renata, one of the

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93 This refers to the tendency of Italians to admire and be kind to children. This was especially
true in this neighborhood parish full of elderly Italian parishioners, including some from my
apartment building.
clinic coordinators active with the sponsoring women’s organization since its inception, stated,

Listen, when we lost our lease and these ridiculous (anti-immigrant) laws passed, we started asking around. And of course, this priest said, “Yes!” right away….Some of his (the priest’s) parishioners do not like it (the clinic in this space), but the Church is very clear. We must treat all of God’s children with dignity.

At the time of Renata’s statement in fall 2009 everyone was wondering exactly how or if the Security Package law she referred to, which restricts undocumented immigrants’ access to national healthcare resources, would be enforced.

The Church, then, was as an actor at several levels. At the local parish level, vis-à-vis the activities in the Diocese-funded immigrant center it presented Latin Americans as “ideal careworkers,” as with Suor Carmen, described in chapter 6. In this case at the Diocese-level the institution supported Italian belief systems about the suitability of immigrants for only domestic or low-wage, low-status jobs, which seemed at odds with the emancipatory human rights discourse used in discussing immigrants’ rights. At the same time, in both small-scale activities like careworker support groups and in the aggressive lobbying of the Italian Parliament, the Church used a human rights ideal, which values the individual person’s talents and attributes, beyond ethnic stereotypes.

Labor Unions and Intellectual Elites: the Strike

Labor unions took a stance, lobbying against the anti-immigrant portions of the Pacchetto, as part of a reconfigured alliance with the Vatican and the Catholic Church of Italy reminiscent of post-Mussolini relationships developed to repel fascism (De Grazia 1992). My interviews with outreach workers from CGIL, ACLI-COLF and the Italian Cultural and Recreational Association (ARCI), a civic society of “international solidarity

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94 There was also a great deal of sensational speculation in the media about exactly how this law, if enforced, would change life for undocumented immigrants and others in Italy. I did not learn about the objections of the parishioners to the use of this space, but it may have been linked to a general anti-immigrant sentiment, most visible on national TV talk shows.
and human rights” focused on workers’ rights (ARCI 2011), revealed that labor unions in Genoa supported immigrant workers, welcoming them into their ranks. This was confirmed in interviews with immigrant careworkers and conversations with their families and is supported by important analyses of the role of labor unions in Italy for immigration policy (Taylor and Mathers 2002; Watts 2002). Though I did not meet any careworkers who were official members of any union, many immigrant women95 I interviewed had sought help at a labor union office. From the early days of immigration into Italy, labor unions have welcomed both documented and undocumented immigrants, more than unions in Spain or France (Watts 2002:35-36). This attitude prevailed when the labor unions lobbied to change parts of the proposed Pacchetto and in their very active support of the strike that occurred as a reaction to the passage of this set of laws.

National Labor Union Lobbying: One More Regularization for Careworkers

One goal of the Pacchetto was that it be comprehensive, and accordingly there were months of debate regarding the proposed legislation. In the process of lobbying and negotiation with interest groups such as the labor unions, one more very specific piece of legislation was passed just as the Pacchetto was being put on the docket for passage. This law, focused exclusively on domestic workers, with language specifically referencing those providing care for the elderly, created another “amnesty” regularization program. As described in chapter 4, regularization, referring to the end result of this process, makes the status of a worker regular or with papers. Amnesty refers to the government reducing or waiving the penalties and back taxes that are the consequences applied to the employer who has set up an illegal work arrangement. This law was passed, in part, because there was concern that the new provisions in the Pacchetto

95 In Italy, immigrant men have enrolled in labor unions at much higher rates than immigrant women. The same difference in union membership by gender held true for Italian-born workers (Watts 2003).
would make it too difficult for both employers and careworkers to maintain current arrangements.

The goal of this careworker-focused regularization was “the legalization of employer-careworker arrangements by using an official work contract, and a permit to stay (permesso) for the worker” so that the immigrant careworkers could stay in the country, and the dependent adult or elder needing help could remain in the community (Calandri 2009). This particular “regularization” scheme allowed employers to pay a limited amount of back taxes and withholdings as they filed paperwork to make the worker “regular” and get her a permesso to remain legally in Italy.96 This was economically possible for many, but not all, Genovese families. For those families that anticipated increasing care needs with accompanying rising costs for the elder in their care, it was the lower-cost and reliable option. Assisted living facilities and home health services are generally much more expensive than the wages being paid to an immigrant careworker. Some families were genuinely panicked that they would lose such a valuable person, the immigrant woman who cared for their family, because of the draconian, frightening Pacchetto laws. I learned that regularization schemes were generally seen as good news for immigrant careworkers, even those undocumented women without jobs. When the undocumented employed worker moved into regular status, she might give up a part-time irregular job, secure in her documented status. This part-time position, while precarious, was still another opportunity for income for the undocumented careworker without a full-time job.

96 The limited number of months for employers and careworkers to act on this opportunity was of concern. During previous regularization periods, which were much longer, many household employers and workers flooded the offices of labor unions (CGIL, ACLI-COLF) and other organizations such as ARCI, seeking assistance with the paperwork to regularize workers and work arrangements. These offices expected a similar response, and some hired extra workers to handle the numbers expected. However, many fewer workers and employers sought help and/or filed paperwork for the pre-Pacchetto regularization. Data from my interviews with union office staff, union documents, and newspaper reports confirmed that the response this time was less than expected by union officials, in line with the findings of Italian labor scholars (Calandri 2009; Campani 2009).
This last-minute regularization law, part of the compromise hammered out as the *Pacchetto* was moving through the legislative process, was seen as more evidence that caregivers are needed all over Italy, not just in the city of Genoa. The unions (including ACLI-COLF and CGIL) threw their support in with the intellectual elites who developed the March 1, 2010 strike in reaction to the anti-immigrant laws.

**The Strike: “One Day Without Us”**

Following a series of revealing press reports about the mistreatment of immigrants and refugees in France and Italy, a French journalist, originally from Morocco, used social media sites, blogs, and email to propose and organize a day for immigrants and those in support of them to strike in Italy and France. Labor unions, university groups, and a variety of political parties joined in the “One Day Without Us” strike and march. The march in Genoa did not begin with labor unions though they were very visible at the event. This strike, which took place on March 1, 2010, resulted in peaceful street protests and marches in 60 cities in Italy (Attac Genova 2010; BBC News 2009; Mentelocale 2010; Merlino 2009).

The name of the strike – “One Day Without Us” - caught everyone’s attention. It highlighted what has been discussed earlier in this chapter, namely, that Genoa (and Italy) needs immigrants to function. This one day event represented the importance of individual rights and respect for the dignity of workers to many people in Italy - both citizens and immigrants. Chavez described similar messages as central to the analogous pro-immigrant rights’ marches held in the United States in response to the possible passage of a federal law that would make it a crime for a person to be an undocumented immigrant in the U.S. In Italy, the marches took place in response to a law already enacted. By contrast, in the U.S., the widespread protest appeared to influence the *proposed* legislation, which in the end did not use the most extreme clause that categorized an undocumented immigrant as a felon (Chavez 2008:152-153, 165).
In the days leading up to the strike there were many meetings, panels of speakers, films, question and answer sessions about the specific meaning of the *Pacchetto*, and informational sessions by Labor Unions. The days surrounding the day of the "strike" were full of discussion in the media, on the bus, and in private homes. I asked many immigrants in the Latin American community if they knew anyone who would participate by not working, even for a portion of the day. One, Yadiva, said ruefully, "I sat for ten minutes when she (the elder client) did not want me to. But she did not understand why I did it, the protest idea. She is forgetful." Yadiva was pointing out that she did "strike" but it may not have been noticed by her client or employer. Yadiva, like many immigrant women, was at work during the march. Most immigrants laughed at my question, as in this response from Jenny,

> Listen there is an economic crisis. You know about it, it is happening in the United States too, I see pictures on the TV of the people who have to leave their houses and the houses stand empty. We want to keep our jobs.

I did not learn of any workers who had *not* worked, even for a symbolic hour.

However, at the evening march I saw immigrants I knew (many of them unemployed), labor union leaders and office front-line workers, Latin American community leaders, immigrants from a variety of countries, Italians of all ages, members of organizations that serve immigrants such as Sant'Egidio, and students and faculty from the University of Genoa. All were part of the march, which some accounts numbered at 10,000 (Anarkismo.net 2010; Mentelocale 2010). The event reminded all of us of the enduring presence of immigrants in Genoa as it stopped traffic late in the afternoon of March first. The start of the procession was to be at one of the main Catholic churches in the *centro storico* (historical center). This quickly became a very congested area, with thousands of participants, many carrying banners, starting to block a main road before the official beginning of the march. Some of the banners read
“Immigrant Youth in Solidarity,” “ARCI supports justice for all,” “Senegalese Italian Association,” “Latin American Women of Liguria,” and “Immigrant Children of Italy.” A variety of immigrant groups were organized by age or by country of origin; some were affiliated with labor unions or organizations such as ARCI. For three hours, the march proceeded along a main avenue to the central square, where there was a massive stage and many speakers and bands, reminiscent of street holiday celebrations in Genoa. The police presence was perfunctory and the marchers, along with those lining the streets, were peaceful and upbeat. One immigrant leader told me a few days after the march that she estimated the marchers to be half Italians and half immigrants.

Health Professionals

While in Genoa in the summer of 2008, I noticed identical simple typeface signs in INHS and non-profit health clinic reception areas saying non denunciare (no reporting or “we do not report”). Included here is a description of the issues and the story behind these signs. This story describes the acts of resistance by a group of Italian health professionals in reaction to the anti-immigrant message coming from the center-right national government officials who passed the Pacchetto. The originally proposed law (Camera e Senato d’Italia 2009: Legislative Decree 733) required that health professionals report any patients that they suspected of being undocumented immigrants. This proposal was consistent with the other Pacchetto requirement that workers representing the Italian government or public services were obligated to ask for identification and immigration status of clients. The Italian National Health System is a public service and one used and generally trusted by immigrants, those with papers and those without. The health professionals used their lobbying power and action in INHS workplaces all over Italy to take a position against this mandated reporting. The proposed requirement to report possible illegal immigrants in INHS health facilities was dropped before the Pacchetto was passed and made into law (Turone 2009).
It is important to note that since the creation of INHS in 1978, under Italian law, health professionals in INHS facilities were forbidden to report anyone’s immigration status information. However, the Pacchetto, in its original form, went on to say that health workers in the public system were obligated to report to the Italian state police anyone they suspect of being an immigrant without documents. Doctor, nurse and health worker organizations swiftly denounced this as contrary to the basic values of their profession and placed signs up in waiting rooms (in public and NGO clinics) that clearly state, “We will not report.” (Maccanico 2009; Porqueddu 2009). The medical professionals responded quickly to the proposal of this change in the law. There were also, for a time, badges worn by health workers in many different clinics and hospitals (not just those that with large immigrant populations) that said Non siamo spie (we are not spies) (Trudell 2009). The proposed law required that INHS workers, which included virtually all health professionals in Italy, act on the behalf of the government in identifying nondocumented immigrants.

Beyond this clear message to patients and a general public relations campaign, the professional organizations were actively lobbying lawmakers. In Italy, the various healthcare team members (nurses, doctors, technicians) are gathered together under a powerful union-like umbrella organization called The Italian Federation of Medical Associations (Ordine dei Medici - FNOMCeO). In a variety of media outlets and in individual communication to professional members, the following message was delivered by FNOMCeO (2009):

97 Also, this position was confirmed by a law passed in 1998 in article 35 of the “Single Text on Immigration” law. It also banned any public official associated with INHS from reporting the documentation status of a patient or potential patient.

98 For example, even those doctors who had a private practice or worked for a private hospital also worked in INHS facilities and/or saw INHS patients. Genoa, in particular, has a low rate of patients who purchase private insurance (Lega and Vendramini 2008).
Health staff who report irregular migrants can be punished. The federation has published a document expressing disagreement with the Security Package.

The Italian Parliament, in the end, removed this requirement from the *Pacchetto*. Under pressure, the law was changed by an addendum to the original Package so that there was no longer mandatory reporting by workers in any health facility. In the end, the law stated that health workers *may* report. However, they may hesitate before they do. One of the health administrators I spoke with pointed out the following information on the FNOMCeO webpage: “Doctors who report the presence of an illegal alien who has gone to a health structure for care to the authorities will be punishable for a breach of the ethical code.” Such a breach could result in a loss of license and/or privileges to practice in a facility. The document went on to report that in February of 2009, prior to passage of the *Pacchetto*, the association met and produced the following:

The document published by the Association reiterated that breaches of the code of ethics are enforceable by membership orders, and indicated that the possibility of reporting illegal immigrants will create hidden routes to care, thus limiting control of common emerging public health diseases, which are now monitored and controlled, and represent a serious threat to every individual, and for society as a whole. (FNOMCeO 2009)

The Italian Parliament changed this portion of the *Pacchetto* so that reporting is not mandatory, but it is allowed. However, interviews with doctors and nurses made it clear that the professional organization had a great deal of power for medical professionals and it was unlikely that any health worker would violate the rules of FNOMCeO (Turone 2009). This action also underscored the power of labor unions and other professional associations in Italian society.
Genoa Operates as a *de facto* Amnesty City

Most of this chapter has addressed the ramifications of the *Pacchetto* for healthcare access and healthcare encounters in INHS clinics, offices, and hospitals. There are other important changes from the *Pacchetto* that, while not directly related to health, are important for understanding the situation of immigrants and the Italians with whom they interact. In the following, public services are to be denied immigrants without documents:

- Law 94/2009 of 15 July 2009, article 6.2 & 6.3 “which requires the need to show identity documents such as the stay permit to access sport and leisure activities and (adult) education to the public officials who have to register inscription to those activities/access to those services.” In case the foreigner refuses to show these identification documents (s)he is punished with a fine up to 2000 Euro and up to 1 year imprisonment (Camera e Senato d'Italia 2009).

- Law Decree 92/2009, article 17 which “establishes that money transfer agencies will have a duty to obtain a copy of the residence permit of third country nationals” (Camera e Senato d'Italia 2009)

- Law 94/2009 of 15 July 2009, article 116 which in effect prevents undocumented immigrants from marrying Italian citizens or documented immigrants in Italy by “requiring that (s)he show an identification document and a permit to stay” (Camera e Senato d'Italia 2009).

According to my data[^99], these last three laws were not enforced in Genoa. I attended public (region of Liguria) adult education classes with undocumented immigrants who were never asked to show their identification. Money transfer agencies continued to send money orders using any sort of identification. Many immigrants and I cleaned Santa Lucia Church several times on Saturdays for weddings in which one of the parties was an undocumented immigrant, and the officiating priest assured me that neither he nor anyone at city hall was going to ask about documentation status and any

[^99]: These data include fieldnotes from participant-observation and consumption of Italian daily media, primarily the TV news and *La Repubblica*. Fieldnotes summarized my conversations with immigrant careworkers and their families, and Italian friends and neighbors, in casual settings, beyond official interviews. In interviews with administrators, conducted after the *Pacchetto* had been in place for over a year, the topic was the way the *Pacchetto* had changed life in Italy (or not).
form of identification would be accepted. This was in spite of one interpretation of a
portion of the Pacchetto, that any public employee could and should ask clients for proof
of their documentation status. Furthermore, they were to report those who did not have
valid legal documents to remain in Italy to the questura, the local office of the
immigration agency of Italy.  

I learned of uneven or nonexistent enforcement of the laws from interviews with
those who serve immigrants. One server had heard of a public nursery school manager
in another city who just quietly ignored the law to report. A Genoa city social worker
reported to me during our interview that he was told by his supervisor to “use his good
judgment,” which he understood to mean that his supervisor would not be following up
with him regarding the law “to report.” This was one typical example of the findings in
my interviews with servers (N=25) and administrators (N=22). By law public workers
were not fulfilling their job description if they did not report. However, I did not find any
examples in the media or in interviews with regional and comune government officials of
repercussions (such as a reprimand or dismissal) that had taken place.

These reactions were very similar to those by public employees in California
cities following the passage of Proposition 187 in 1994. This California law denied
publicly-funded services to any non-citizen without legal status to remain in the United
States (Chavez 2008; Chavez, et al. 1997). Chavez also found that public workers in
California, such as child welfare workers and those in publicly-funded emergency rooms,
immediately condemned the law as nonfunctional and as violating human rights.

100 This “obligation to report” did not apply to health system workers, who were also government
employees delivering public services. This law was taken out of the Package as seen in the
previous pages of this chapter.
101 In Genoa, teachers in public schools, social workers, and workers in many city offices, such as
the one that issues marriage licenses, were all continuing with business as usual and ignoring the
law. However, Italians and immigrants remained watchful for local developments that any of the
new laws be enforced, such as the law requiring that public officials request documents to
prevent undocumented immigrants from entering into marriages with legal immigrants or Italians.
However, in the case of Proposition 187, the law was repealed. The portions of the *Pacchetto* under discussion here remained “on the books” and were not repealed. However, as of November 2010, as I exited the field, I had not learned of any instances of nondocumented immigrants being denied services by public workers at city/county offices in Genoa.

**Public Health Concerns**

Individual careworkers, immigrant women in the focus group, and individual health providers and administrators all introduced concepts related to truly universal care as promoting better health for all. The terms volunteered in interviews I conducted included: community safety, community health, public health, and health for all. One self-identified atheist community organizer working with poor immigrants referred to “caring for the poorest among us so that all can have a better life—our psyche, our spirit, our body.” She was referring to the idea of community quality of life and is concerned that a law that abused members of her community, namely immigrants, influenced her life negatively as she was in that community. Ligurian and Genovese gatekeepers chose to serve the healthcare needs of undocumented immigrants, in conflict with the anti-immigrant sentiment circulating in the public discourse surrounding the *Pacchetto* (Cuadra 2010). In interviews, administrators, health professionals, and community leaders brought up more altruistic idea of community health and the pragmatic idea of good public health practice. Indeed, some of the health administrators who had trained in public health departments pointed out that not caring for immigrants was poor policy on a variety of levels. A researcher for the Genoa city department of services to seniors pointed out to me during an interview,

>This is just good sense. The women who care are inside with their client—they are changing diapers, giving enemas—I have seen this! – and also giving hugs and making the very agitated and confused Alzheimer’s person feel safe. They are all spending many days together – everyone should have good health."
In this comment she points out the physical proximity of intimate care and the potential for disease transmission.

Hygiene training and universal precautions were a regular part of caregiver trainings at Santa Lucia and in training materials from the Red Cross and Alzheimer’s association. Most of the messages were framed in terms of protecting the worker. When I asked workers to describe a “typical day,” many of them started with a discussion of the importance of hygiene; as Maria pointed out,

> To protect my health and hers (meaning the client). If I cannot show up to work, look, I will not get paid. My body and my ability to be here is my paycheck, which means money for my family. I have to take responsibility for my health.

Maria was not alone in her approach to self-responsibility. This issue was discussed in 70% of my follow-up interviews (N=24) and in the focus group (N=10). In individual interviews, careworkers also named fears for public health and consequently the health of their children and loved ones who live here because “new arrivals are not getting care.” A group of seven South American migrants talking outside of a church were discussing what should be done to convince new undocumented immigrants that it was safe to access the INHS. One man pointed out,

> I do not want to be here at mass, at lunch in the hall with people who are not taking care of themselves. I want my family to stay healthy. We (meaning immigrants) need to take care of ourselves, and there is no reason to avoid the health clinic. Everyone just keeps going (to the INHS for appointments). This law means nothing there (in the health clinic).

This speaker points out a concern for public health, especially a fear of contagion of infectious diseases. He also points out concern for the health of a particular immigrant community within Genoa, and confidence in the continued use of INHS. Public health can be considered a way to act upon the value of civic well-being. Taking care of the essential workforce of immigrant careworkers is a very specific way to act on this value.
Immigrants are Not Wanted but Careworkers are Needed

In interviews with politicians, government bureaucrats, and health administrators, all acknowledged that the passage of the *Pacchetto* by the Italian Parliament and the subsequent media coverage of the real and possible consequences have sent a message to undocumented immigrants – “You are not welcome” (Margiotta 2010; Mauro 2009). This was followed up by the conflicting but less-overt message, coming from the Ligurian regional government, the Genoa city/county government service agencies, the labor unions, and the local INHS office - “We need your labor, so please stay.” There were ample quotations from administrators and servers to illustrate this idea; two follow.

In discussing these mixed messages, the Director of Gerontological Medicine for the INHS in Genoa pointed out during his interview with me,

> Of course this is ridiculous, do you understand how many old people live here? Do you understand how many of them completely depend on their care assistant? We have people who could not survive, who cannot go anywhere else if all of the irregular care assistants have to leave. We do not have beds or rest homes in our system.

He was commenting on the pragmatic reason for providing healthcare to immigrants, regardless of documentation status. In order to keep the large numbers of Genovese elders in their homes, INHS had to maintain the health of low-wage immigrants, whose labor was exploited by the family to provide care in the absence of Italian state support for aging elders. Ligurian and Genovese officials not directly involved were also interested in eldercare, and by extension, care of immigrants. During our interview, a Genoa city council member said,

> Remember the last mayor? Well, she was of a different…hmmm, ideology from the current one, but they are both clearly supporting immigrants being treated fairly. It is practical and the Christian thing to do.

I chose this from among the many comments from administrator interviews for several reasons: (1) he directly spoke to the practicality of fair treatment of immigrants; (2) he
pointed out that whatever the political stance\textsuperscript{102} of the Ligurian and Genovese leaders, they recognized this practicality in order to address the needs of a large group of voters (elders); and (3) he referred to “fair treatment” as tied to Christ’s teachings in the Catholic faith, one of the two ideologies I heard in interviews with administrators and health providers. The other ideology often used was that of a “civic good,” typically linked to the human rights-motivated Article 32 of the Italian Constitution.

A Ligurian regional council member introduced the idea of a “civic good” during the interview I conducted in her office in Fall 2010. She said,

We need to make good decisions for our region (Liguria), that is what I am elected to do, and I am one of the representatives for Genoa. These laws (meaning those restricting services to undocumented immigrants) are just (waving)…well, the people in Rome. We are expected to do the right thing for our region. Everyone knows that.

Her statement reflected her belief that the Italian parliament expected that each region would do what works best for that region’s citizens. In this case it was the region-specific idea of what is a “civic good” and in this situation it included keeping the essential labor force healthy. This quote reflects the attitude of many Genovese, which was that laws created in Rome were not always worth considering seriously.

**Summary**

As noted throughout this chapter, the messages to immigrants, to service providers and to the general public were mixed. This emphasized the idea that immigrant workers, while not wanted, were very much needed in Italy. As careworkers who have spent any length of time in Genoa have found, there were many situations where regulations and laws simply were not enforced as the enforcers themselves did not believe in the rules, or did not want to be bothered enforcing them. In addition, the superior power of regional government, linked to the importance of regional identity for

\textsuperscript{102} The city councilman was referring to the fact that the previous mayor was more politically conservative than the present one in his use of the term “ideology.”
Italians, gave Ligurian government officials the confidence to defy these laws by simply not enforcing them (for example, following its passage, the governor of the Puglia region made a public declaration against the Pacchetto, Porqueddu 2009). In other situations, such as with medical professionals, professional ethics trump any authority that might be invested in the law.

Regardless, the fact remained that immigrant caregivers, so greatly needed there, were relatively free to live and work in Italy, without the fear that there were laws that might get in their way. In contrast, the lingering effects of Prop. 187 (discussed above) and the other changes in U.S. immigration law have created a high level of fear and mistrust for undocumented immigrants in the U.S., and Latin Americans have been those especially under scrutiny, as seen in the work of Chavez (Chavez 2001; Chavez 2008; Chavez, et al. 1997). This raises the question - What imbued these experienced immigrant careworkers with such confidence in INHS and the local government? The answer is a set of interrelated factors: (1) as I discuss in chapter 8, immigrants’ familiarity with the culture of INHS due to their job duties made them move with more confidence, than, for example, an immigrant in another low-wage job such as selling umbrellas on the street or working to harvest fruit; (2) the position of Latina women at the top of the racialized hierarchy of immigrant workers in Genoa as “the Worker” immigrant (described above); and, (3) when groups such as Lega Nord discussed their ideas in the national media they often described “the immigrant threat” (Chavez 2008) to be people they view as looking and speaking very differently from Italians, i.e., the Other immigrant.

The careworkers I interviewed were aware of their relatively privileged position as the Worker immigrant in the racialized and gendered hierarchy of immigrants\(^{103}\). After

\(^{103}\) The Latin American women sounded similar to my Italian neighbors when they warned me, at least once a week, of the Other immigrants, Moroccan and Romanian robbers who were waiting to get me on the bus and on the street. In Italy, the word ladro (robber) was sometimes
examining the political and economic macrostructural forces of the Pacchetto, it is
important to turn to intersectionality to analyze the ways that the Pacchetto affects
individual lives. In the case of Latin American female careworkers, their interlocking
identities of race, religion, gender\textsuperscript{104} and occupation positioned them as the “desirable”
Worker immigrant in many situations in Genoa. One of the women from Bolivia,
Margarita, laughed as she pointed out during a group interview, “Who sees us? We are
inside with one family’s elder every day. So we are not a problem, they do not see us as
the problem.” Also, the fact that these women did not have collective semi-public
workspaces and were located as individuals in households all over Genoa meant that
they had become a part of the landscape. One of the Ecuadorian careworkers met my
Italian neighbor, who remarked, “I see you all the time on the street, and I know you are
Franca’s friend. I was sure you were Italian.” Franca, an Italian woman, is a friend and
neighbor to both women.

Examples of immigrants considered to be threats to “fortress Europe” and the
“integrity of Italian-ness” according to Lega Nord (Avanza 2010; Garau 2010:139-140)
were the refugees from Libya or Somalia, and the Romanian families living in
encampments on the outskirts of Milan and Rome. Some of the harshest laws
specifically targeted these groups (Hackman 2009; Merlino 2009). Immigrants from
Romania, Senegal, and Morocco were the individuals targeted by the khaki-uniformed
Citizen Patrols, groups sanctioned by one of the Pacchetto laws to look for “others” in
the name of safety(Amnesty International 2009; Mauro 2009).

\textsuperscript{104} The women I spoke with understood that Latin American men were seen as potential threats
to Italian society in a way they themselves were not. Scholars have observed this also, for
example see Ambrosini and Palmas (2007).
Immigrant women working as low-wage careworkers in Genoa were the “model” Worker immigrant, filling a job they were seen as being “naturally” suited for (see chapter 6). Many of these women continued their lives as though the *Pacchetto* did not exist. However, the very existence of the law created a greater level of precariousness, especially for those in Italy without documents and new to the country. The *Pacchetto* was an undeniable fact, and it represented the racism and xenophobia existing in Italy, including Genoa.
Chapter Eight: Addressing the Stress —  
Careworker-Identified Health Concerns and Strategies to Address Them

Introduction

In this chapter the reflections of the careworkers on their work and health experiences in Italy are analyzed to understand the interlinking influences of each on the well-being of immigrant careworkers in Genoa. I conducted individual interviews (N=50) with women who had worked with elders in Italy for four or more years, and many of them reflected on the injuries and consequences they sustained over the years. I interviewed doctors, clinic managers, pharmacists, social work case managers, and several Spanish-speaking psychological counselors. In interviews, careworkers and those who served them noted that even for an experienced careworker in a good situation, the stress was, according to Tanya, a careworker, “simply part of the job” and according to a primary care doctor, “pervasive, unavoidable, overwhelming.” In this chapter I privilege the voices of the immigrant careworkers who participated in my research project. In doing so I draw from the ethnographic work of Parin Dossa with Iranian female immigrants in Canada, who privileged the terms chosen by the women to describe their experiences, which Dossa viewed as revealing the correlation between emotional well-being and social factors (Dossa 2002). In Dossa’s study, the women chose the term “emotional well-being” to discuss mental health issues. In my project in Genoa, careworkers and providers used the English word “stress” most often when describing the consequences of carework for health and well-being.

I organize this data analysis by naming two distinct sources of stress, then discussing the generalized influence of stress, writ large, on the everyday well-being of careworkers with whom I spoke by using the concept of social suffering (Kleinman, et al. 1997). Next, I outline the ways in which careworkers handled stress and its effects. When medical diagnoses were reported by the women and discussed by health
practitioners in relationship to the stressors described I include them in my description. I then explain the particulars of access to INHS resources for different categories of immigrants, and the influence of the Pacchetto on immigrant well-being. Finally, I examine the resources outside of INHS and the Catholic Church used by immigrant careworkers for health maintenance. I end by naming barriers and strategies associated with access to healthcare resources. In doing so I explain how experienced immigrant careworkers have strategized to “take care” in the uncertain climate of post-Pacchetto Italy.

Some careworker-participants attributed the injuries and diminished well-being they experienced in their first year in Genoa to poor working conditions they were willing to accept in their first job. These conditions included: not taking breaks (or being offered them) and not asking the client to help adjust their position to make a safer lift or transfer. They reflected on how, especially in their first jobs, they experienced “feeling down,” difficulty sleeping, mental stress and physical strain more often than they did in their current or recent work situation. As of 2009, most of these women had last worked or were working with a legal contract. Many of the workers had developed strategies to get breaks, to ask for assistance, and get what they needed to make the job conditions tolerable, in a way they would not have upon their arrival.

**Stress, the Women from South America, and Their Lived Experience**

In an important retrospective and future-thinking essay, Arthur Kleinman points out that a substantial but not complete overlap exists between social suffering and specific mental health/illness diagnoses (Kleinman 2012:182), such as those drawing from categories in the Diagnostic and Statistical Manual (DSM). Kleinman regards the relationships between DSM mental health diagnosis categories and more generalized but still intensely experienced social suffering as indicative of the way that, in his example, “political economy creates suicide just as surely as genetics does” (Kleinman
When workers and health providers specifically spoke of mental health diagnoses such as anxiety or depression and medical treatments for these diagnoses, I used their terms. The word anxiety is generally used for the medical mental health categories of anxiety-depressive disorder, and generalized anxiety disorder. The term depression likely refers to a mood disorders such as major depressive disorder (American Psychiatric Association 2000)\textsuperscript{105}.

In using the words of the women to describe their distress and specific bodily experiences of it, I draw from the idea of social suffering as the response to how institutional and economic power influences everyday life conditions. In the use of social suffering to consider subjectivities, it is important to consider the “how these forms of power themselves influence responses to social problems” (Kleinman, et al. 1997). Kleinman notes that “economic depression and psychological depression and societal demoralization/anomie are systematically related” (Kleinman 2012:182).

In describing the social location of the immigrant careworker, it was important to consider the difficulties involved in being an immigrant in a society that had recently acted on anti-immigrant sentiment. Here I highlight the careworker’s location as an outsider, the immigrant, before I locate her as a low-status worker living with and feeling the consequences of the conditions of her work role. Before I considered the consequences of these conditions of work, I realized I must consider the day-to-day strain of living as an immigrant in Italy. Parsing out the two different sources of stress also draws from intersectionality theory in that the processes that involved the careworkers in my study as immigrants are described here as distinct from, yet interlocking in their relationship to the study participants as careworkers.

\textsuperscript{105} I did not see any medical records but one practitioner acknowledged that the terms he uses in patient interactions represent these categories, which have almost identical medical descriptions in the ICD-10 Classification of Mental and Behavioural Disorders produced by the World Health Organization; it is the “international” DSM.
Stress of Being an Immigrant

Isolation as a New Immigrant

All of the following factors contributed to a particular social location and level of stress for anyone performing carework: the low status of in-home carework, the responsibility associated with the job, the isolation of live-in work, and the physicality of the careworker job. The relationships and experiences of work, and the resources for healthcare are all nested within the experience of being an immigrant. The fact of being an immigrant likely increased stress levels, which in turn increased the likelihood of mistakes. This could increase work-related injuries and/or physical health problems that develop as a direct result of the carework. A new immigrant feels the separation from family and other loved ones more acutely than one who has been in the destination country longer (Anna 2011; Mirdal 2006). Four of five women participating in individual interviews were mothers, and they especially worried about what was going on back home, especially with their children, as in the following from Ana:

I wanted my faith to pull me through but I was so dis-spirited and so worried about my youngest child at home, his Aunt was not keeping an eye on him and I worried so much! (sobs) She was not keeping him off of the street with the bad kids. I could not function and I could not create more problems by not having money so my friend said “listen you have to get help.” My doctor gave me two kinds of pills to help me and they did. It turned out that one pill was to help Ana sleep at night, and the other was an anti-depressant, taken upon the advice of her INHS physician. Part of being a new immigrant was adjusting to the separation from loved ones, especially in the case of the many women who immigrated first in their family to Genoa to do carework and support their children and husbands back home. This stress was attributed to being separated from home and family, not directly to the tasks of carework for a disabled or elderly person. However, when the transnational transfer of reproductive labor operates in such a fashion, so that individuals must leave their family members, this source of stress was
intertwined with being a domestic-based careworker in a new country (Cohen 2001; Colen 1990).

Most immigrant women expend a great deal of energy to adjust to a new culture (Llácer, et al. 2009). While approximately half of the group of 50 immigrant careworkers I interviewed had a family member, such as a spouse, child or parent living in Italy as of 2009, that person often followed the original migrating woman (Ambrosini and Palmas 2007; Canchano 2011; Pagnotta 2008). Also the relative was sometimes more distant, for example as found in these descriptions from interviews: “ex-sister-in-law,” “my faux-sister from my childhood,” and “wife of my father’s cousin.” The feelings of isolation that the women in this study experienced four or more years prior to the interview, when they first arrived in Italy, were easily and viscerally recalled when I asked them about their initial work experiences in Genoa. The difficult often-solo experience of being a new immigrant was named as a concern by both servers (such as psychologists and social workers who served immigrant women) and the women themselves. One server, a Spanish-speaking counselor at the Catholic immigrant center, noted:

You need to understand that the person doing this work may also have stress from other places – her husband, her kids who may be far away in Ecuador, learning how to live in a new country and it can be hard to learn the language, a person can feel very lonely if they do not understand what is going on around them.

The last part of this observation points to the isolation that can accompany being a newcomer who does not speak the language (yet).

Moving from a Higher- to a Lower-Status Occupation

The social location of the worker as an immigrant is firmly established as below that of the native-born Italian in the general social hierarchy in Genoa. The category of immigrant dominates these relationships; that is, the social location of native-born Italian as being well above the immigrant was true regardless of the socio-economic background or educational level of the individuals involved in such a comparison. I
talked with a number of careworkers who told me that some of their employers were not 
gentele (gentle) and that the careworker had to pretend to have respect for the 
employer. As Tanya said of her various employers in Genoa, “I have had people worthy 
of respect and people that are low class in every way, no better than me and I was an 
office cleaner back home in Peru.”

The data from my study show that this lower status seemed to be more sharply 
felt by those immigrant workers who had moved from high-status employment positions 
in their home country to the low-status job of careworker, performing tasks of 
reproductive labor in an elder’s home. Of the fifty careworkers participating in individual 
interviews for this project, eight had held jobs similar to that of careworker in their home 
country, as nanny, babysitter, maid or housekeeper. For many of the careworkers, the 
downward mobility that was a consequence of their migration was a difficulty that 
contributed to their level of stress. One woman who worked in Ecuador as the principal 
of a middle school was now doing live-in work for a frail elderly woman, and had worked 
in similar jobs in Genoa for ten years. Lucy summed up her views in the following way, 
“I would rather have 25 terrible middle-schoolers to teach than one of these mean Italian 
elders to have to change a diaper for!” Lucy remained in Genoa due to the higher 
salary that contributed to her family back home in Ecuador and her own sustenance in 
Italy. In my research, attaining more capital was the primary motivation for keeping 
these low-skilled jobs; other researchers of global female domestic workers have similar 
findings (Kalir 2005; Raijman, et al. 2003). Parreñas terms the situation of women 
moving to a lower-status job and to higher-pay as contradictory class mobility and 
identifies it as a central defining experience for the Filipina women who participated in 
her study of domestic workers, and one that demonstrates the hierarchies of global 
capitalism (Parreñas 2001a:150-152).
My analysis of the data gathered in group and individual interviews show that for those women who moved from a higher-status job to low-status careworker employment, the stress was often attributed by the careworker to the large adjustment that had to be made in her identity. For instance, the women who had worked as home-based cleaners, or janitors in stores and factories in their country of origin expressed a more matter of fact or accepting or even slightly positive attitude toward their carework in Genoa. As expressed by Rubi,

Listen, I worked a lot without respect and really without much money in my home (country) and I did that for my children. It is the same here, I do this for my children, the Italians don't respect me but the rich Ecuadorians did not respect me either, but here I make more money and, it depends on the job, but sometimes it is a better situation. The house is smaller, for the cleaning part (of the job) that is better.

This reflection is representative of the way women who worked in low-status jobs back home characterized their current status as an immigrant careworker in Genoa. In contrast, the following is a typical viewpoint of a woman who has moved to a lower-status job. Bianca, who worked as a community college professor of speech and rhetoric in Ecuador, said,

My father was a professor, my mother was an assistant to a politician, using the intellect is important in my family, and continues to be. My children are both in graduate school. One is an architect. The other is a specialist in accounting. (sighs heavily) I am changing diapers on an old lady, but I make a lot more money than they (her children) could if they were working now. This is the part that is hard, not to be respected. My first employer understood and could talk with me, oh we had such great talks and she helped me to translate some of my articles and lectures from Spanish to Italian. She appreciated my mind and my profession.

The above quote also points out that in the same way a person cannot be categorized as “immigrant” unless there is a category of “native,” there cannot be “low” status work such as caring or cleaning unless there is work considered “high” status work that exists due to accompanying characteristics such as high(er) salaries and education requirements. Teresa, and other immigrants who increase earning power as they
simultaneously experience a decline in social status as measured by their job role, have
retained an understanding of a social employment hierarchy in which domestic worker,
whether for cleaning or caring, is a low status job and college instructor, architect, and
small grocery manager are higher status jobs.

**Stress of the Conditions of Work**

The working conditions of the in-home carework sector were described in chapter
5. Here I discuss those conditions which, according to the careworkers interviewed,
most acutely influenced the careworker’s well-being.

**Never ending responsibility**

One important finding from the literature was that the person providing care often
felt solely responsible and that she had to be present to ensure the safety and well-being
of the elder receiving care (Kokanovic 2006; Nelms, et al. 2009). Much of this research
has been done with unpaid family caregivers, but the same outcome was visible in my
analysis. This feeling of never-ending responsibility was a theme that emerged in 60% of
my interviews, both group and individual, with the immigrant careworkers (N=67). In the
following Germania described this feeling, which she experienced with an 80-year old
female client:

I did not really understand this feeling of constantly being needed, not
even when I had my children or helped my mother with my grandparents
back home. The son is in Milan, there is no one else. It is all up to me. I
worry when I take my weekends away that the cousin or the person she
has hired will not show up or prepare food she (the elderly client) will eat.
And if I come back and she is all agitated, has not slept, her routine is off,
it can take a few days to get the calm back.

It was clear that this careworker, who worked live-in (Monday through Saturday)
was not *really* taking a break when she was away from her workplace-home, and so felt
the cumulative effect of such constant stress, a consistent finding in the family caregiver
“burden of stress” literature (Krevers and Oberg 2011; Lorig, et al. 2012; Romero-
Moreno, et al. 2011). Over half of the workers interviewed with live-in and live-out
experience reported that when their client was feeling poorly or having a bad day, they felt like they could not take their *riposo*—not just a legally mandated break, but a Southern European cultural institution. In interviews, careworker-participants offered examples. The responsibility of care for another person created a sense of obligation for careworkers.

A specific version of “never ending responsibility” was the burden associated with caring for a medically-fragile person (Lamura, et al. 2008). Liguria had the highest percentage of the “oldest old” in all of Europe and as individuals entered their 90s many more experienced conditions such as severe osteoporosis (LeBlanc, et al. 2011), dementia (Payne, et al. 1999), or congestive heart disease (Mattke, et al. 2006) that required vigilant assistance. Many careworkers interviewed were both proud of and burdened by their ability to carry this responsibility. This is seen in the following reflection by Elisa:

> She (the elderly client, 104 at the time) did not eat very much while I was gone to Ecuador for 40 days, but I had not been away (to home) for three years, and I wanted to meet my new grandson. Her family is wonderful, but she was used to me and I knew how to read her.

What Elisa and Germania described was the overall responsibility they felt for their client’s well-being, even when they were not “on the job.” However, Jenny used the following to explain to me the source of her “constant worry” at work in her live-in job from the past: “It is never done, the work, will she need me? Will I hear her if she gets

106 According to Jenett, “No, no, that is not right – how could I leave her, poor thing? Who would get blamed if she fell or like a man I once cared for, turned the stove on and burned himself when I was not there? He would get agitated – dementia – and then I had to keep an eye on him every minute. And I was with him until his daughter got home from work, so if there was bad traffic, it was a long day.”

This also speaks to the constant level of responsibility felt by many of these careworkers, especially when they had a client with a fragile condition, such as extreme osteoporosis, or a problem (such as Parkinson’s disease or stroke-related dementia) that produced a wide range of behaviors. Interviewees described clients in their care who were cooperative and communicative one hour, and near-catatonic or resistant the next because of a mental condition. The unpredictability of client behavior is one aspect of care for elders with dementia that is linked to heightened stress for care providers (Romero-Moreno, et al. 2011).
up to use the toilet in the night? What if she falls?” Jenny was reflecting on her level of worry while at the worksite, pointing out that this responsibility, this obligation to be the one who worries is part of the job of carework.

Isolation Associated with Live-in Work

As discussed above in chapter 5, the non-public workplace of the home can foster a feeling of isolation for the careworker, even for one that is “living out.” However, this isolation can be even more acute for a live-in worker. This idea of isolation is seen in the following from Anabel: “You have too much time to think and be by yourself.” This is different from the isolation that comes with not knowing the language or having a social network (both associated with being a new immigrant); this is the isolation that is part of being in a private home space all day with one other person. Many interviewees describe the situation of working live-in as directly leading to increased stress and “a bad balance in my health.” This last comment was from Nury, a careworker who tapped her head as she said the word health during our interview.

Careworkers, reflecting on their work history in interviews, report that it was being a newly-arrived immigrant in combination with live-in carework that created a profoundly stressful situation. Rosa’s description of her initial live-in work provided a glimpse into this phenomenon:

I had no idea that I had rights, I was really scared I would lose my job, my place to live, my passport and have no way to get home and no money. The daughter-in-law would say, “listen my mother-in-law is so agitated when you are not here, you need to stay, and it is not so easy for me to get away from my other responsibilities” – she had a big job- and so I thought, well it is up to me to make this woman comfortable and as well as she can be, stuck at home, poor thing. So I stayed.

PM: Did you take afternoon breaks, or days off, or weekends…?

Rosa: No! I was scared and the nonna (grandma) was kind and not too much work, she was getting odd in the head, and that makes them scared of new people or change. So I stayed. I worked for three months with no days off.
PM: Were you able to go out just to walk around the neighborhood? Get some air?

Rosa: I tried that once and my nonna was so upset when she woke up from her nap and I was not there. I was afraid she would complain to her son and daughter-in-law and then I would lose a pretty good situation. I needed the money for my kids back home.

This recollection was typical of forty of the women interviewed. In this particular situation, Rosa was essentially confined to the home of her client, which was Rosa’s residence, as she was involved in a live-in work situation. Under such “situational house arrest” it was, of course, not easy or even possible for Rosa to exit the home to attend to her own health needs. Due to the concern over keeping a job, the lack of information regarding rights, and the practical problem of not knowing anyone else, it was very common for immigrant careworkers in their first position to live with complete responsibility for the elder in the elder’s home without a break,

Live-in careworkers often had elders with dementia as their clients, as the disease had often limited the capacity of the elder to remain safe at home alone all day. One-third of my participants, reflecting on their live-in experiences, described how the client’s mental capacity would decline, the behavior of the elder would become more erratic and sometimes combative, and this made their job “more trying.” This was consistent with the research on various care dyads (i.e., family member-elder, agency worker-elder, rest home worker-elder), which reports that the level of caregiver stress is associated with the dementia-related stressors and behaviors suffered by the client (Pinquart and Sorensen 2007; Rudd, et al. 1999; Sink, et al. 2006).

The Lived Experience of Stress

All but three of the 50 careworkers interviewed introduced the topic of stress as a health concern related to carework. In most interviews it was the first or second topic that clearly emerged as a health concern linked by the worker to the conditions of work.
The other was back pain. Some careworkers and servers\textsuperscript{107} took care to distinguish between feelings of isolation, feeling too worried to sleep well, being so tired, feeling depressed, and being anxious. Others described a variety of experiences and labeled all of them “\textit{lo stress}.” Practitioners, such as counselors, doctors, social workers and nurses also used the English word, preceded by the Italian article \textit{lo} (the).

Phrases and words to describe stress were used most often when describing live-in experiences. However, several themes emerged from descriptions of both live-in and live-out work experiences.

First, the stress linked to the emotional investment of the careworker in interpersonal relationships that developed at work. For some careworkers in my study the loss of a client due to death or a move into another care situation created “deep sadness,” and “feeling like I could never be happy again.” Some women (15 of 50) experienced a dulling of their ability to care (compassion fatigue) in combination with the feeling of being bored with the work. The close emotional connection that sometimes developed between careworker and client brought increased job satisfaction and/or increased the stress associated with grieving the death of the client. Careworkers described the difficulty of their intimate involvement in the moment-to-moment, day-to-day activities of a person who was suffering and when the person died. In several interviews with careworkers, as I guided them to recall their work history, the women cried as they recalled a previous client\textsuperscript{108}. For example, Elisa, showed me a photo of her client of 10 years, who had died at the age of 103, describing her relationship with this client,

\textsuperscript{107} Many providers discussed the link between some physical ailments (such as high blood pressure) and general stress.
\textsuperscript{108} The potential long-term nature of the relationship between the careworker and the client involves many hours of daily contact over a period of years. Bella, a careworker, noted the lingering effects of such a long-term emotional investment in describing a long-term client from her past in Genoa, “He really understood me, and helped me so much, and I had such respect for him and his son. I miss my \textit{nonno} every day.”
Look, here she is my Rosetta, picollina (my little rose, my little one) (pauses to cry)... It is hard to describe how sweet she was, and we had a great understanding, even when she could not speak very well. The doctors did not treat her right in the hospital. I knew how to care for her.

As this careworker wept and kissed the picture, it was obvious that genuine affection had imbued the careworker role with meaning for her and made the death of her client emotionally stressful.

A second major theme was feeling of being "closed in," which was mentioned by 2/3 of careworker-participants (N=50) as a distinct category. Jenny used the following description when pressed for an example of the anxiety associated with live-in work: “I feel closed in, like I cannot breathe fully.” The idea of being in a closed in situation was often named in contrast to “how it is healthy to be out and about and socializing with others and in the open air” (from an interview with Marjorie). Indeed, many careworkers insisted on remaining outside on public benches or at outdoor café tables for interviews. This was a consistent preference; Luzmila said, “It is better to be out every minute I can.” The following sentiment was repeated during interviews with many different careworkers, as this from Yadiva: “You are shut up in a little world with your elder, and even if this is a good situation with a kind person, it is bad to be so closed in.”

A third theme found in my analysis was the worry the women linked to the lack of trusting relationships with the client and/or the family of the client. Several women cried when recalling the day that they were accused of stealing from their employers, and how terrible, worried, and sad it made them feel. Mari Carmen recounted, “They did not want me bringing my own lunch and insisted that I ate what they provided, which was sometimes the dry end of the loaf (of bread)...they were worried I would take something home in my lunch bag.” I had ample ethnographic examples, the following is typical of an experienced careworker reflecting on her experiences with employers who did not trust her. Teresa noted,
I give advice to women who are new to live-out carework. I say “Don’t carry a purse because these old Genovese they will think you are stealing. If you have a bag show it to them as you leave the house when you leave for the day.” It is sad not to have trust from them.

Women who described this new feeling of not being trusted also described how the worry about these accusations was worse because they had arrived alone, without a family member or friend with whom to discuss these feelings. In half of the follow-up interviews, the women described “being worried” in the same conversation regarding problems with sleeping.

Mitigating Stress

Immigrant careworkers most often dealt with stress in talk therapy done with counseling professionals and paraprofessionals in settings associated with the Catholic Church. In addition, the social relationships formed with other immigrants and with Italians were used by immigrant careworkers to handle the stress associated with their life and work in Genoa. They also named social institutions as important for their well-being in Italy.

The Catholic Church

At the immigrant center, Santa Lucia, the staff had hired a native Spanish-speaking social worker, originally from Peru, to be available to serve immigrants with mental health concerns, family problems, or emotional concerns. At the developing Latin American community at Don Bosco, a counselor certified in both his native Columbia and Italy was on retainer to work with Latin American families and individual family members. There was a variety of groups to support careworkers in several parish churches. In other parish churches the support group function was fulfilled by being in a choir or bible study group. When I attended a Spanish-speaking bible study which

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109 One of these parish groups served as the basis for a focus group for this research; the leader helped me to gather women to discuss their views of the Pacchetto and work experiences from the past. I learned of careworker support groups that were not related to the Catholic Church, e.g., Red Cross center.
took place in a largely-Italian parish church, most of the women at the weekly afternoon
gathering were careworkers from South America.

In 2009, a 20-year old women’s cooperative organization moved its weekly free
health clinic to the priest’s office at San Giacomo parish, an upper-middle class largely-
Italian congregation. The women’s cooperative had conducted needs assessments just
prior to my arrival. This organization had two specific missions for the non-profit weekly
clinic: (1) to provide support to address the stress involved in being an immigrant, a
woman, and a careworker; and (2) to provide a place where the women’s health
concerns of undocumented immigrants could be addressed with a focus on prevention.
According to the clinic director in one interview, the cooperative was concerned for years
that new undocumented immigrants generally felt hesitant about using any government-
sponsored healthcare service. When a doctor in the women’s cooperative cut her
practice as she moved into semi-retirement and the uncertainty emerged regarding the
enforcement of the Security Package law regarding undocumented immigrants’ access
to the INHS, the clinic took steps to reach out specifically to undocumented immigrant
women. Every week a psychiatrist or psychologist was on hand and one or two
women’s health nurses and/or doctors were there to meet with women who walked into
the clinic. The mental health professional was with patients all two and a half hours of
every clinic, conducting counseling sessions in an inner office. I served as a greeter to
help women find the difficult-to-locate clinic hidden in the labyrinth of the church building.

The number of women who arrived every week at San Giacomo increased
steadily over the 9 months of my time observing there. The clinic had relocated to this
church and reopened with a more defined two-fold mission in September 2009. The
number of women attendees every week ranged from 3 to 12 in the last few months of
2009. In January through May of 2010 the number of women arriving each week varied
from 8 to 20. In April and May a number of immigrant men arrived with questions about
non-health resources, which were addressed as possible. Many of the women left with specific referrals for health services that could not be provided at the weekly clinic, sometimes to specific providers in the INHS\textsuperscript{110} or a non-profit clinic. Other referrals were to help women address concerns with their children in school, help with legal or housing problems, or to access other resources that would mitigate sources of stress. I did not have permission to talk with women at this clinic and did not follow up with the clinic clients directly following these referrals.

However, I did have the opportunity to talk with clinic volunteers, the administrators, the two nurses, the general practitioner and the psychiatrist who regularly served the clinic, who discussed their work in a general and aggregate way with me, preserving patient confidentiality. They named the concerns as: parenting, family reunification, transnational family relationships, marital stress, domestic violence, and economic insecurity, and anxiety and depression related to all of the above. Many women in the initial months arrived hoping that this weekly clinic also was a job referral site\textsuperscript{111} and while some left discouraged upon learning that there were no employment resources, others stayed for the opportunity to see a counselor or to discuss a health concern. Women often returned to meet again with the mental health professional or her paraprofessional helpers, though this was not necessarily expected. An informal counseling group formed every week in the waiting area outside the two professionals' offices, often facilitated by a nurse.

\textsuperscript{110} Clinic volunteer workers encouraged the undocumented immigrants to use the INHS for treatment, especially for physical ailments that they were not prepared to address. Some accompanied women to secure a STP card, which did not require documentation or the use of the individual’s real name. This card was needed to access the INHS for medical services and is explained in greater detail later in this chapter.

\textsuperscript{111} I heard the clinic volunteers and community leaders promote the clinic and they never presented it as remotely associated with finding employment. The fact that so many women (and a few men) arrived hoping that this immigrant-friendly space may also have some employment assistance is one indicator as to how opportunities for employment were becoming scarcer as the economic crisis deepened.
Social Relationships – Immigrant and Italians

The data showed that the social relationships of the worker helped to mitigate the stress of their lives and work, and that these relationships were often facilitated by the Catholic Church for women from South America. The strength of social relationships with other immigrants was seen as important for general well-being. Social relationships were also used for remembering home remedies, and for finding someone trustworthy to work as a substitute during a vacation or a doctor-mandated rest period, and in these practical ways directly affected the careworker’s well-being. In the tight economic times of 2009-2010, women named the practical use of friends as a valuable resource. The most frequent example given was how important it was to have a friend to live with rent-free during the period in-between jobs, or on weekends away from a live-in position. Twenty of the seventy-five women participating in group and individual interviews named a relative or friend as an important conduit for learning of a housing and/or job opportunity.

However, this analysis reveals that these networks were valued most for their usefulness in mitigating stress and supporting immigrant workers so they could remain in difficult work situations. As Maria stated, “Having someone to talk with is the most important thing to keep me from going out of my head and becoming like my client, who has Alzheimer’s.” Rosa, who worked 12 hrs every night, six nights a week, noted:

Listen, I just need a safe quiet place to sleep during the day. A friend from my hometown, a little town on the coast near Guayaquil, she rents me a room for a good price. And her sister and little daughter are kind to me, like family. We leave food for each other, and share in other ways.

Rosa, a mother of seven, sent money back to the little coastal town in Ecuador to support her three youngest children. She continued,

My friend’s mother was there when my oldest died of AIDS, and she was very generous to me, not with money, but with her heart, and her daughter is the same. I would go crazy (gesturing with a wave) if I did not have this kind family to live with outside of my work.
I learned in my analysis that Catholic churches were important places for social contacts to be made, even by those who may not have had a great interest in the Catholic faith. Many Latin Americans arrived 45-90 minutes before the Spanish-speaking masses at Don Bosco and Santa Lucia, and remained even longer afterwards, just to socialize. Usually 50-125 parishioners were on hand for this service at Don Bosco, which was a growing Latin American community, supported by the Diocese of Genoa. At Santa Lucia, the congregation at the service for Latin Americans sometimes swelled to more than 400, with standing room only. As many as 150 people lingered in the public areas near the sanctuary before and after the service. In both of these settings I met women to interview, and saw women who had participated in my research.

Often groups would gather after mass on Sundays to celebrate birthdays or other occasions. These groups were largely made up of immigrants who had arrived in Genoa da solo (alone), without other family members. I attended these gatherings, often invited by Mari, a careworker from Peru. These parties were usually held in restaurants (Latin American or Italian) for a big Sunday lunch following the church service. The groups seemed to be formed by people who had originally met to coordinate the liturgy, at choir practice, or to teach youth group and Sunday school classes. The data showed that these celebrations were viewed by the immigrants as important for fostering feelings of support and “family.”

These celebrations were one “typical” way that South American women spent their holidays and time away from work. They spent part of their day off with other

112 I was often included in the same spirit. For example, when she was on her way to work one morning, Mari, a careworker, and I happened to see one another at a busy bus stop near the civic center of Genoa, where we were both transferring buses. She invited me to her house for an Italian (and Catholic) holiday, the day of the Immaculate Conception. We talked about how my partner was in Genoa and I learned that she had a middle school daughter in Genoa. Then she said, “One of the other young women from the last birthday lunch, she rents a room from me, and there are at least two others, singles, coming. We will be a family, you cannot have lunch with your parents or brothers and sisters in the U.S. Come to my house!”
immigrants, window shopping, riding the bus to walk in a park, or going out for a coffee. In the Latin American community, it was expected that new immigrants would join in organized activities, such as Italian language classes organized at Don Bosco or the cleaning crew lunch every Saturday at Santa Lucia immigrant center. These were the first steps toward building important networks. Following these formal gatherings, one or two more experienced immigrants would often take the newcomer aside and offer information about other places to learn Italian, obtain resources, find work, and make their way in Genoa. Generous, experienced immigrants like Mari and her group of friends, who first met when they were all in the choir years ago, also provided important social relationships and welcomed newcomers.

The relationships developed in the private home sphere in which the care assistant worked influenced future opportunities, quality of day-to-day work life, and quality of housing, especially if a live-in position (Andall 2003; Lyon 2006). The employers were usually Italian citizens. Relationships with Italian neighbors, friends, clients and bosses were often important social ties that were used by the careworkers to address their own healthcare needs. In fact, many workers reported social relationships with Italians that influenced the general well-being and therefore, the health of the careworkers. According to Jenett,

Someone in the family drove me to my pre-natal appointments because my husband was away at work. When my baby was baptized my Italian “mother” and “grandmother” gave me a silver bracelet that had been the grandmother’s, given to her at her confirmation.

This was recounted as an example of how this careworker had experienced her employer helping to lower her anxiety and as a result making her feel respected and that she had a genuine connection with an Italian family. Jenett and her husband were able

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113 Regular labor migrants and irregular migrants, working or not, in urban areas such as Genoa are building networks with other migrants, but these networks do not guarantee job contacts, higher quality of life, housing, or social life (Trinci 2006).
to purchase a small flat, and sought advice from this Italian family before making the purchase. As Jenett recounted

Listen, the son of my nonna, he was a lawyer, and knew business, so we brought him to the office of the real estate person, so that they (the real estate agents) would take us seriously. This guy (the son) also looked over the agreement to make sure we were being treated fairly. And he had helped me get my papers (permit to stay) here too.

Another worker, Isabel, talked about accessing the relationship with an employer for the practical purpose of procuring needed medicine:

I was without papers, and they said, “What do you need?” So I called my cousin, who has a close friend who is a doctor in Peru and he told me what I needed for my allergies. My boss called her family doctor and asked for the medicine and I am not sure how, but she got a prescription for me. I paid for it, it worked well.

In this situation, finding a practical solution for a chronic health problem improved the everyday quality of life for Isabel, thus resolving one area of stress in her life in Genoa. The use of kin and friend networks in Peru in combination with an Italian she trusted to help her was an excellent example of the way in which careworkers utilized a variety of social networks to address their health needs.

Social Institutions - Touchstone Institutions

NGOs that provided Italian language classes, regional (Ligurian) and city (Genoan) resources that provided job training and Italian language classes, and labor unions were all named as social institutions that careworkers had used and returned to for support from time to time. I use the term touchstone to describe these institutions that remain, sometimes in the background, for immigrants to check in with as needed. This idea came from an interview with a woman who worked to serve immigrants at one of the labor unions in the city center of Genoa who said, “It means something to them (the immigrant workers) to know that we are here. Even if they have not used us, they know of a friend, or have seen a flyer. And we are here.” The labor unions were most often discussed when women recounted past work experiences in which they did not at
first understand their rights, for instance, to a two hour rest period every day, or for the right to get time off to attend to their health.114 The data pointed to other touchstone institutions, including Sant’Egidio, the Red Cross, a variety of parish churches, Don Bosco, the women’s health clinic at San Giacomo, language class offices associated with the city of Genoa, and the immigrant center at Santa Lucia.

Table 8.1. Health conditions reported by workers as a consequence of carework activities

<table>
<thead>
<tr>
<th>Stress*</th>
<th>Back Pain</th>
<th>“Closed In” Feeling</th>
<th>Headache</th>
<th>Stomachache</th>
<th>Mental Health Diagnosis**</th>
</tr>
</thead>
<tbody>
<tr>
<td>47/50</td>
<td>42/50</td>
<td>33/50</td>
<td>16/50</td>
<td>12/50</td>
<td>13/50</td>
</tr>
</tbody>
</table>

*Forty-seven women used this word in interviews, and other phrases, as discussed above, to describe how work affected their health
**These were women who offered information about their diagnoses as they showed me their prescription medication in interviews.

Medical Diagnoses from the Data

When discussing worry and sadness, women often quickly moved on to discuss the health problems they or their health providers associated with stress, psychosomatic conditions - headaches and stomach/digestion problems. In conceptualizing a psychosomatic model, the mind and body are mutually dependent on one another (Wolf, et al. 2007:144). Psychosomatic health conditions have been linked to fatigue (Bäärnhielm and Ekblad 2000), linked to the relationship of work to health for immigrants in Italy (Mattia 2000) and used when interrogating ideas of depression and well-being (Keyes and Ryff 2003).

In interviews with individual careworkers, 16 women named the health concern of headache or head pain as linked to the stress of their job. More women discussed their chronic headaches but did not link the occurrence of headache pain to their job as a carework. The 16 women who did make the link between work and the onset of head
pain discussed both chronic and acute headaches. A few careworkers discussed not being able to sleep as part of their current work situation, and linked their poor quality of sleep as a trigger for their headaches. As Norma recalled,

I worked hard, long days in my job in an office before, and I never had any headaches. The times I get them here are when I have a job fissa (live-in) and must help the elder get up at night – he needs the toilet, he is scared and confused, it is my job. But it gives me headaches.

Several of them mentioned headaches as a consequence of feeling closed in and being inside for their carework job so many hours a day. Some pointed out that their doctor and their friends and even television programs tell them that they should relax, should take deep breaths, and should exercise to help handle their stress, and perhaps cut down on their headaches.

Twelve women discussed stomach discomfort or pain that they linked to their working conditions. Many of them pointed out that they are so used to worrying, as Mirela recounted in a listing of her worries,

About money, about my darling nonna who is so upset when I go away, about my (upcoming) trip to Ecuador to see my mother, who is doing poorly.

Mirela went on to say, “I feel most of these worries in my stomach, it is just my way.” She had consulted an INHS physician who had convinced her she did not have an ulcer, but she was hoping to gain some relief by changing her diet, over which she had great control. The management of stress-related concerns that were manifest as somatized health concerns such as headache and stomachache was most often addressed by INHS via individual appointments and diagnostic gastrointestinal exams.

Careworkers with mental health diagnoses from a physician, such as anxiety or depression, often used prescription drugs recommended by doctors at INHS. The

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115 Others referenced multiple sources of stress, as discussed earlier in this chapter. As Rosa commented, “I do not know, is this from work? From worrying about my husband and daughter back home? From my son here who hates school? I have a headache from…life.”
critique of the medicalized categories of the DSM (American Psychiatric Association 2000) by medical anthropologists has included the concern over the pathology/normal dichotomy inherent in such medical label, the overall medicalizing of everyday life experiences (Gaines 1992), which may gloss over the large scale structures as those inherent to the everyday taken-for-granted forms of structural violence (see, for example: Bourgois 2009; Farmer 2004; Kleinman 2011) that create inequality, trauma, and associated distress. I use these categories here to specify the lived experienced of the immigrant careworkers and the ways in which they interacted with resources such as INHS. In one-fourth of the individual interviews (N=50) when the conversation turned to the management of stress, the careworker participating in the interview opened up her handbag to show me the variety of meds. Over the course of twelve interviews, I saw bottles of Haldol (anti-anxiety), Prozac (anti-depressant), Valium (anti-anxiety), and Ambien (to aid sleep). These interviewees had been diagnosed by their primary care provider in the INHS and given the prescriptions so they could purchase these pharmaceuticals. In one example among many, Livia said,

Look, this is for anxiety and this is for the depression (voice cracks), I just was feeling so low. And this one (pointing to another bottle of pills) it helps me sleep. I cannot stop worrying about...what will happen when this one (elder client) dies and I need to find a new job, it is hard now. And it can be so hard learning about a new house and how they want to do things, and this work is so much responsibility. I just worry.

According to individual doctors, and clinic managers, the doctors prescribed medicines such as Prozac and Haldol most often for the diagnoses of depression and anxiety. They noted that talk therapy was a needed-and-lacking resource in INHS. This gap in mental health services was also felt by Italians using INHS, according to health care providers and administrators with whom I spoke.
Back Pain Related to the Physical Tasks of the Work

There were physical tasks inherent to carework that directly led to physical health consequences for the careworker. Back pain was named as a health problem associated with carework by 42 of the 50 interviewees. I have many descriptions from women of the moment when they felt their back sustain an injury. One careworker, Bella, stated flatly, “If anyone who talks with you for this project does not tell you about having back problems in their work as a careworker, they are lying to you.” In addition, those who serve immigrant careworkers, e.g., physicians and social workers, also named back problems in response to the interview prompt, “What are the health problems typical of this group of workers?” As discussed in chapter 1, these findings match what has been seen in other countries and work settings, especially in studies on health assistants in institutions and those employed by agencies (Capacci, et al. 2005; Kim, et al. 2010; Payne and Appel 2007; Scherzer and Wolfe 2008). In all of these settings, supporting the weight of a person who cannot stand alone requires strength. All of the many ethnographic examples in my data linked the back pain experiences to the care of an adult who requires transfer, as Bella described it, “From bed to wheelchair to toilet to wheelchair to dining chair to wheelchair and on and on through the day.”

Using INHS Resources after the Pacchetto arrived in Italy

State Resources Available to Documented Careworkers

The services available to documented immigrants were equal to those available to Italian citizens; these services were accessed as described in chapter 2. INHS employees and participant careworkers told me that immigrants sometimes asked around to find a primary care physician who was “immigrant friendly.” Being immigrant friendly generally meant displaying a positive attitude toward non-Italians, having office hours, such as on Saturday or an evening, that supported immigrant work schedules, and perhaps having a good reputation with other immigrants.
In 1947 the Italian Constitution named “health as a human right for all within Italy”; in 1998 the law reforming the healthcare system, Italian Legislative Decree No. 286/1998, named documented workers as clients of INHS (Mapelli 2000); and, with a specific 2002 law, the Italian state officially named legal immigrants as recipients of comprehensive INHS care equal to that provided for Italian citizens (France, et al. 2005:188). Prior to institutionalizing this standard (in the years approximately 1978 through 1998) immigrants were receiving care from INHS services, in some regions with access to most of the services available to citizens. Part of the 1998 INHS restructuring process included setting health policy targets regarding the health of migrants in Italy. A similar priority in the 2003-2005 health policy target plan named “health of immigrants and the poor” and in “the Plan” for 2006-2008 one of the twelve priorities named was “health interventions for immigrants” (Lo Scalzo, et al. 2009:167). Health policy scholars considered “the Plan,” which names target priorities and the inclusion of immigrant patient populations in the discussion of priorities, to be a more advanced approach than that in many other EU countries (Karl-Trummer, et al. 2010; Karl-Trummer, et al. 2009). However, it seemed unclear whether the INHS had the ability to implement this well-developed policy (Giannoni and Mladovsky 2007; Mladovsky 2009).

In a 2009 review of the EU health systems, the country report for Italy stated, “At the time of writing, regular immigrants are registered in the SSN in the same way as Italian citizens: they have access to primary care, ambulatory care, hospital care, rehabilitation and emergency care.” (Lo Scalzo, et al. 2009:154) This sentence represented the uncertainty that pervaded Italy as the government introduced, debated, discarded and/or enacted various anti-immigrant measures in the last half of 2008 and into 2009, as I began this research and before the passage of the Pacchetto (detailed in chapter 7). Even this team of policy analysts was careful to note “at the time of writing,” as it seemed in 2009 that many rights, even for legal documented immigrants, could be
lost with the passage of legislation promoted by Lega Nord and other political parties responding to concerns over immigration policy and the presence of immigrants in ever-increasing numbers.

Many immigrants were quick to tell me that the Italian National Healthcare System was one of the best systems of healthcare in the world. Some of them even quoted the report by the World Health Organization (2000:152) that rated Italy as having the second best healthcare system in the world. INHS was used by both undocumented and documented immigrants for their own health, the health of their immediate family members, and to broker health for their elderly clients. Because documented immigrants accessed the system the same way in which Italians did they were subject to some of the same copayment requirements, described in chapter 3. The political battle (waged over the last decade by policy makers in Rome) over who was exempt from these copayments sometimes influenced documented immigrants. For example, patients who had completed a form to use the system as “a person of limited means” generally did not have to make copayments; immigrants without a job often applied for and receive this status. This was confirmed in interviews with immigrant women, an INHS nursing supervisor, two social workers, and an INHS clinic manager.

None of the immigrants I spoke with used private clinics or hospitals in Italy. Whether documented or undocumented, all of the immigrants I spoke with (in formal interviews and in casual conversation) reported use of the Italian National Healthcare System. The ways in which undocumented women utilized this system are outlined in more detail below. The emergency room is considered next, as it is a typical point of entry for immigrants.

Emergency Room Care

In Italy, the pronto soccorso (emergency room) was an important site of care where anyone who entered was treated. It was also of particular import for immigrants
as it is here that many undocumented immigrants first encountered INHS, either as a careworker supporting an elderly client, as an advocate supporting a friend with an illness or injury, or to deal with her own healthcare concern. Those undocumented immigrants who arrived for their own health emergency often were directed to obtain an STP card (described below) to facilitate follow-up care in the system for their condition.

All of the 67 immigrant women who participated in my research had at least one encounter with the emergency room, most often for their own health. Seven of the women had never visited for their own health but had been to the emergency room at one of the hospitals in Genoa to aid a friend. Fifteen of the women had visited the emergency room to accompany a family member and never for their own health. Twelve of the women had visited the emergency room in service of their client, but never for their own health. These women recalled being in such distress about their client’s health that they had to ask a neighbor with a car (often an Italian) or call an ambulance for transportation. The ambulance service in the city of Genoa was staffed in part with volunteers organized into Red Cross-type chapters\textsuperscript{116} that function to operate, train, and staff ambulances. Many male immigrants from South American countries were quick to let me know of their volunteer work with a “Cross” ambulance crew once they learned I was doing research on health in Italy.

Most of the immigrant women participating in my research had visited Genoa’s largest emergency room, at the hospital Galliera, but all of them reported confidence in the emergency rooms that functioned in other hospitals in the city. The confidence that

\textsuperscript{116} There were a variety of colors associated with healthcare, community service, non-profit, and emergency transport services. \textit{Croce rosso} (red cross), \textit{croce bianco} (white cross), \textit{croce verde} (green cross), and \textit{croce blu} (blue cross) dominated the signs and vehicles on the street, with a white cross most often seen on the ambulances that arrived at the emergency room at the hospital across the street from my apartment. There was disagreement among those I spoke with regarding the services and organizations the various colors represented. However, immigrants and Italians assured me that there was a reliable rotation in place so that when someone called the emergency number in Genoa, one would arrive promptly, staffed with knowledgeable emergency medical technicians, paid or volunteer.
many women had in INHS was linked to their first impressions from initial encounters with the “INHS system.” Significantly, many of these initial INHS encounters for the immigrant participants in this study took place in the emergency room in the years 1999 to 2004, when INHS was developing strategies to directly address immigrants’ health needs (Devillanova 2008), and long before any challenges to the Italian constitution’s idea of healthcare for all entered the public discourse vis-à-vis the *Pacchetto*.

State Resources Available to Undocumented Careworkers - Then and Now

According to the letter of the law, undocumented immigrants had the same access to INHS resources after the implementation of the Security Package (2009) as they had before (1998-2009). What had changed was the climate within which the law operated, as discussed in chapter 7. The media coverage of anti-immigrant rallies, speeches and debates by politicians, policy analysts, and everyday Italians and immigrants created a fear of the unknown (for newspaper accounts, see Calandri 2009; Mauro 2009)117. In the case of healthcare for undocumented immigrants the concern was if the definition of what were “necessary” healthcare services would change in the anti-immigrant environment of 2009-2010.

The women from South American countries who participated in my research encountered the INHS using the STP card when they were undocumented immigrants. All but one of the immigrant women I interviewed arrived in Italy without a legal contract, and most of them first encountered INHS as an undocumented immigrant using STP. Some of them (in 2009) were out of work tied to a legal contract and had been without legal work for more than six months. Therefore, some careworker-participants had re-entered the status of being undocumented, and were using their STP card to access INHS.

117 For academic analyses of this discourse, especially that involving *Lega Nord*, see Castellanos 2004; Zaslove 2003.
When I asked these women who had used STP prior to the passage of the Pacchetto and again now after its passage about the provision of care, they all said, “It is equal.” I asked some of the women how it was different from when they, as a documented immigrant, had a primary care physician, and Laura replied: “It is the same, I call my doctor when I need anything and he or his nurse calls in the prescription or tells me to come in for an appointment, I just use my STP card instead of my regular INHS card.” This point was made in individual follow up interviews (6/24) and in the focus group (n=9) and one group interview (n=7). Another immigrant careworker, Lucy, speaking in a focus group, pointed out that once she was back using STP instead of a regular INHS card she had a hard time making it to the STP clinic to get her maintenance blood draws done to monitor her thyroid. She called her primary care provider, who told her to just come in to the “normal” lab to get the work done. Her understanding was that her provider wrote in her record that this was an essential health service, allowing her to use this service as though she were documented. These careworker-participants were positioned much differently from new undocumented immigrants. They have a history of healthcare with INHS and relationships with individuals in INHS, and so they maintained a confidence in the ability of the Italian state to provide healthcare. As discussed in chapter 7, the effect of the Security Package has been to scare new immigrants away from using the services available to them as undocumented immigrants in Italy. Without a history of care and without ties to INHS, the new immigrants could not move with the confidence of the experienced immigrant careworkers I encountered.

Non-Institutional Resources

Home Remedies - a South American-Italian mix

Over half of the 67 careworkers who participated in the individual and group interviews used some sort of home remedy, most often for managing symptoms related
to common illnesses such as colds, headaches, stomach problems, and complaints associated with menstruation such as cramps, bloating, and headaches. Home remedies were offered when I asked about general health maintenance, as in, “What do you do when you have a cold and need to show up to care for your elderly client?” Sometimes I had to prompt the research participants to recall what for them were everyday normalized activities of self care (Garcés, et al. 2006). Chicken soup as a way to address upper respiratory problems was credited as having origins in Ecuador, Bolivia, Peru, and Brazil. Jessica noted, “They think they invented it here (in Italy) but trust me, my mother’s great aunt (in Ecuador) thinks that she invented it. All that I know is that it works.” Chamomile tea was also seen as having great healing properties, useful for calming upset stomachs, soothing sore throats, and keeping the lid on a growing headache. After chicken soup, it was the most often-named home remedy, and most of the women (35) who mentioned it as a health resource talked about using it back in their home country. They also acknowledged that the Italians use it as well, for many of the same symptoms. Discussing home remedies seemed to stimulate positive memories from childhood for many of the women I interviewed, who recounted stories of grandmas or aunties preparing a mustard poultice or menthol rub poultice or a special tea for them when they were small children and very sick with a cold. A close third in the lineup of home remedies was the use of a mixture of hot water, lemon, honey, and garlic. Sometimes sugar replaced the honey in the recollection of the recipe, sometimes ginger replaced the garlic, and sometimes a bit of alcohol was added. This mixture was used to calm a sore throat, still a cough “so I can get some sleep and keep my job” according to Janice, and settle an upset stomach. A few women noted that older Italians use a similar mixture and some of them learned about this home remedy from an employer’s household in Italy.
Pharmacists and Herbalists in Italy and “Back Home”

The preliminary fieldwork done in summer 2008 suggested to me the types of healthcare resources that may be available to immigrant careworkers. I used the three categories already named - INHS, home remedies, and emergency room - to organize my initial analysis of healthcare resource use. However, I had to add this fourth category – pharmacists and herbalists – after reviewing the data, especially from the interviews with careworkers and the interviews with those individuals who serve immigrants.

Many careworkers dealing with chronic and health maintenance issues described the neighborhood pharmacist as a valuable, easy-to-access resource. The neighborhood pharmacies were often a stop for the careworker doing the morning shopping, as they were the most convenient place to buy over-the-counter drugs. Italians expected pharmacists to dispense advice, and diagnostic questions as part of the advice conversation were seen as everyday business. In Italy, pharmacists control access to many drugs; for instance, one must visit a pharmacist to get an aspirin, even though a prescription is not required. Some women talked about their employers buying them over-the-counter drugs to ameliorate symptoms from a fever or cold. Others, such as Bianca, reported they were sent to the pharmacist to “get a diagnosis and the right pill.”

When recalling their life before they understood how to access the INHS, many women talked about going to the pharmacy in their neighborhood, urged by a friend, neighbor, or employer. One INHS administrator working to develop services to meet the needs of undocumented immigrants noted, “We knew that they (immigrants) will often get to know the pharmacist in their neighborhood, so part of our assessment was to ask them (the pharmacists) for their ideas.” A pharmacist I spoke with had learned medical Spanish while in Pharmacy school for two reasons: she has an ongoing interest in language learning; and, she wanted, in her words, “to be ready to really help the
people that will come to the pharmacy where I work.” Her experience was that many Spanish-speaking immigrants appeared in neighborhood pharmacies to meet their own needs or that of their clients.

For both health maintenance and chronic health concerns, many immigrant women were working with relatives back home to get pharmaceuticals or herbal medicines sent that did not require a prescription in their home country, but did require one in Italy. They described the comfort of using a familiar product and the convenience of not having to interact with a health provider to get the prescription. Some used resources back home, e.g., Ecuador, to get a prescription-only drug sent for their use in Italy. One woman described her nonna pesterling her to find the generic name for a medication the careworker had taken back home in Bolivia for migraine headaches, then watching in surprise as the elderly client called her own doctor in the INHS to request a prescription for this drug.

I also saw herbalists in every neighborhood in Genoa, sometimes next door to and associated with a pharmacist. In Italy herbalists and pharmacists were regulated by the federal government (Baldo, et al. 2007; Benzi and Ceci 1997; Fattore and Jommi 2008), but did not receive salaries from the government as INHS medical doctors and other health employees did. Many pharmacies were small- to medium-sized family businesses. In Genoa, the relationship with the herbalist or the pharmacist was one example of a relationship that some interviewees considered a social or neighborhood relationship that influenced the health of careworkers.

**Barriers and Strategies in Accessing Healthcare**

Medical anthropology has produced a great deal of literature on immigrants’ access to healthcare which is often clinic-based (Sarmiento, et al. 2005; Shin, et al. 2005). Researchers have identified barriers such as language of practitioner (see Garcés, et al. 2006; Ivanov and Buck 2002), and examined strategies by migrants and/or
providers to ensure access to care (Festini, et al. 2009; Manderson and Allotey 2003). Two obstacles to healthcare access named in the literature and relevant for my research were: (1) language barriers; and, (2) lack of information about how to access healthcare resources. In addition, an obstacle for in-home careworkers was (3) finding time away from work.

I begin with the third barrier, which emerged in early interviews. Careworkers participating in research generally agreed that being able to take time away from work could often be difficult, whether worker was in a live-in or live-out employment situation. Maria summarized a group interview (N=5) discussion by saying, “it all depends on the Padrona and the situation.” Overall, the data show that those who live in as a condition of their employment have more difficulty getting time away from the workplace to attend to their own health. Even health providers with evening and riposo hours could be inaccessible to the worker who was in the home-workplace 9-10 hours a day, and must take 30-60 minutes on public transportation to get to their appointment. Careworkers reflecting on their work histories and healthcare histories noted that when they were new and had less confidence with the language, less knowledge about their rights, and fewer contacts in the Italian and immigrant communities it was especially difficult to get time away from work because they were afraid to ask. However, I learned in follow-up interviews that even for experienced careworkers this was a barrier at times. In our interview, Bianca pointed out: “You have to be away-from the home, from your person that depends on you – before you can go to INHS or to the physical therapist. It is a lot, just to get away.” This touches on the idea never-ending responsibility described earlier in this chapter.

To address this barrier the immigrant careworkers used a variety of strategies, which had been developed with experience and in learning from other immigrant careworkers’ stories. The data revealed that four main strategies were used by
careworkers seeking time away from work to attend to their health, regardless of the type of healthcare resource being used. These were: calling a friend to “cover” for them with their frail elderly client; making a plan with a family member of the elder in advance; asking an Italian friend and neighbor to attend to the elder in their absence; and, asking a visiting relative (such as a mother-in-law visiting from Peru) to do their work while they took time away to attend an appointment at a clinic. Ten of the fifty careworkers I interviewed in 2009 and 2010 mentioned in individual interviews that they did not ask, they merely informed the Padrona, well in advance, of their healthcare appointment so that the Padrona could make arrangements for care in the home.

The remaining two barriers to care named above involve a skill (language use) and knowledge (of INHS and other healthcare resources in Genoa). There are skills that are part of carework that directly transferred into the private sphere of the immigrant careworker and influenced positively the way she accessed healthcare resources for her own well-being. There are two skills that immigrants must master at a certain level to remain employed as a careworker in Italy: (1) Italian language conversational skills that enable the careworker to communicate regarding the elder’s well-being; and, (2) the ability to assist with healthcare needs of the elder, including making and attending appointments and other interactions with the INHS.

Because so much of carework involves communication – with the elder client, with the client’s family members, with the other providers to the client (such as physical therapists), with neighborhood merchants (such as grocers and pharmacists) – it is out of necessity that the immigrant careworker learns the Italian language early in her stay. Because these women have learned the language for their work, and their work often gives them the opportunity to practice this newly acquired language, as patients they have an advantage when compared with immigrants in other work sectors (Médecins
Sans Frontières 2009). Unlike immigrants who have not had the opportunity to learn
the language of their work country and are very likely to experience language barriers in
the medical encounter (Garcés, et al. 2006), these workers have a linguistic advantage.
In some cases the vocabulary related to the job of carework directly aided the immigrant
careworker in her own health encounters with INHS.

Other research has shown that an important barrier to care for immigrants is a
lack of knowledge on where to seek care (Remennick 2003). However, due to their work
tasks, careworkers sometimes communicated with INHS on behalf of their client,
including accompanying the client to medical appointments. Thus, the workers in this
employment sector were well equipped to encounter the formal medical system in Italy.
Even if the elder or one of her family members made arrangements with INHS, the
careworker was in the home when calls were made, prescriptions were refilled, and
appointments were confirmed. All of the interactions the careworker is involved in on
behalf of her client, with appointment schedulers at the INHS, with receptionists, with
nurses, pharmacists, technicians, and doctors were sources of knowledge. This
knowledge about how the system worked, which resources were available, and the
informal routes taken to get the formal system to serve the needs of the patient aided the
worker in accessing the INHS for her own health needs.

Women recounted how in their first months at work, they would prepare for
making telephone calls to primary care providers or pharmacists on behalf of their
clients, wanting to use the newly acquired language skills and their INHS knowledge
properly. Bianca contrasted this with her more recent communication with INHS, saying,
“I am always picking up the phone to ask a question about my own health, or calling the

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118 Sharing a language with the medical provider can increase compliance (Loue 1998), heighten
confidence in the medical encounter, and increase overall satisfaction with the healthcare
resource (Koehn 2006).
physical therapist for my client, or calling her primary physician – the INHS knows me well by now (laughs)."

A couple of workers volunteered that they felt their general confidence increased over time because they had more opportunities to test their skills. In follow-up interviews I learned that they were not only referring to their confidence with the language but also with their work role and their knowledge of services and other Latin Americans in communities in Genoa. Some of the women had never cleaned a house or cared for anyone as they had servants at home in their country of origin, and were overwhelmed at the range of duties involved in performing their work role as they negotiated a new culture in their first jobs in Genoa. Several noted that after they had successfully addressed a problem by negotiating the language and culture on their own, they then felt confident as a “person who belonged” in Genoa.

Summary

Generally, all women report confidence in using the Italian health system (via the emergency room) for acute health concerns such as those reported in interviews, which included: severe back pain, a twisted ankle, severe abdominal pain that ended up being appendicitis, high fever and severe headache. Women with chronic health problems such as ongoing depression, allergies, or thyroid conditions used all three types of healthcare resources, informal (such as home remedies), formal state (such as the Italian National Healthcare System), and NGO formal resources (such as a support group or a clinic sponsored by a church or labor union). In addition, women used pharmacists and herbalists as resources, and what one server called “long distance self-medication.”

The immigrant careworkers who participated in my study also named the increased use, over time, of deeper and broader social networks in order to cope with the stress of their jobs and their life as an immigrant. These included social connections
made with other native Spanish speakers in Genoa and former employers, a strategy used for decades (Wall 2004:31). Workers also used formal organizations, which I characterized as “touchstone organizations.”

In my analysis of the data from interviews with workers and those who served them I learned that, generally speaking, workers who had lived longer in Italy had three distinct advantages. They spoke Italian better than women who had arrived more recently, and they had more diverse and extensive social networks. Third, the fact that they had a history with the national health system, either as an undocumented worker or as a regular worker with documents made them move with more confidence and utilize the system to access health resources. It is important to remember that these experienced careworkers encountered INHS before the looming specter of the Pacchetto appeared as it did in 2008 as proposed, much-discussed legislation. Three workers specifically reflected on their medical appointments early in their time in Genoa and how scared they were to talk to the medical professionals because of their limited language skills and uncertainty about how the Italian system functions. If they had entered the country in 2008 or 2009, this uncertainty would likely be increased, due to the Pacchetto. The recollections of these experienced careworkers who entered Italy as immigrants during a different political moment contrasted with their current view (in 2009 and 2010) of themselves as informed users of an excellent health system.
Flexible Workers in Genoa

Ten months after my initial interview with Virginia and her grown daughter Lisa, I talked with Lisa at a Sant’Egidio Italian language class, where she was working to gain confidence in conversation. Because she lived with her (bilingual) relatives and had worked a live-out night carework job she had not been in a situation to practice speaking Italian. Unlike many of my older interviewees, Lisa studied Italian in formal classes in Guayaquil prior to her emigration to Italy to join her mother, and so writes and reads the language better than she speaks it. The relatives of her mother’s workplace have been instrumental in helping Lisa make contacts for her own job opportunities. Lisa had a job lined up and a permit to stay as she entered the country, but then, as the elderly client died the day Lisa arrived in Genoa, she subsequently had six months to find another client before moving into undocumented status. She then secured a legally-contracted live-out night job for four months with a regular contract until the second client also died, so as of June 2010 her documented status was secure for another 6 months. Lisa was an example of the second wave of immigrants, who now have experiences and family that connect them to a place in Italy, but were not seen as employable by Italian hiring managers in many work sectors beyond domestic-based jobs. Lisa’s short work history pointed out in the most obvious way the inherent precariousness of carework employment, most obvious from the perspective of the worker.

However, Lisa’s situation also highlighted the extreme advantage to the employer and the state of such worker flexibility. The “making” of Lisa – as a neoliberal subject (Bakker and Silvey 2008; Gill 1998), as a disciplined and highly-skilled worker, as a healthy community member — had occurred in Ecuador. The maintenance of Lisa’s well-being, her education, her growing up, all of these processes of social reproduction (Burawoy 1976) took place in Guayaquil. Even her orientation to employment in the
carework industry had been done by her mother and other immigrant relatives in Italy, making her a “ready-to-go” worker (Ong 1999). The racialized hierarchy and xenophobic structures of inequality in Genoa positioned immigrant women like Lisa as being “naturally suited for” and relegated to the jobs of caring or cleaning in the home, regardless of their other attributes as workers (Pagnotta 2008).

Lisa was also a single woman, in Genoa, the “ideal” person to be in carework, as her personal energy, i.e., labor power, could be channeled almost exclusively into her work. Her status as a single female made her the ideal live-in worker in this carework sector in Genoa. The worker arriving alone was, and continues to be, necessary for the externalizing of the social reproduction of the workforce in Italy (and in a variety of work sectors in a variety of settings throughout the world (for examples, see: Anna 2011; Bakker and Silvey 2008; Chavez 2008; Gill 1998; Gunewardena and Kingsolver 2007; Naples and Desai 2002). The alone-ness of being a new immigrant, without kin or support networks was then interrelated to the work of being an in-home careworker to such a great degree that it was almost entirely a condition of the work. Thus the condition of being an immigrant was intertwined with the conditions of in-home carework and seen in the level of well-being of the workers. The transnational transfer of reproductive labor was visible in the quality of well-being and general health of the individual workers.

As I exited Genoa, Virginia, her mother, was in good health and continued working at her live-in job, returning to the apartment of her sister’s family for approximately 32 hours every weekend to sleep on the sofa. While Virginia was in good health in 2010 and had the experience to make decisions and influence her employers enough to maintain a safe working environment, one bad moment lifting her wheelchair-bound client could end her ability to perform her carework job as she does now. In her early 60s, Virginia will develop health concerns sometime in the next two decades and
need care herself. Virginia’s situation as an “aging careworker” points to a question that is starting to engage policy-makers and researchers in both sending countries (such as Ecuador and Peru) and receiving countries (such as Italy and Spain). The ways in which the careworkers in this study managed communication, created opportunities, endured hardships, negotiated systems, and maintained their own health so that they can arrive to work every day in the home of an elder elucidates how the global economic forces are revealed in individual lives.

Virginia has a son, grandchildren, and other family in Ecuador; Lisa has a brother and half-brothers and more relatives, also in Ecuador. Both women have reasons to live in either country, or to maintain a transnational relationship that involves both countries. Will Lisa be able to find steady work in the current (2012-2013) economic downturn in Italy or should she return home to Ecuador? Should Virginia retire in Ecuador near her son’s family? Could she semi-retire in Italy and continue with more economic security (Boccagni and Lagomarsino 2011)? Can economy security be relied upon in the precarious economic realities of Italy in 2012?

Precarious Life at Different Scales

By using the life experiences of careworkers like Virginia I have described how women who have immigrated to Genoa from Latin American countries negotiated their precarious work- and life- situations to maintain their health in order to earn money to sustain themselves and their families. At the larger scale, in doing so I have examined the state-like institutions of labor unions and the Catholic Church, the role of the Italian state in elder care policy and the Italian National Healthcare System (INHS), and the histories of Italy and Ecuador. The Pacchetto arrived as I entered the field, and only served to create more social tension and a sense of increased precariousness for those who employed immigrant careworkers, those who served immigrants, and for the careworkers themselves. My theoretical approach, working to use critical medical
anthropology (CMA) theory in tandem with intersectionality theory, served me well, as it aided my ability to situate the new actor (the *Pacchetto*) into the analysis of interlocking relationships. Intersectionality focused the analysis on social location of individuals, and CMA informed the way I approached the structural inequality and shifting terrain of power that arrived along with the Security Package. My CMA–informed approach moved me to view the careworkers as both patients and practitioners in the overall healthcare system in Italy.

When I considered elder care a form of health maintenance, the Italian state was seen as responsible for creating a low-cost workforce of in-home careworkers; the Italian state maintained the health of this workforce by addressing the physical health needs vis-à-vis INHS as coordinated by the Ligurian Regional Health Authority. Thus, the essential workforce remained healthy enough to attend to the burgeoning elderly population. The Italian state and the families of these elders may point out that the Italian government considers care of elders to be a familial responsibility, but in fact this “burden of care” had been passed from the state to the family and then onto the low-wage immigrant worker.

This dissertation research extends and interrogates some important ideas in current scholarship about the consequences of the work of care. I focus on how individuals utilize resources to care for themselves when they are in a precarious situation, such as unprotected work arrangements in an informal economy. The caregiver-focused literature has produced a substantial amount of literature focused on the family caregiver, and has emphasized the importance of in-home care and the need to increase support for those who provide such care. By contrast, there have been many fewer publications on privately-hired, home-based, paid careworkers during this same time. The family caregiver is often portrayed as a heroine (Spillman and Pezzin 2000), juggling many responsibilities, and, in service to my project, the research is most
often squarely focused on her well-being. For the paid, home-based careworker, the research is often not focused on her well-being, but examines how to prevent burnout (Faul, et al. 2010; Kristensen 2006), retain workers (Giver, et al. 2010; Howes 2009), and improve the quality of care by improving training and supervising of paid careworkers (Osterhout and Zawadski 2006; Zeytinoglu and Denton 2006). The home-based low-wage worker is most often mentioned in the literature on support for family caregivers as a resource to tap for respite care or for additional support to help the family caregiver deal with the overwhelming burden of care (Prince, et al. 2012). She is generally seen as a solution to help a person in real need, not as a person with needs that may stem from her own working conditions. My study fills this large gap in the literature by beginning with the in-home paid careworker and focusing on her well-being in the tradition of the family caregiver research.

At a more personal scale of analysis, I examined the work histories and healthcare experiences of individual careworkers in order to understand the health consequences of the stress of carework for the women who perform reproductive labor. These findings continued the work of feminist scholarship, regarding: using intersectionality to increase our understanding of social location and its influence on health; and considering gender as one factor in understanding the negotiation, reinscription, resistance, and creativity of low-wage workers in a transnational service economy. For instance, the strategic use of employer household relationships, social ties with other immigrants, and the Catholic Church as resources to mitigate stress displays the creative and necessary coping responses on the part of the transnational workers exerting agency. In terms of the general aims of anthropology, this study adds to our understanding of individual power and agency. By focusing on a particular community of workers (careworkers from South American countries) it examines this
community’s collective power; these women constitute a significant portion of Genovese society.

**INHS and Immigrants**

The women in this work sector had to learn skills and knowledge to deal with INHS on behalf of their client; this “on the job” training was directly transferable and helpful in their own dealings with INHS, especially to address physical ailments and medicalized health conditions of carework. These immigrant women, employed as careworkers in Genoa experience INHS and healthcare in very different ways than other “flexible workers” employed in other work sectors, such as agriculture.

One idea for future research is to act on these initial findings, based on my review of the secondary literature and the data from my research, especially gained in interviews with careworkers, INHS administrators and servers. What strategies do immigrants from other sectors utilize? Do relatives of immigrant careworkers use INHS differently (more frequently? with more confidence?) than the relatives of immigrants employed in other sectors? A perfunctory examination of my data indicates that when a careworker’s family members such as spouses, children, or aging parents join them in Genoa may also benefit from her knowledge and skill as they deal with INHS. It appears that the careworker’s skills and knowledge base were used to assist in the health maintenance of the family using the national health system. Establishing how employment sector influences use of INHS, and by extension, the quality and type of health encounters of the worker’s family members would yield useful information, to aid in providing healthcare in a system such as INHS, and to further theorize how social processes and institutions influence health.

Another obvious area for future research in this field site is to follow up on the small-but-critical study on emergency room use in Genoa before and after the *Pacchetto* (described in chapter 7), initiated by Rehhal Oudghough of the University of Genoa.
While this study adds insight into the healthcare-seeking strategies of a significant segment of the population of Genoa, one that is sometimes hidden, there is important work to be done with immigrants who have arrived in Genoa since the Pacchetto became law. In my data I have the words of those who serve immigrants and the experienced immigrant careworkers who may know some new arrivals, but I did not talk with new immigrants. What is at stake for them as they encounter (or not) INHS or other healthcare resources in a society with an institutionalized creed of anti-immigrant sentiment? How do they negotiate the precarious terrain created by the Pacchetto’s arrival? The experienced immigrant workers with whom I spoke build on a very different set of experiences with the state. Linked to this research strand for the future are my findings that INHS administrators and front-line workers were looking for new ways to reach out to all immigrants. The INHS research participants and those who worked closely with INHS (such as the volunteer medical people at the San Giacomo clinic) made it clear to me in interviews that they were interested in providing excellent care with the resources they receive from the state. But were these comments merely impression management or hopefulness on the part of these health system workers? A next research project should include a series of interviews with new immigrants and an examination of how the Pacchetto functions three or four years after its establishment and in the wake of serious economic downturns in Italy.

Since the initial idea for this research project was conceived, there have been shifts in the political climate in Italy. In 2008, the Italian Prime Minister (Berlusconi) facilitated opportunities for Lega Nord to gain credence, resulting in the passage of the Pacchetto. This package of laws went into effect in July of 2009, as I prepared to enter the field in Genoa. Parts of the package were declared to be “out of compliance” with the human rights standards of the European Union Commission (Maccanico 2011; Merlino 2009), but the laws remained largely intact. Since my departure from Genoa in
November 2010, the Italian government has been led by a new “technocrat” prime minister, Mario Monti. The Italian government was supported in dealing with its overburdening national debt by the European Union only after the resignation of Berlusconi, the installment of Monti, and a severe cutting of the budgets of a variety of programs (Faris 2011). In September, 2011 the sovereign credit ratings on the Republic of Italy were downgraded one level by the ratings agency Standard & Poor (Shaddock 2011). In the meantime, Italy’s extremely small safety net, providing impoverished elderly and disabled individuals some state support, has been severely curtailed and monies for attendants of the severely disabled are likely to be cut in 2013 (Gori 2011).

**Regional Identity Influencing Immigrant Life in Italy**

My dissertation research adds to an understanding of Genoa as one site and at a particular moment in the global marketplace when a variety of forces are converging: a disproportionately large population of elders; the availability of low-wage immigrant workers; mixed messages from the Italian state regarding immigration; and provision of services by Catholic-related agencies to both elders and immigrants. In focusing on a particular city with a unique demographic situation, my project reflects the importance of regional identity to everyday life in Italy. While my work is unique in that it focuses squarely on the health of immigrants as a lens into the culture of work, care and life in Genoa, it is following the Anglophone anthropological tradition in that it focuses on a set of regional processes and the strength of regional identity (Chell 1997; Cole and Booth 2006; King 2002; Schneider 1998; Schneider and Schneider 2003). For instance, Cole examined reactions to the two simultaneous phenomena of (1) increased immigration to Italy along with (2) the development of the European Union. He based his ethnographic work in a working class neighborhood in Palermo, forging new insights into the way that regional, in this case, “Southern,” or Italian identity affects worldview (Cole 1997:18-19). Using the lens of health and well-being, this project provides insight into state and state-
like actors such as, regional, provincial and municipal governments, labor unions, and the Catholic Church.

The European Union is important, the nation-state is influential, but it is the power imbued in regional identity that matters in two important ways that are at times in conflict with one another. The importance of regionalism led to the rise of Lega Nord resulting in extreme nationalistic sentiment and a discussion of who is truly Italian and should be allowed the rights outlined in the Italian constitution. In addition to fanning anti-Southern Italian sentiment, even proposing a separate north and south state (Castellanos 2004; Zaslove 2003), the Lega Nord (discussed in chapter 4) and the party of Interior Minister Maroni, the National Alliance, have introduced the idea of sangue – blood – as being important to establish what makes a genuine Italian, regardless of citizenship or documentation status (d'Orsi 2010:10). Other ideas about what it means to be a “real” Italian have been linked to religion, naming a preference for those immigrants who are Catholic (Garau 2010). It was the power of Lega Nord that created the anti-immigrant measures of the Pacchetto.

However the idea of regionalism is also what has led to the regional control of the healthcare budget – and to the decisions on the part of the Ligurian officials to ignore the Pacchetto laws, as discussed in chapter 7. INHS in Liguria, due to regional-level decisions, has created an immigrant-friendly climate, including the facilitation of access to healthcare, detailed in chapter 8.

**Shifting Relationships between the Church and the State**

An area of concern for the future is to consider the role of the state-like institutions associated with the Catholic Church in relationship to the Italian state, in terms of economic concerns and immigration policy. Garau’s (2010) observations regarding the statements from the Vatican regarding immigration include an analysis of the way in which the Church views immigrants, especially in Italy. In her view, the
Church sees immigrants as an opportunity to keep the Church relevant and filled with members in an increasingly secular world. Non-Catholic immigrants, such as the Muslims that constitute a large portion of immigrants in Europe, are seen as potential converts and Catholic immigrants, such as South Americans, are seen as those who can help the Church maintain its traditional values (Garau 2010:162-165). She also pointed out that the statements by the current Pope regarding what makes a genuine Catholic seem eerily similar to the Lega Nord rhetoric regarding what makes a genuine Italian.

The Church has recently changed its relationship to the Italian government; instead of all legislation passed by Italy automatically being the law in the Vatican (the tiny autonomous country that exists within the borders of Rome) now each law is examined and accepted or rejected, one by one (Willey 2009). Also, since Prime Minister Monti’s arrival and his work to stabilize the Italian economy, the Church now has to pay taxes to the Italian state. This is a new development since I exited the field and it remains to be seen how it will affect the ability of Catholic nongovernmental organizations to address the needs of people in Italy during these precarious times.

At the local, diocese and parish, levels the Church was simultaneously addressing the stress that accompanies the intensity of being an immigrant and being a careworker in a private home and stereotyping women from South American countries as destined to do (only) domestic work. The theme of precariousness was seen in these findings, because the message from the Church can be summed up in the following: life is precarious; you must deal with what is handed to you, using the gifts that God has given you; and, as a “naturally-nurturing” Latin American woman you must be thankful that you have a job that suits you so well.

**Aging Immigrant Careworkers**

Immigrants like Virginia, who arrived in Genoa during the Ecuadorian economic downturn of the 1990s at the age of 40, will be in their 70s by the year 2020. A look at
the enrollment in the public schools of Genoa reveals that a significant portion of the children and grandchildren of these female “pioneer” arrivals are well established in the city (Caritas di Roma 2008; Caritas di Roma 2009). These family ties will encourage many of these long-term economic immigrants to remain in Genoa for their own retirement. It is likely that non-native born elders will comprise a significant portion of the population and will start to develop the needs that accompany older age such as living with several chronic health conditions, and perhaps feel the effects of performing the physically-taxing and mentally-exhausting work of caring for elders and performing housework. Italy has relied, and continues to rely, upon the care of a substantial number of elders to be done by sometimes invisible workers, whose own needs are not of consequence to the state. Thus, health as a human right is abrogated for a certain category of humans. By examining the precarious position and healthcare strategies of the careworkers, this research project has yielded data linking social location(s), everyday acts, and the local constraints and opportunities of migrants to the broad transnational fields within which they operate (Zelizer 2002). The aging workforce from South America in Genoa will likely reveal new barriers and creative responses to the actions of the state and state-like institutions, such as the Catholic Church and labor unions.

Since the Italian state’s elder care policy for its citizens is to name the family as responsible, with limited to no assistance from the state, it is not likely that the policymakers in Italy will develop a plan for this aging workforce of both undocumented and documented immigrant careworkers. If INHS continues to support the health of immigrants and elders at the current level in Liguria, will the struggling Italian economy be able to afford the costs to maintain everyone’s health? Will long term immigrant careworkers legally and culturally become citizens of Italy? (Salvini and De Rose 2011) Perhaps “the latent hostility that derives from ‘not knowing your neighbor’ (will) dissolve,
little by little” (DeWaard 2011) as friendships develop with neighbors, language expertise approaches “native fluency,” family members are involved with Italian institutions such as the public schools, and immigrant careworkers worship with Italians at the local parish church (De Santis 2011). Or perhaps instead the unequal structures, fueled by status quo xenophobia and racism, will maintain barriers between long-term immigrants and Italian citizens, so that hierarchies remain and aging immigrants are merely older second-class, servant-class citizens.

The chain of care, which Parreñas has noted is visible in both Glenn’s “racial division of reproductive labor” (Glenn 1992) and Parreñas’ own extension of this concept into “the international division of reproductive labor” (Parreñas 2001a). Genoa in 2009-2010 was one site of commodity exchange in the market, and by considering workers’ health the consequences of the transfer of reproductive care are highlighted in this dissertation. Considering the well-being of aging immigrant careworkers, wherever in the world they may be, is an opportunity to follow the chain of care in a new direction across transnational fields.

One forward thinking elder services administrator-researcher for the comune of Genoa asked during her remarks at a conference in December 2009, “What is our plan for caring for the immigrant woman who arrived here 15 years ago at the age of 45 and in a decade may need care and may not have returned to Ecuador or Albania? What is our plan for caring for these women who have cared for our elders?” (lecture by Roberta Papi, Policy Assessor for Social Health, Comune of Genoa, December 17, 2009). It is non-profit agencies such as Caritas and Sant'Egidio, among others who have experience in serving both immigrants and elders. In many ways, these organizations

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119 This was one of the keynote addresses at the conference held in Genoa at the Palazzo Rosso [Red Palace], a building that houses many government offices, a museum, and a conference center. The conference was titled: “Do not call them badante anymore: careworkers and best practices for care of the elderly.”
are well-positioned to address a need that will arise in the not-so-distant future. However, their financial security in the economy of 2012 makes this a less certain resource. This research provides insight into the bridging function that these agencies and the Catholic Church have served for immigrants upon their arrival in Genoa. These findings can inform research on the possible role such organizations play as the careworkers transition into old age in Genoa. In addition, a useful next step in this research trajectory would be to examine other transnational economic and social activity, such as the situation of retired careworkers going home to Ecuador, some to start small businesses with the support of the Ecuadorian government. A related research strand is to follow the relatives of these careworkers, people like Lisa, who have arrived in Italy at a time of economic upheaval.

**The Shadow Healthcare Economy: the Informal Economy and Health**

This research project examines the healthcare strategies of migrant careworkers and thereby contributes to migration research. It also adds to medical anthropology’s understanding of human-economy-reproductive care interactions and to a view of health and carework as commodities. I argue that health is a lens through which we can examine global economic processes, revealed in particular locally positioned ways. The term “health” includes the everyday care of individual bodies. Because elders are “living independently in the community” their bodies are not considered to be a part of the formal healthcare system. Thus, providing care, which is most often assistance with Activities of Daily Living (ADLs), is a way in which the work of low-wage immigrant women employed as careworkers is related to health.

The formal and informal economies are seen as linked in works by a variety of economists (Kumaranayake and Lake 2002) and anthropologists (Appadurai 2000:6-8). These are linked in significant ways that affect the elder carework sector of the informal economy, which I refer to here as the *shadow healthcare economy*. I use the term
shadow because the official economic exchanges were “off the books” and taking place in the shadow of the formal economy. I use the term healthcare because these exchanges were done to secure the well-being and care of elders. If this task were turned over to the Italian state it would be disaster and ill health for many. The shadow healthcare economy must exist to prop up the Italian state and the current structure and function of the Italian family (Anderson 2006).

My research findings regarding the connections and tensions between state institutions such as INHS and in-home carework point directly to the link that is critical to recognize for work investigating the connections and tensions between public/private, family/non-family, unwaged/waged, and informal/formal as part of care and health in an aging world. The low-wage non-licensed home caregiver contributed in a foundational way to the healthcare and elder care system, and by extension, a substantial portion of the formal economy, of the Northern hemisphere "work" country to which they migrated. This contribution was seen in the following two ways. First, in keeping elders healthy at home for as long as possible, these bodies were kept out of the medical system. The medical and long-term care system had a limited number of beds and could not absorb the number of post-war baby boomer elders who required assistance with ADLs and associated health problems. Second, the economic investment in hiring, for example, a live-in, low-wage caregiver to provide care yielded a high-value return for the household. If the wages that would have been lost from an employed family member who left the workforce to provide care were considered, this investment produced an even higher return (Guberman 2002; White-Means and Chollet 1996). The fact that many caregivers were live-in meant that their labor could be exploited for even more hours in the work week.
Lessons from Genoa regarding Reproductive Labor

The commodity of care is often linked to the work of women, and consumers in this market of care in industrialized nations often choose women as careworkers. Two reasons for this choice are: (1) the reproductive household labor that is being done by a “replacement” non family paid careworker is often done, without wage, by female family household members until the careworker is hired, and; (2) gender-specific practices and beliefs persist in many places regarding what kind of person is best at or most “natural” at caring. This commodified care is most often purchased in the informal economic sector.

Dalla Costa’s discussion of Marx’s idea of surplus labor (Dalla Costa 1988; Dalla Costa and James 1972) and Parreñas’ concept of the chain of care (Parreñas 2001a; Parreñas 2005), highlight the consequences of care for family households. My research continued this trajectory by introducing the idea of the very real consequences for immigrant careworkers and their elderly clients should resources not be made available to support the careworker’s health and well-being. In the case of Genoa, with such a paucity of younger family members and such a large percentage of the population requiring some sort of care at home, the situation could be dire should the Italian state at the regional health authority level interpret details of the Pacchetto so that immigrants would be denied healthcare. Because Italians over 70 years of age, plus the immigrant population, both documented and undocumented, together comprised such a large portion of the population of Genoa and Liguria, and because there was a living arrangement in which the careworker immigrant, and sometimes her family, lived with the elder client in the private home-workplace, it was important that support for everyone’s health remain high.

Genoa maintains a flexible workforce in order to care for the burgeoning population of elders, who are left by the Italian state policies to be cared for by their
families, which turn to the informal—and flexible—economy. Because the region of Liguria is where a healthy workforce of careworkers is most needed at this time, and because immigrants need to earn money to support their families, the informal economy thrives. The Ligurian Regional Health Authority has taken steps to ensure immigrant access to healthcare resources and immigrant women are using these resources and others to actively maintain their health, which is an important asset for securing a carework job. In a flexible labor market the level of employment security is low; immigrant women entering carework jobs knew that many aspects of the employment would be precarious and are beyond their control and so took steps to care for their own health as much as possible. These women knew that poor overall health or a health condition that becomes visible as a problem in the highly-scrutinized home work environment would make for an even more precarious employment situation.

Due to demographics, family support policies and a thriving informal economy, Italy in general and Genoa in particular are microcosms of transnational words of the future for many countries. Thus they can serve as “laboratories” for both social scientists and the administrators of governments and large social institutions. An INHS general practice doctor I interviewed made this observation, “Liguria is like a laboratory and all of Italy should be paying attention, learning from our mistakes, and maybe helping us.” He was referring to the fact that Liguria today, demographically, looks the way the other regions in Italy will appear in twenty years – one-third of the population over 60 years of age, very few relatives in younger generations to provide care due to decades of low birthrates, and many immigrants arriving to enter into informal arrangements to provide care (Burlando, et al. 2009). This study provides detailed information about how workers negotiated situations and created opportunities to maintain good health and can lend useful insight to other cities in Italy that will have the demographic profile of Genoa twenty years in the future.
Appendices

Appendix A: Ethnographic Anchors/Field Setting

1. Santa Lucia (pseudonym) – I participated in and observed: careworker training classes 2 times every week; the cleaning of the church/immigrant center followed by lunch every Saturday; and mass(es) every Sunday. I also attended the Friday night prayer service once every six weeks.

2. Don Bosco – I attended mass every Sunday morning, sporadically attended meetings of the careworker support group; and participated in activities and meetings of the developing Latin American congregation monthly. I also helped with a neighborhood census by the Don Bosco community and with the follow up activities, including distribution of flyers about church activities. I participated in the planning and execution of a community religious retreat, as part of the team of cooks.

3. Sant'Egidio – I participated in Italian language classes twice a week for six months, and occasionally observed new-immigrant orientation and food and clothing distribution. And I participated, as a “waitress,” in their annual Christmas dinner for elders living alone, immigrants and needy Italians young or old.

4. San Giacomo (pseudonym) – I helped with this weekly women’s health clinic almost every week after discovering it in a caregiver training where the clinic volunteers were doing outreach. I helped women find the difficult-to-locate space in the back of the church, acting something of a greeter-receptionist.
Appendix B: List of Workers Interviewed

<table>
<thead>
<tr>
<th>Careworker Participants (pseudonym)</th>
<th>Date of Interview</th>
<th>Age</th>
<th>Job prior to migration</th>
<th>Nationality</th>
<th>Yrs in Italy</th>
<th>Live In/Out</th>
<th>Marital Status</th>
<th>No. Chn</th>
<th>Loc. of Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alba</td>
<td>01/27/10</td>
<td>20s</td>
<td>Administrative Asst.</td>
<td>Ecuadorian</td>
<td>5</td>
<td>Both</td>
<td>Single</td>
<td>0</td>
<td>Italy</td>
</tr>
<tr>
<td>Alicia</td>
<td>01/31/10</td>
<td>30s</td>
<td>Adv. Practice Nurse</td>
<td>Peruvian</td>
<td>4</td>
<td>Live-out</td>
<td>Single</td>
<td>0</td>
<td>Peru</td>
</tr>
<tr>
<td>Ana</td>
<td>03/27/10</td>
<td>50s</td>
<td>Unknown</td>
<td>Ecuadorian</td>
<td>10</td>
<td>Both</td>
<td>Unknown</td>
<td>3</td>
<td>Ecuador</td>
</tr>
<tr>
<td>Anabel</td>
<td>02/26/10</td>
<td>40s</td>
<td>Editor’s Assistant</td>
<td>Brazilian</td>
<td>8</td>
<td>Both</td>
<td>Married</td>
<td>1</td>
<td>Italy</td>
</tr>
<tr>
<td>Aracely</td>
<td>11/09/09</td>
<td>30s</td>
<td>Student</td>
<td>Ecuadorian</td>
<td>8</td>
<td>Both</td>
<td>Single</td>
<td>0</td>
<td>Ecuador</td>
</tr>
<tr>
<td>Bella</td>
<td>04/16/10</td>
<td>50s</td>
<td>Full time mother</td>
<td>Ecuadorian</td>
<td>11</td>
<td>Both</td>
<td>Married</td>
<td>2</td>
<td>Italy</td>
</tr>
<tr>
<td>Bianca</td>
<td>03/18/10</td>
<td>40s</td>
<td>Community College Professor</td>
<td>Ecuadorian</td>
<td>4</td>
<td>Both</td>
<td>Married</td>
<td>3</td>
<td>Ecuador</td>
</tr>
<tr>
<td>Carmen</td>
<td>01/16/10</td>
<td>50s</td>
<td>Store clerk/Full time mother</td>
<td>Ecuadorian</td>
<td>7</td>
<td>Both</td>
<td>Married</td>
<td>2</td>
<td>Ecuador</td>
</tr>
<tr>
<td>Carmen Maria</td>
<td>12/05/09</td>
<td>50s</td>
<td>Full time mother/Clerk</td>
<td>Ecuadorian</td>
<td>11</td>
<td>Both</td>
<td>Divorced</td>
<td>2</td>
<td>Spain and Ecuador</td>
</tr>
<tr>
<td>Elisa</td>
<td>04/03/10</td>
<td>60s</td>
<td>Administrative Asst.</td>
<td>Ecuadorian</td>
<td>9</td>
<td>Live-in</td>
<td>Separated</td>
<td>3</td>
<td>Ecuador</td>
</tr>
<tr>
<td>Elvira</td>
<td>03/31/10</td>
<td>50s</td>
<td>City Manager</td>
<td>Ecuadorian</td>
<td>14</td>
<td>Both</td>
<td>Married</td>
<td>3</td>
<td>Ecuador Italy</td>
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<tr>
<td>Emma</td>
<td>02/14/10</td>
<td>50s</td>
<td>House cleaner</td>
<td>Ecuadorian</td>
<td>9</td>
<td>Both</td>
<td>Married</td>
<td>6</td>
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</tr>
<tr>
<td>Fatima</td>
<td>01/22/10</td>
<td>50s</td>
<td>Store clerk/Mother</td>
<td>Peruvian</td>
<td>7</td>
<td>Both</td>
<td>Separated</td>
<td>3</td>
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<tr>
<td>Germania</td>
<td>03/17/10</td>
<td>30s</td>
<td>Lab Assistant</td>
<td>Ecuadorian</td>
<td>4</td>
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<td>Giuseppina</td>
<td>03/24/10</td>
<td>50s</td>
<td>Data Entry</td>
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<td>07/19/10</td>
<td>20s</td>
<td>Student</td>
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<tr>
<td>Iris</td>
<td>03/06/10</td>
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<td>Store/Café Owner</td>
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<tr>
<td>Isabel</td>
<td>01/14/10</td>
<td>50s</td>
<td>Administrative Asst.</td>
<td>Peruvian</td>
<td>7</td>
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<td>Peru</td>
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<tr>
<td>Janet</td>
<td>03/16/10</td>
<td>20s</td>
<td>College Student</td>
<td>Bolivian</td>
<td>4</td>
<td>Both</td>
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</table>
### Appendix B: List of Workers Interviewed, continued

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Age</th>
<th>Position</th>
<th>Nationality</th>
<th>Gender</th>
<th>Relationship</th>
<th>Marital Status</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janice</td>
<td>04/30/10</td>
<td>60s</td>
<td>Bank Teller/ Babysitter</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Separated</td>
<td>2</td>
<td>Italy/Ecuador</td>
</tr>
<tr>
<td>Jenett</td>
<td>01/30/10</td>
<td>30s</td>
<td>Nurse</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Married</td>
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</tr>
<tr>
<td>Jenny</td>
<td>04/03/10</td>
<td>20s</td>
<td>Journalist</td>
<td>Ecuadorian</td>
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<tr>
<td>Jessica</td>
<td>01/08/10</td>
<td>40s</td>
<td>Hosp. Billing Clerk</td>
<td>Ecuadorian</td>
<td>Both</td>
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<tr>
<td>Josephina</td>
<td>05/08/10</td>
<td>50s</td>
<td>Housekeeper</td>
<td>Ecuadorian</td>
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<td>Italy</td>
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<tr>
<td>Laura</td>
<td>02/04/10</td>
<td>40s</td>
<td>Teacher/ Assistant Principal</td>
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<td>Both</td>
<td>Divorced</td>
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<tr>
<td>Livia</td>
<td>03/31/10</td>
<td>40s</td>
<td>Retail clerk</td>
<td>Peruvian</td>
<td>Both</td>
<td>Married</td>
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<td>Peru</td>
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<tr>
<td>Lucy</td>
<td>03/27/10</td>
<td>50s</td>
<td>Middle School Teacher</td>
<td>Ecuadorian</td>
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<tr>
<td>Lupe</td>
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<td>40s</td>
<td>Lab Assistant</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Unknown</td>
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<td>Ecuador</td>
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<tr>
<td>Luzmila</td>
<td>12/09/09</td>
<td>30s</td>
<td>Graphic Artist</td>
<td>Ecuadorian</td>
<td>Both</td>
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<tr>
<td>Margaretta</td>
<td>03/16/10</td>
<td>20s</td>
<td>Restaurant Manager</td>
<td>Bolivian</td>
<td>Both</td>
<td>Married</td>
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<td>Italy</td>
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<tr>
<td>Mari</td>
<td>03/14/10</td>
<td>40s</td>
<td>IT Support</td>
<td>Peruvian</td>
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<td>Married</td>
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<tr>
<td>Mari Carmen</td>
<td>02/20/10</td>
<td>30s</td>
<td>Non-Profit Administrator</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Single</td>
<td>0</td>
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<td>Maria</td>
<td>01/22/10</td>
<td>40s</td>
<td>Waitress/Maid</td>
<td>Ecuadorian</td>
<td>Both</td>
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<td>Ecuador</td>
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<tr>
<td>Marjorie</td>
<td>03/22/10</td>
<td>40s</td>
<td>Café Co-owner</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Married</td>
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<td>Ecuador</td>
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<tr>
<td>MaryLuz</td>
<td>04/01/10</td>
<td>20s</td>
<td>Student</td>
<td>Ecuadorian</td>
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<td>Single</td>
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<td>Ecuador</td>
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<tr>
<td>Mirela</td>
<td>05/01/10</td>
<td>40s</td>
<td>Engineering Student</td>
<td>Ecuadorian</td>
<td>Both</td>
<td>Married</td>
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<td>Italy</td>
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<tr>
<td>Natali</td>
<td>03/07/10</td>
<td>20s</td>
<td>Student</td>
<td>Ecuadorian</td>
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<tr>
<td>Norma</td>
<td>02/18/10</td>
<td>60s</td>
<td>Govt. Administrator/ Translator</td>
<td>Ecuadorian</td>
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<td>Married</td>
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### Appendix B: List of Workers Interviewed, continued

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Age</th>
<th>Occupation</th>
<th>Nationality</th>
<th>Age</th>
<th>Relationship Status</th>
<th>Country</th>
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<tbody>
<tr>
<td>Nury</td>
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<td>60s</td>
<td>Ins. Agent/Owner/Comm. Coll. Prof.</td>
<td>Ecuadorian</td>
<td>12</td>
<td>Both</td>
<td>Divorced</td>
</tr>
<tr>
<td>Patrizia</td>
<td>04/15/10</td>
<td>20s</td>
<td>Store Clerk</td>
<td>Ecuadorian</td>
<td>6</td>
<td>Both</td>
<td>Married</td>
</tr>
<tr>
<td>Rosa</td>
<td>12/05/09</td>
<td>50s</td>
<td>Bank Teller</td>
<td>Ecuadorian</td>
<td>6</td>
<td>Both</td>
<td>Married</td>
</tr>
<tr>
<td>Rosamaria</td>
<td>03/31/10</td>
<td>40s</td>
<td>Housecleaner</td>
<td>Peruvian</td>
<td>7</td>
<td>Both</td>
<td>Married</td>
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<tr>
<td>Rubi</td>
<td>11/29/09</td>
<td>30s</td>
<td>Housecleaner/Full time mother</td>
<td>Ecuadorian</td>
<td>7</td>
<td>Both</td>
<td>Single</td>
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<tr>
<td>Tanya</td>
<td>01/22/10</td>
<td>60s</td>
<td>House cleaner/Secy</td>
<td>Peruvian</td>
<td>4</td>
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<td>Widowed</td>
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<tr>
<td>Teresa</td>
<td>06/08/10</td>
<td>30s</td>
<td>Architect’s Assistant</td>
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<td>Married</td>
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<tr>
<td>Valentina</td>
<td>04/07/10</td>
<td>50s</td>
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<td>Both</td>
<td>Married</td>
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<td>Veronica</td>
<td>02/20/10</td>
<td>20s</td>
<td>Student/Store clerk</td>
<td>Ecuadorian</td>
<td>7</td>
<td>Both</td>
<td>Married</td>
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<tr>
<td>Vilma</td>
<td>04/17/10</td>
<td>30s</td>
<td>Accountant</td>
<td>Ecuadorian</td>
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<td>Married</td>
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<td>Virginia</td>
<td>11/24/09</td>
<td>50s</td>
<td>Barista/Nanny/Housekeeper</td>
<td>Peruvian</td>
<td>10</td>
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<td>Widowed</td>
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</table>
### Appendix C: Those Serving Immigrant Careworkers in Genoa/Key Informants

<table>
<thead>
<tr>
<th>Interview Number and Affiliation</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>1. Health clinic for undocumented women</td>
<td>Doctor-volunteer</td>
</tr>
<tr>
<td>2. Two Catholic Church immigrant centers</td>
<td>Psychological Counselor – volunteer/paid</td>
</tr>
<tr>
<td>3. Latin American women’s group</td>
<td>Secretary</td>
</tr>
<tr>
<td>4. Health clinic for undocumented women</td>
<td>Clinic administrator-volunteer</td>
</tr>
<tr>
<td>5. Multi-ethnic non-governmental immigrant women’s group</td>
<td>Founder and Co-President (1st of 2)</td>
</tr>
<tr>
<td>6. INHS “Main Hospital” Urgent Care</td>
<td>Nurse and Nurse supervisor</td>
</tr>
<tr>
<td>7. Ecuadorian Community Leader</td>
<td>Former Board President of Ecuadorian Immigrant Group</td>
</tr>
<tr>
<td>8. Private care home for the elderly</td>
<td>Chief doctor</td>
</tr>
<tr>
<td>9. Private care home for the elderly</td>
<td>Chief administrator</td>
</tr>
<tr>
<td>10. Multi-ethnic non governmental immigrant women’s group</td>
<td>Founder and Co-President (2nd of 2)</td>
</tr>
<tr>
<td>11. City of Genoa Department of City Solidarity</td>
<td>Research Assistant Director</td>
</tr>
<tr>
<td>12. City of Genoa family social services</td>
<td>Social Worker – Caseworker for families</td>
</tr>
<tr>
<td>13. Weekly Careworker Support Group</td>
<td>Volunteer Organizer/Liaison with parish priest</td>
</tr>
<tr>
<td>14. City of Genoa social services</td>
<td>Social Worker</td>
</tr>
<tr>
<td>15. Catholic Church immigrant center for Latin Americans</td>
<td>Licensed counselor – paid and volunteer</td>
</tr>
<tr>
<td>16. INHS geriatric services and private non-profit hospital</td>
<td>Nurse, semi-retired</td>
</tr>
<tr>
<td>17. Catholic Church immigrant center</td>
<td>Trainer in careworker classes</td>
</tr>
<tr>
<td>18. Labor Union</td>
<td>Information and advocacy worker</td>
</tr>
</tbody>
</table>

---

120 This list does not include Suor Carmen of the Santa Lucia Immigrant Center Careworker Placement program. She was a very busy nun, Latin American community resource coordinator, and a someone who expressed skepticism about my research, but allowed me to attend her careworker classes two times each week during the time I was in Genoa from Fall 2009 through Summer 2010. I did not interview her formally, but talked with her to ask permission to attend her classes. She spoke at least once a week, giving her opinions on a wide range of topics. Much of this is discussed in Chapter Six.
Appendix C: Those Serving Immigrant Careworkers in Genoa/Key Informants, continued

19. Parish Church careworker immigrant support office  Caseworker, careworker support
20. INHS Regional Pharmacy Services  Pharmacist, drug prescription researcher
21. Non Profit Counseling Center and Private Practice  Psych counselor, counselor trainer
22. Health clinic for undocumented women  Doctor, volunteer for this clinic
23. Health clinic for undocumented women  Clinic administrator assistant, volunteer
24. Labor Union  Information and advocacy worker
25. Labor Union  Information and advocacy worker
## Appendix D: Administrators (September to November, 2010)

<table>
<thead>
<tr>
<th>Interview Organization</th>
<th>Position</th>
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<tbody>
<tr>
<td>A. Red Cross of Genoa</td>
<td>Director</td>
</tr>
<tr>
<td>B. Department of Health and Social Services, City of Genoa</td>
<td>Department Director, Services Counselor</td>
</tr>
<tr>
<td>C. Italian National Health Service, Genoa, Main Hospital</td>
<td>Doctor, neurologist, geneticist</td>
</tr>
<tr>
<td>D. Italian National Health Service, Genoa, Emergency Room, Main Hospital</td>
<td>Director of Nursing Services</td>
</tr>
<tr>
<td>E. Sampierdarena Neighborhood, Genoa</td>
<td>City Council Member (elected position)</td>
</tr>
<tr>
<td>F. Catholic Church immigrant center for Latin Americans</td>
<td>Pastor</td>
</tr>
<tr>
<td>G. Regional Government Council – Liguria</td>
<td>Council Member (elected position)</td>
</tr>
<tr>
<td>H. Regional Government of Liguria, Health and Human Services</td>
<td>Staff Assessor of Health</td>
</tr>
<tr>
<td>I. Private practice, works with Italian National Health Service</td>
<td>General practitioner doctor</td>
</tr>
<tr>
<td>J. Department of Health and Social Services, City of Genoa</td>
<td>Researcher, assessing needs of elders in Genoa</td>
</tr>
<tr>
<td>K. Italian National Health Service, City of Chiavari, ASL4</td>
<td>Director of Health</td>
</tr>
<tr>
<td>L. Italian National Health Service, City of Chiavari, ASL4</td>
<td>Director of health clinic “No One Excluded,” for undocumented migrants</td>
</tr>
<tr>
<td>M. Italian National Health Service, Genoa, Department of Geriatrics</td>
<td>Director of Services for Geriatric Patients</td>
</tr>
<tr>
<td>N. Italian National Health Service, Neighborhood Hospital Office for Foreigners</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>O. Latin American Women’s Group</td>
<td>President (elected position, held for 3 years)</td>
</tr>
<tr>
<td>P. Italian National Health Service, Genoa, Main Hospital Emergency Department</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Q. City of Genoa, Office of Culture and Innovation</td>
<td>Director of Cultural Programs for Elders</td>
</tr>
<tr>
<td>R. Catholic Church, Diocese of Genoa</td>
<td>Director of pastoral services for health</td>
</tr>
</tbody>
</table>
**Appendix D: Administrators (September to November, 2010), continued**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| S. | Italian National Health Service, Genoa, Neighborhood Hospital ASL3  
   | Pediatrician, Director of immigrant women/children program  
| T. | Italian National Health Service, Liguria, Regional level health office  
   | Director of purchasing for all health facilities, formerly director of neighborhood hospital  
| U. | INHS Regional level health office  
   | Director of acquisition, health economist, U of Genoa professor  
| V. | Clinic in historic center for undocumented immigrants  
   | Administrative Director of the clinic  


### Appendix E: Group Interviews

<table>
<thead>
<tr>
<th>Interview Type</th>
<th>Characteristics of Interviewees</th>
<th>Features of the Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Interview following Santa Lucia Carework Class</td>
<td>Seven participants-- five from Bolivia, one from Peru, one from Ecuador. Age Range estimate: 20-60. Work Experience: all had worked four years to eight years in Italy except for one woman who had worked for almost two years.</td>
<td>50 minutes at a bar near the Church. Hot drinks in the warm space stimulated conversation following the two hour meeting in the unheated marble space of the Santa Lucia immigrant center. The talk quickly focused on working conditions in the early days of their jobs in Italy and now. The last 15 minutes the discussion drifted to the Pacchetto and what it would have been like for them if this sort of talk had been going on when they first arrived and were undocumented and needed healthcare via INHS.</td>
</tr>
</tbody>
</table>
Appendix E: Group Interviews, continued

<table>
<thead>
<tr>
<th>Focus Group held at the regular time/place of a careworker support group facilitated by a careworker/community leader in a Parish Church on the outskirts of Genoa</th>
<th>Nine participants – six from Ecuador, three from Peru. Age Range estimate: 30-50. Work Experience: four had worked four to ten years in Italy. One had worked almost three years in Italy</th>
<th>70 minutes in a church classroom next to the Church sanctuary building. The careworker support group leader and I had contacted women during the two previous weeks' group meetings and with individual phone calls asking them to come and discuss the <em>Pacchetto</em> and their own work/health experiences. Two women brought notes, one brought her diary she has kept during her time in Italy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Interview following Careworker Support Group/Educational session facilitated by two social workers at Don Bosco Parish Church, a program funded by the city in conjunction with the Church as an “immigration-integration” activity.</td>
<td>Five participants – four were from Ecuador, one unknown. Age Range Estimate: 30-55. Work Experience: four had worked four to eight years in Italy.</td>
<td>35 minutes in the parish school classroom where the careworker support group had just discussed self-care and self-confidence following a presentation by a psychologist. The two social workers who led the class and the guest presenter psychologist did not stay for the group interview. The discussion quickly moved into a discussion of working conditions and salaries and “stories” the women had heard or had experienced about particularly stressful clients.</td>
</tr>
</tbody>
</table>
## Appendix F: The Catholic Church in Genoa Service Provision

<table>
<thead>
<tr>
<th>For Established Immigrants</th>
<th>Don Bosco</th>
<th>Santa Lucia</th>
<th>Sant’Egidio</th>
<th>Caritas</th>
</tr>
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</table>
Appendix F: The Catholic Church in Genoa Service Provision, continued

<table>
<thead>
<tr>
<th>For New Immigrants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to services for Established Immigrants (see above): Meet other Spanish speakers, and meet people that may be part of network from “back home.”</td>
<td>Meet other Spanish speakers, and meet people that may be part of network from “back home.” Attend Sr. Carmen’s caregiver course and Italian language classes.</td>
</tr>
<tr>
<td>Language classes, basic needs (food and clothing, help with housing), job training. Outreach to refugees. Participate in Christmas luncheon. Hot noon meal 5 days/week near city center.</td>
<td>Social work / case management and counseling relative to immigrant needs. Referrals to language classes. Provision of food and clothing for “Listening Centers.”</td>
</tr>
</tbody>
</table>
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Zuppa, Antonio Alberto, et al.
Patti Ann Meyer

Place of Birth: Grand Island, Nebraska

EDUCATION:

Master of Arts in Anthropology, San Francisco State University 2003, San Francisco, CA

Master of Science in Education Administration, Southern Illinois University Carbondale, 1988, Carbondale, IL

Bachelor of Arts in Speech Communications, University of Nebraska-Lincoln 1985, Lincoln, NE

PROFESSIONAL POSITIONS HELD:

Visiting Assistant Professor, Department of Anthropology/Sociology
  Transylvania University, Fall 2012, Spring 2013, May Term 2013

Instructor, Department of Anthropology

Teaching Assistant, Department of Anthropology
  University of Kentucky  Fall 2006

Student Affairs Officer, Career Center
  University of California, Berkeley (June 2000 to August 2006)

Internship Program Manager, UCSF National Center of Excellence in Women’s Health
  University of California, San Francisco (March 1999 to May 2000)

Clinical Research Assistant, UCSF Women’s Health
  University of California, San Francisco (December 1997-February 1998)

Project Assistant, MASTEP (Math and Science Teacher Education Program)
  National Science Foundation Grant, San Francisco State University and San Jose State University (August 1996 to November 1996)

Master of Science Unit Head/Administrative Assistant
  UCSF School of Nursing, University of California, San Francisco (May 1994 to July 1996)
Director of Student Activities, New Student Orientation, and the Student Union  
Macalester College, St. Paul, MN (August 1990 to October 1993)

Director of Student Activities and New Student Experiences and Coordinator of Student Activities  
Franklin and Marshall College, Lancaster, PA (July 1988 to July 1990)

Instructor, Freshman Experience-Liberal Arts Learning Class,  
St. Mary’s University, San Antonio, TX (1985-1986)

Scholastic and Professional Honors:

Student Representative, Society for the Anthropology of Work 2012-2013

Presidential Fellowship, University of Kentucky, 2011-2012

National Science Foundation, Cultural Anthropology Doctoral Dissertation Improvement Grant, 2010

Association of Emeriti Faculty Endowed Fellowship, University of Kentucky, 2009

Italian Institute of Culture Scholarship, for Italian language study in Genoa, Summer 2008

Kentucky Graduate Student Scholarship, Out of State Tuition Waiver, 2006 to 2013

Papers and Presentations:

Article submitted for review to the Journal of the Society of Economic Anthropology  
Inequality and Equality in the Italian State Policies on Care, April 2013

Invited Session Paper Presentation, Society for the Anthropology of Work  
San Francisco, CA November 2012  
Praxis or Perish: Forms of Solidarity, Agency, and Collective Action among Service Workers  
Unlikely Alliances: Labor Unions, Italian Elders, and South American Immigrants

Organizer of Session/Paper Presentation, Symposium on Latin American and Caribbean Studies  
Lexington, KY October 2012  
Latin Americans in Local and Transnational Encounters and Disencounters with the State(s)  
Maintaining the Health of Workers: the Mixed Messages of the Italian State

Invited Session Paper Presentation, Society for Medical Anthropology  
Baltimore, MD March 2012  
Rethinking the Boundaries of Care, Intimacy, and Health  
Italian Institutions, Conflicted Messages about Care and Health
Poster Presentation, American Anthropological Association Annual Meeting
Montreal, Canada November 2011
Religious Conversations and Transformations
The Role of the Catholic Church in the Lives of South American Careworkers in Genoa, Italy during Times of Anti-Immigrant Sentiment

Paper Presentation, Medical Humanities Conference
Kalamazoo, MI September 2011
Medical Humanities Across Cultures
“Non Denunciare” = We Will Not Report

Paper Presentation, Seventh International Carework Conference
Las Vegas, NV August, 2011
The Catholic Church: The Construction, Support, and Surveillance of Laboring Bodies

Invited Session Paper Presentation, American Anthropological Association Annual Meeting
New Orleans, LA November 2010
Gendered Economies of Carework: Global and Local Dimensions of Theory and Practice,
Care for the careworkers: Subject Positions and Health-seeking Strategies of Immigrant Careworkers Laboring in the Homes of Elders in Genoa

Paper Presentation, Transforming Care Conference 2010 entitled “Transforming Care: Provision, Quality, and Inequalities in Late Life” Copenhagen, Denmark June 21-23, 2010
Sponsored by the Danish National Centre for Social Research, the University of Hamburg and the University of Vechta
Care for the Careworkers: an Ethnographic Study in Genoa

Panel Coordination / Paper Presentation, Sixth International Carework Conference: "Bridging Worlds of Care" San Francisco, CA August, 2009
Embodying Empowerment, Managing Power: Immigrant Low-wage Careworkers in Multiple Contexts
Who cares for them? Healthcare Seeking Strategies of Transnational Low-wage Careworkers

Paper Presentation, American Anthropological Association Annual Meeting
Washington, D.C., November 2007
Fortress America: Migration from the Global South
Religion and Transnationalism