

**“We do the things that matter”: ethics of care orienting medical and social care for forced migrants in Rome**

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## **Abstract**

The paper explores the welfare and health practitioners' representations of work practices and professional values underpinning their engagement with forced migrants in a Rome-based healthcare service. The health centre was founded in the mid-2000s as a pilot project entailing the partnership between local health authority and a faith-based organization, delivering both medical and social care to forced migrants and offering about 100,000 consultations to several thousand women and men patients since its inception. In Italy the right to access healthcare is in principle extended to all applicants and beneficiaries of international protection, however in practice an effective access to healthcare for forced migrants is complex. The paper explores the integrated approach developed to overcome these barriers and cater for asylum seekers and beneficiaries of international protection's specific needs. Building on interviews with health professionals and welfare workers, the article aims at unpacking, using the ethics of care framework, how dimensions of attentiveness, responsibility, competence, responsiveness, and solidarity are talked about by staff and what kind of values are put forward by health professionals and social workers.

## **Keywords**

ethics of care; Italy; health professionals and social workers; forced migrants

## **Introduction**

When the term 'refugee crisis' entered the public domain in 2014, the Italian system for hosting asylum seekers was challenged by a twofold process (Campomori 2018) of policies regulation (2015-2016) and restriction (2017-2018). Concurrently, there has been a burgeoning of specialist literature on the effectiveness and (dis)functioning of welfare provisions for asylum seekers in Italy (Bolzoni, Gargiulo, and Manocchi 2015; Tizzi, Albani, and Borgioli 2018) as well as on volunteer-based projects aiming at fostering forced migrants' inclusion (Pizzolati and Sterchele 2016). Reception policies and practices are extremely heterogeneous at regional and local level, given the autonomy and specificities of regional welfare and health systems and in relation to the differences in voluntary activism. The local dimension of the Italian governance of asylum has recently been defined as a battleground (Ambrosini and Campomori 2020), grasping effectively also the complex interactions between public and non-public actors.

Despite the genuine effort of the Italian state and civil society to mobilise in the reception of constant streams of migrants arriving from Libya to the shores of Lampedusa and Sicily in the past decade, policymaking in Italy is characterised by weak planning capacities and made worse by the ongoing need for emergency decision-making which, over the years, have hindered a more effective and long-term vision to deal with the migration and asylum question (Bazurli, Campomori, and Casula 2020). By the mid-2010s, a stable and far-reaching asylum system was in place, however humanitarian emergencies of a greater scale (Caponio and Cappiali 2018) increased the pressure for new legislation regulating the reception system. The 2015 'Reception Decree' (Law no. 142/2015) re-organised the Italian asylum system temporally into three different stages and administratively by allocating responsibilities across different governmental tiers (Semprebon and Pelacani 2020). Following this, due to a change in political sentiment evident in the political ascent of anti-migration populist leader of the far-right Lega Matteo Salvini, appointed Minister of Interior from June 2018 to September 2019, the

public discourse quickly changed from reception to security and the 2018 ‘Security Decree’ (Decree-Law no. 113/2018) dismantled the previous provisions. Changes that have impacted a large number of forced migrants include the suppression of the two-year humanitarian protection status, the introduction of administrative detention for identity verification, and the abolition of second-tier reception of asylum seekers with a pending application.

In Italy all asylum seekers and beneficiaries of international protection can be enrolled in the national health system enjoying - in principle - an equal treatment and full equality of rights and obligations with Italian citizens. The right to access healthcare is acquired at the moment of the asylum application and remains in place during further application processes such as the temporary leave to remain (usually 5 years). While these provisions are in place, in practice however access to healthcare for forced migrants is complex, due to administrative fragmentation in the hands of local health authorities and providers. Asylum seekers for instance lack a social security number which facilitates their access and, in addition to this, medical fees exemptions have recently been reduced from six to two months. In light of these barriers, a service provision able to cater for forced migrants’ specific needs requires developing an integrated approach which can work as a vital lifeline for this highly precarious population in Italy.

The paper explores the approach developed by SaMiFo (SAIute MIgranti FORzati, Forced Migrants’ Health) effectively delivering both medical and social care to forced migrants in Rome. SaMiFo was founded in the mid-2000s as a pilot project entailing the partnership between local health authority (LHA) and Centro Astalli, a local branch of the international catholic organization Jesuit Refugee Service (JRS) - an advocacy group working on behalf of refugees and forcibly displaced people. Over the years, the clinic expanded by gaining additional staff, acquired a specific space within a LHA in Rome and is attended by an ever-increasing and differentiated number of patients. SaMiFo provides a significant context in which to inquiry the factors shaping the practices of social workers and health professionals involved in the joint provision of services to forced migrants.

Through the focus on how social and health workers represent their work practices, with this qualitative research we aim to analyse how these actors define the professional values underpinning their engagement. Narratives emerging from the interviews suggest that personal values are transposed as professional values and qualify participants’ office as a milestone in personal and professional biography.

### **Ethics of care**

As evident from the socio-economic turmoil caused by the current Covid 19 public health crisis, care is a concept, a practice, a moral discourse resonating with local people (Nguyen, Zavoretti, and Tronto 2017). According to Ethics of Care scholars, care represents a broad moral concept re-orienting behavior towards caring actions for other human beings, for the environment, for the self. It assumes an understanding of human vulnerability and mutual dependence as a starting point for tackling inequalities. This world-view extends beyond the domains of the individual, private and familiar sphere to encompass a broad public ethics implicated in social and institutional arrangements of human society (Midgley 2018).

What we understand today as Ethics of Care was first conceptualized by the psychologist Carol Gilligan in the 1980s. Her book 'In a Different Voice' (Gilligan 1982) is considered a milestone for feminist understandings of care in the context of human development, although her views reflected the belief of the time that caring attitudes are innate for women. The political scientists Held (2005), Tronto (1993) and Sevenhuijsen (1998) further developed theories of care suggesting that care is the result of a combination of processes and practices of caring which are simultaneously relational, situated and embodied.

Until then ethics of care, which conveys ideas of vulnerability and dependency suggesting they are inherent to the human existence, had been marginalised in the mainstream Western tradition of thought compared to other ethical concepts such as justice and freedom, embodied in the neoliberal notion of the autonomous subject (Datta et al 2010; Nguyen, Zavoretti, and Tronto 2017; Midgley 2018). One of the primary aims of an Ethics of Care is deconstructing the neoliberal notion of the independent, autonomous subject who can self-sufficiently access care through privatised means. Looking through the lens of an ethics of care meant challenging rationalist and abstract systems of thought, firstly as care was seen as confined to the domestic sphere hence not relevant to public life - and secondly because its emphasis on interdependence did not chime with the idea of the autonomous neoliberal subject. In line with a specifically feminist ethos, care for the self and for the others is imbued in discourses about private and public. Care on the one hand is symbolically situated in the domain of the home, on the other hand public policy discourses valorise and encourage individualised autonomy, self-responsibility and self-sufficiency for well-being. The act of caring is seen as a response to vulnerability - where interconnectedness is made explicit as opposed to the attributes valorized in the neoliberal autonomous subject. This discursive binary is not new in liberal capitalism, yet is still solidly rooted in the way the concepts of care and self-responsibility are understood and practiced in contemporary public policies (Fraser 2013). This article aims to unpack how this polarised understanding of care being situated in the domestic realm as opposed to autonomy and self-sufficiency characterising the public domain can be challenged through the work health professionals and social workers do at SaMiFo.

Dominant discourses have also tended to see migrants themselves as providers of care, especially migrant women, reflecting a devaluation of care professions and migrant women filling the cracks of a disintegrating welfare in what has been defined as a 'crisis of care' (Kofman and Raghuram 2015). Other work has also discussed how, within third sector organisations, migrant women from the position of service users have gained the role of active volunteers and in some cases have accessed paid work within the same organisations, sitting at the border between visibility and invisibility (Martin 2014, Vacchelli and Peyrefitte 2018). Our paper's focus on health professionals and social workers as providers of care offers an opportunity to shift the perspective from migrant women as care providers, prevalent within the migration literature, to (forced) migrants situated at the receiving end of this provision. Care has often been discussed in the context of civil society volunteers providing services for migrants and other groups in vulnerable positions (Maestri and Monforte 2020). Mindful of the disparity in power relations existing between care providers and care receivers, in this paper we aim to offer a reflection on practices of care and responsibility as acted by a range of health

professionals and social workers making a simultaneously individual, collective and institutional commitment towards forced migrants' complex needs in their everyday work and personal biographies.

The article aims at unpacking how Ethics of Care dimensions of attentiveness, responsibility, competence, responsiveness, and solidarity are talked about by SaMiFo's staff and what kind of values are put forward by health professionals and social workers. In order to do so, we will apply the politics of care framework developed by Tronto (2013). Drawing on Fisher and Tronto (1990), Tronto (2013) outlines the caring process as a series of phases corresponding to moral predispositions for these phases to be accomplished. (i) Firstly, caring about is explained as attentiveness. This is described as the moment when someone (a person or a group) notices unmet caring needs and of one's self interest is temporarily suspended. (ii) Once these needs are identified, the caring person takes on the burden of meeting these needs. In this phase, taking care is understood as taking responsibility for somebody. (iii) Caregiving is seen as a form of competence which has both technical and a moral dimension. (iv) The concept of responsiveness articulated in Tronto's ethics of care consists of a response from the person cared for where the caregiver notices what new needs emerge. Importantly in this phase, the act of caring is framed as a response to vulnerability and an action that makes our interconnectedness explicit. In Tronto (2013)'s analysis, this phase also raises ethical concerns for how this responsibility is managed in practice. (v) Caring with is yet another aspect of the prism of care; this last type of care refers to practices of solidarity, plurality, communication and trust. Trust in vulnerable and unequal care relations necessitates negotiations with regards to certain needs and responses to these needs.

The feminist ethics of care articulated by Tronto consists of series of caring practices nested within one another. In her vision, individuals are conceived of as being in relationships and at the same time vulnerable and fragile. Her ethical position understands all human life as fragile and constantly vulnerable to changes in body conditions and sees all humans as simultaneously recipients and providers of care. In this sense, recognising the intrinsic vulnerability of all human beings represents an important point of departure for acknowledging structural causes of disadvantage, instead of seeing disadvantage like a personal failing in line with liberalist views. This reasoning is at the core of Tronto (1993)'s political claim suggesting that vulnerability is in itself constitutive of human agency and this very precariousness lays the foundations for an ethics of mutual responsibility (Mesaric and Vacchelli 2019). This theoretical position allows to throw a different light on vulnerability where agency is enabled by vulnerability rather than excluded from it.

### **Context and methodological notes**

The outpatient clinic SaMiFo is located in Esquilino district, a central area in Rome easily accessible from most of the capital's districts and neighbouring towns as the main train station is located there; situated to the east of the historical centre, it represents a symbolic place of immigration in Rome as a multicultural social space. The Esquilino area is also a theatre of diffused criminality and street violence.

Ten years after its foundation as a pioneering and unique experience in Italy, SaMiFo was included in the organizational structure of municipal statutory organisations responsible for improving public health, providing primary health care, and commissioning secondary and tertiary care services. The clinic, in the summer of 2017 when the data for this research was collected, consisted of a front office (reception and orientation) and a back office, both managed by social workers and linguistic mediators, a GP practice and psychiatry, psychology, forensic, gynaecology and obstetrics, orthopaedics clinics where doctors and specialist health professionals are assisted by linguistic mediators.

Over a period of ten years (2007-2017) more than 11,000 patients have been treated and have been offered almost 100,000 consultations (Santone 2018). In this period, eight out of ten patients were male; in the year of the research (2017) and in the previous year, female patients increased to a proportion of about 30%. In 2017, SaMiFo patients were from 57 different countries mainly in the African continent, the Middle East and Central Asia. In recent years, there has been a trend towards an increase in the average age of patients: in 2017 six out of ten of more than 1300 patients cared for by general practitioners were aged between 30 and 50. In the same year the psychiatry service assisted 176 patients, and 137 in psychology (almost half of these were women). Gynaecology and obstetrics professionals treated 231 patients. Over the two-year period 2016-2017, 348 forced migrants, mostly men, obtained official certification for asylum purposes of having undergone physical violence in the country of origin or during the migration journey.

The case of this clinic was investigated as part of a European action research project aimed at exploring and comparing forced migrant's policies in action (with a focus on women) in Denmark, Italy, Spain, and the United Kingdom. We gained access to participants through Centro Astalli which was a partner in this project. A total of fourteen audio-recorded semi-structured interviews were completed with SaMiFo staff. Eight health professionals and six welfare workers were engaged of which eight were female and six male. Three of the participants were migrants themselves.

The interviews were completed between June and July 2017 by a research assistant. Prior to the interviews, the RA spent four days at the clinic in order to acquire some familiarity with organizational practices and patient handling. During the fieldwork, some participating observations were made (i.e. at the front desk, in the waiting room and during some of the team meetings). These observations helped us understand more clearly what was mentioned in the interviews about the logistical and organizational aspects of the service. Although flexible, the interviewer worked from a semi-structured interview guide exploring matters related to career paths and working practices. The interviews were conducted in Italian and the duration ranged from 30 to 60 minutes; all the participants gave their consent for digital recording.

An iterative process of manually coding transcripts for thematic analysis involved both authors. We identified those parts of the staff's accounts that focused on rewards and challenges deriving from and affecting their work at the clinic and the needs of patients, their improvement and worsening paths. The identification of key themes drew our attention to the way participants made sense of their everyday work practice through a commitment to responsibility towards patients and mutual/self-care practices that we are not looking at in the course of this paper.

Respondents were offered anonymity through omission of personal information and identified as codes and areas of work: health (include general practitioner, psychiatrist, psychologist, specialist in forensic and legal medicine, gynaecologist, midwife) or welfare (include social worker, case manager, intercultural mediator). All quotations have been translated from Italian into English by the authors.

### **Ethics of care in action**

Our data suggests that professionals at SaMiFo mobilise the full repertoire of Ethics of Care as identified by Tronto (2013) when they discuss the ongoing relationship with service users. The thematic analysis presented here is a reading of these narratives through the Ethics of Care prism of attentiveness, responsibility, competence, responsiveness, and solidarity. Interviewees talk to the ongoing challenges encountered at the centre, including aspects of their work yielding to increased motivation and sense of accomplishment in their daily life.

### **Attentiveness as a way of caring**

The particular quality of attentiveness during the caring process discussed by Tronto (2013) emerged in our interviewees' discussion, in particular when they expressed their commitment in identifying their patients' complex needs and responding to these needs in a way that goes beyond their professional duty. Similarly to what Schmid (2019) found in her research on the practices and values of female refugee support workers in Germany, this disposition to attentiveness seemed informed by genuine sense of care and responsibility for the people they are supporting. Our interviewees made the point that SaMiFo is different from other services in the same area, as not everyone is attentive enough towards the refugees' specific mental health needs. As a participant explains:

Very often we meet people [...] who feel hopeless and have a series of symptoms that other centres are hardly able to understand and address (6health).

Attentiveness also entails taking on board professional understanding of patients' needs starting from patients' own point of view, in order to create an individualised picture of each person. An understanding of the full experience of each patient, ranging from the conditions and reasons for SaMiFo's users forced migration to the context of current migration policies concerning health service provision, is discussed by health professionals as key for the efficiency of their professional intervention as specified in this extract:

If one does not make an effort, the kind of therapeutic alliance, the therapeutic relationship could weaken so this effort is key to, let's say it enables the therapeutic project, a project of care and assistance (3health).

This attempt relies on personal inclination to do so, rather than just complying with existing health policies and professional practices. The participant above refers

specifically to a therapeutic alliance or project of care and assistance, thus drawing on consolidated repertoires of care ethics, such as the importance of relationships and the attentive recognition of the context of each individual patient. Emphatic attention to individuals is also highlighted in the following quote:

Patience is one of my personal attributes so I tend to listen and identify with patients (9health).

Attentiveness can stretch beyond what is openly communicated as indicated by a participant who further illustrates SaMiFo's empirical practice of care:

They often manifest their need for accommodation, mainly for accommodation, but then it's up to you to decipher what are their real issues because sometimes these are not even clear to themselves and certainly they cannot express these needs in a clear way, sometimes it's not just accommodation, it's something broader, it's a project that you should be doing with them (11welfare).

From the quotes in this section it is evident that, for our participants, attentiveness is a specific quality of care and an attentive approach is fundamental for an efficient and well-coordinated intervention in both physical and mental health of the patients. In order to practice attentiveness, one has to rely on their own vocational inclinations and an attention to the specific needs of every individual in their care, at times going beyond what is explicatively manifested.

### **Taking responsibility is caring**

Taking responsibility is a theme that emerges consistently across our interviews, in particular with regards to the kind of support offered by health professionals at SaMiFo in granting forced migrants' access to a range of state welfare benefits. In 2006 SaMiFo was created specifically in order to grant asylum seekers access to health care. As a participant who has worked in the clinic for many years recounts, at that time refugees' formal rights to access healthcare were not fully applied because

There were no places available and medical doctors were not equipped to respond to the needs of people who could not speak Italian and address other complex needs of our service users (8welfare).

The creation of SaMiFo represented a further incentive for service users to be supported in accessing their rights to access public funds and in particular avoid the recurrent drop in disability benefit provision. Some service users find it difficult to access their rights because

They are not well supported by standard agencies [...] given the level of complexity of the system. Even standard organisations find it difficult and tend to get lost in the system and we try to provide a more integrated approach (11welfare).



Our interviewee further explains that some officers working at service reception are not always collaborative when it comes to granting benefits to applicants. In this circumstance, the direct intervention of SaMiFo operators is central in overcoming this barrier. Taking responsibility means looking after service users in a more comprehensive way going beyond the immediate professional remit of the service - as this guarantees effectiveness of the service (Vacchelli and Mesaric 2020).

At SaMiFo, patients' needs are considered a priority in a way that transcends professional roles' specifications merely based of professional practice as explained by a participant:

We do the things that matter, when there's something in particular that needs doing, I don't mind making a phone call and say 'please find a place because it's fundamental for this person' I just do it directly and I don't wait for the social worker to do it (3health).

Another interviewee adds:

It's not that we have just one task to do and that's it, we really try to help in every way we can [...] if I see I can advise and help I do it, we do our best to help (10welfare).

Various research participants contend that patients often find it difficult to locate relevant services in different places across Rome - for this reason, members of SaMiFo make sure to accompany them. This specific aspect of SaMiFo's assistance to forced migrants is talked about as a distinctive feature of the centre, in that it involves everyone and not only intercultural mediators. For instance, a practitioner comments on the work of her colleague who was accompanying a patient to the nearby hospital:

She is being accompanied there because we would have not been able to make it understood where the hospital is [...] [our colleague] has also asked for a doctor consultation on the spot so we immediately knew what needed doing (4health).

Taking responsibility for the patients also implies, in the experience of our interviewees, offering a different kind of service from the ones that are common within the same professional field, providing care whilst at the same time using a pragmatic approach. The specificity of SaMiFo professional practice is described in terms of both quantity and quality:

Here we provide better care for patients because of their level of need: these patients find it difficult to navigate health services and institutions and we help and address them [...] SaMiFo is very different and we provide better care due to the level of individual attention we pay to our patients (4health).

Taking responsibility also extends to daring to bend the existing rules when they represent a barrier to providing the best possible care as revealed in these words:

I saw some patients who were not registered [...] for this reason [a patient] could not be given prescription medicines but we can get hold of these medicines anyway, we are much more anarchic than other centres (14health).

Similarly, internal organisation is adjusted to the needs of the patient, as a practitioner explains recounting of the women who arrive at SaMiFo without appointment:

One cannot afford to be bureaucratic in this line of work and with these kinds of patients, absolutely not, you can do that with women in more settled circumstances [...] you cannot reject a woman who comes here from a centre for migrants in Vietri [a town situated 260Km from Rome] just to give you an example, who took a train, probably left very early in the morning, then she gets here among thousand other difficulties and because she is three hour late you say 'no, I am sorry madam we cannot see you, you can go' this obviously does not make sense (5health).

As in Schmid (2019), responsibility is part of a moral obligation to help those that are less well-off and is grounded in their comparative wealth and privilege. Our interviews confirm this and offer an understanding of responsibility as a duty to overcome administrative barriers while at the same time helping service users access their substantive rights.

### **Competence to assess the best approach to care**

Competence is often the outcome of several professionals' trajectories, especially when these are non-standardised and include formative years abroad. Our interviewees refer to their own competence as a form of gratification: the professional and moral dimensions of their involvement are intertwined in that the skills acquired over time are used to help several patients and do it more effectively. A practitioner mentions her own knowledge of foreign languages which in her previous job was not that relevant as it is now:

I have been lucky to find myself in a situation where I can capitalise on my skills and be useful to so many people (4health).

Likewise, another interviewee refers to being able to use his competences in terms of privilege:

I find myself in a situation of privilege as I am working in the field of PTSD... which kind of summarises what my medical interests are - on the one hand, the transcultural aspects of mental health and on the other hand trauma therapy, both from a pharmaceutical and psychotherapeutic perspective (14health).

A competence synergy among members of SaMiFo staff is expressed as follows:

Here I can really help asylum seekers... and here we can do a lot for those who arrive, do not know anyone, are not familiar with the place, where they are, what they need to do and do not feel well physically and mentally (7welfare).

In highlighting how their own skill are used to help others, a practitioner explains:

I am particularly interested in encountering patients who carry some sort of emotional pain, in their options for agency, which is not such a radical idea that saves people, it's just about

being able to encourage people and say ‘carry on, you can do it’ and help them in this process (6health).

Time that patients need - during and beyond office times - is talked about as a moral dimension of duty of care. Time allocated to patients extends well beyond office hours. For instance, a practitioner told us that the day before, after she finished work late in the afternoon, received a phone call from the intercultural mediator who had assisted her in one of her consultations - she wanted to know more and ask for clarifications about the patient’s condition:

It is totally natural to keep talking about what one has seen, what happened [...] working at SaMiFo is indeed very demanding, for lack of a better expression, that is working here means that often when you get home you are still working, but as far as I am concerned I am happy to do it (4health).

Her colleague also comments on work beyond contract and confirms that for her too asking information on the conditions of hospitalised patients is habitual. This includes calling the relevant hospital during weekends. Likewise, a psychiatrist reported his habit of working late in the office in order to follow up all patients in his care. Another SaMiFo professional specifies:

Anyway you go the extra mile, I mean it’s not that I check the watch, I stay so long as the issue is solved because for us it’s about how the person is doing. When they get here, the majority are not well especially at the moment when they arrive (7welfare).

If standard time for a consultation is not sufficient it is adjusted according to the specific need. Moreover, time of care at SaMiFo is extended beyond the official 2 years sanctioned by law, as explained by a psychologist who refers to a patient she has been following for five years because of specific needs of this particular patient. In other words, SaMiFo staff strategically use their competence to assess the needs of the patients they care for and do not hesitate to allocate more time when needed. A further insight into the way SaMiFo staff practices care mobilising the idea of competence is expressed in this passage which also highlights the level of complexity these professionals are dealing with:

[...] when assisting asylum seekers like I have been doing, you soon realise that over the last 15 years the type of demand has changed. While in 2000 we had say 80-90% asylum seekers coming from war zones, today we have about 20-30% of this type of applicants. [...] In other words, today we have more humanitarian migrants rather than forced migrants as such, according to the Geneva Convention definition. [...]. I am not saying their circumstances are not challenging [...]. What I am saying is that one difficulty we have today is identifying people who do come from war zones and have been victims of torture in their own country of origin. Today we mainly have people who have been tortured or mistreated in Libya’s detention centres. I don’t want to discriminate but the type of persecution people were subject to in Sudan or Congo has a different meaning as the motivation leading people to leave is different. So you have to balance things out, you have to start being more flexible, understand who is in front of you and what kind of rapport you can create and come up with a joint strategy (11welfare).

In discussing their work, competence was both a moral dimension, evident in the assessment of when extra time is needed to assist service users and a technical dimension demonstrated in the ability to assess the changes in migration circumstances and policies over time.

### **Responsiveness to others' vulnerability**

Responsiveness is an act of caring that refers to taking on board others' vulnerability. According to Tronto (2013) responsiveness is an intrinsically moral concept as it implies inequality (as in differential power relations between who is providing the help and who is receiving the help, i.e. the so-called vulnerable). Our interviewees are situated in a favourable power position as they are the people who provide care and in the course of the interviews conducted at SaMiFo they offer comments on the way their patients have responded to care they received. In general, participants define their own role as those people who can somehow activate the inner resources of the people they help. For instance, the narratives describing a positive outcome for the patients tend to refer to patients' inner resources in this way:

The political refugee and the partner of the political refugee as we intended it initially is normally well educated, and in general knows better how to negotiate the new situation (2health).

Iranian women luckily have a good level of education - I can say, so they learn Italian more easily, they are more independent so they only needed the support I offered at the very start. I keep in touch with some of them, they have now fully integrated and there's no need for them to come here (7welfare).

The quotes above mention education as a central to be able to navigate the Italian system and learn the language in order to facilitate the integration process and maximise the positive effects of the help received at SaMiFo. Personal resilience is also important when initial circumstances are challenging:

When she came here she was in a bad way, the test results were terrible, everything looked grim and despite this, this woman could get a nursing qualification, I think, if she did not already have one, anyway she finished her studies and now works as a nurse. She keeps her health in check and manages the consequences of the violence she endured - last time I saw her she looked really well (5health).

Responsiveness in this context also means aligning one's decision to live to an inner disposition to accept all the help that is on offer:

Sometimes after a few sessions people manage to take better control of their lives, of their tools and resources [...] when these women make the decision they want to live, they really do, on the contrary it can happen they give up and get sick. When they decide to live, they are open to any kind of help (6health).

Both a social worker and a psychiatrist argue that patients who respond in a powerful manner often have strong personal resources demonstrating proactive responsiveness to the help they receive at SaMiFo. It is also reported that women tend to have better relational resources compared to men and clearer ideas of what they are good at.

On the other hand, some patients' condition had worsened after their arrival in Italy. Professionals at SaMiFo tend to ascribe this to structural conditions that go beyond their need for health related care services. Their narratives suggest that the support they provide does not necessarily result in an improvement for everyone. These barriers are both structural and relational. For instance, families in the country of origin are perceived as a barrier as they do not often provide emotional support to the migrating relative:

Families in the country of origin often do not believe their migrating relative with regards to the difficulties they are experiencing, they think that they are lazy, that they don't really want to work, that they are cursed, something along these lines, and other things that are far removed from reality (1welfare).

Physical conditions moreover can be seriously compromised from the experience of forced migration, especially when it has been marked by violence:

Unfortunately some women get here in a very bad way and then you don't see them anymore; these are the ones that make an impression on you [...] we don't always manage to help them in the way we'd like to, they really have terrible life stories (5health).

From a structural point of view, labour integration represents a further barrier in responsiveness to the help offered by SaMiFo as illustrated by these quotes indicating that integration trajectories started in a successful manner however failed at some point along the way:

Now we have many returning patients - even though they had a good start, they leave second-tier reception system accommodation and for a range of crises-they come back because they lost their job, because something happened to them and they are back in this space of need, many people now come back as patients (6health).

Others due to lack of accommodation and work really change - from a situation where they seem strong enough to face the future they then let go and this impacts on their mood, on their physical aspect you really see them whither (9health).

Another interviewee expands on the enormous challenges of social integration:

We have more and more people who return as patients after several years bringing painful experiences from a missed opportunity to integrate in our society. In Italy it has become so difficult to integrate - integrating means finding a job, let's face it, this is the starting point and then you need social relationships, love etc, but without a job you lack the basic autonomy and you keep hanging around between support centres for migrants and refectories. At some point you realise this and we see people who are worse from the time they arrive because there are additional pressures from home, families back home who expect money and a dignity that starts to crumble (8welfare).

In the context of the challenges in social integration described above, the interviewees recognize that in most cases users are able to positively respond and capitalise on the help they received.

### **Caring with: showing solidarity with forced migrants**

The last emerging theme that maps onto the ethics of care outlined by Tronto is the feeling of solidarity that health professionals and social workers at SaMiFo feel for the people they assist. In particular, our research participants, like Schmid's (2020) imagine and locate 'sameness' and 'difference' when discussing the refugees' experience. A recurrent theme emerging in our interviews is a talk of direct and indirect sameness in life experiences between forced migrants and their own, including war and migration.

A psychiatrist links his own ability to feel empathetic towards people who flee from dramatic circumstances to the experience of his own parents who also had to flee with their families during the second world war. Parallels with personal migration experiences can be seen here:

I'm also a migrant, an internal migrant. When I was 18 I greeted my parents and came to Rome (from a region in the South of Italy) where there was no medical school at the time [...]. Of course I came here to study, in a place where I could speak my own language so I had nowhere near the hard time our patients are experiencing. I did though experience a kind of up-rooting as I was living in a small village of 600 inhabitants where primary education was hardly provided, in the deep South of Italy, so this also led me to have an interest in helping this kind of patient (2health).

Migration was a little bit like my personal story, which was a story of internal migration in the 1960s, from South to North, so am a second generation migrant born in the North of Italy - I found this story very familiar and simple and was second nature for me to understand these stories (6health).

Solidarity is expressed here in terms of sameness:

[Working at SaMiFo] is also a chance to have relationships with people who come from other places but you find out they are so very close in so many ways, I find it very interesting (8welfare).

Narratives detected in SaMiFo interviewees also depict representations of difference, where participants report a need to provide support for those who find themselves in situations of material disadvantage which are far removed from their own life circumstances. For instance, a practitioner lives in a neighbourhood (the same where SaMiFo is based) which he defines as 'diverse and also suffering' and working at SaMiFo represents the strongest motivation to try to 'alleviate this suffering'. Discovering life experiences that are difficult and different from one's own is something that is described as fulfilling:

The rapport that is possible to forge with a person is rewarding [...] it makes you picture realities that you did not think could exist, with challenges that for us Italians are unthinkable and they unfortunately have to face (9health).

Difference is also expressed in the words of another participant:

Here in the women's medical centre and the GP practice in general you hear stories that make you understand cultural difference and make you think of integration not just as a two way thing but as a real opening towards different points of view - you might not accept these but at least you have to understand them otherwise you cannot really address people's needs [...] we are really interested in understanding the variety of people's backgrounds, for instance at times 40-45 different nationalities mean that there are 100-150 different ethnic groups within these (1welfare).

Our interviewees' interpretation of their own relationship with people they care for is somewhat similar from what has emerged in other research on the emotional component of support offered to forced migrants. Maestri and Monforte (2020) in their work on volunteers working in British charities suggest that simultaneous forms of identification and dis-identification with others' afflictions tend to co-exist and this very acknowledgment represents the basis for an understanding of empathy based on social justice and not on pity.

## **Discussion**

A thematic analysis of our data makes it clear that SaMiFo's staff mobilises the full range of Tronto (2013)'s ethics of care repertoire to speak about the work they do, demonstrating how caring for forced migrants as part of their work intersects with their own personal biographies, values and belief systems. The work of SaMiFo professionals is informed by an ethics of care in that their aim is to improve both physical and mental health of their patients whilst also having a mostly positive impact on their lives broadly conceived. SaMiFo professionals' empathic disposition is evident from the multiple strategies set in place to meet the more manifest and hidden patients' needs. As demonstrated in the course of the interviews, these strategies range from bending the rules in order to help people in need, to expressing genuine concern for the conditions of their patients beyond their working time, being flexible in accommodating diverse needs and willingness to forge a personal alliance with each patient. Participants moreover draw on ideas of sameness highlighting continuity between forced migrants' and their own experiences of mobility and adapting to new life circumstances.

Attentiveness in shaping an individualised picture for each patient, taking responsibility by showing awareness of administrative barriers and the complexities forced migrants face in a new endeavour, competence is assessing international migration flows and legislative turns and the individual responsiveness of each patient, mobilising the concepts of sameness and difference to express solidarity - all highlight how ethics is grounded in the empirical practice of care. The personalised caring at SaMiFo also frames emotions as moral tools and inscribes an act that is normally typical of the private sphere, the caring, into the public domain of a polyfunctional service in Rome, thus

fulfilling the definition of what Tronto understands as ethics of care (Schmidt 2019). Like in Midgley (2018), where recipients of free meals in a shelter-like cafe are seen as negotiating their own vulnerability in the act of receiving, at SaMiFo the relationship between care givers and care receivers helps the management of care relations within the centre. Our respondents' interviews demonstrate that these negotiations are inherent to an individual's response to their own vulnerability and perceive their roles as activating their patients' inner resources' while at the same time being aware of their own privilege. This view challenges constructions of passivity and dependency associated with care/vulnerability and translates into an interest in patients' options for agency.

Some organisational literature tends to be critical of a blind celebration of the work of charities. Dean (2020) argues that 'there is a tendency to paint charities as perfect organisations, staffed solely by well-meaning and committed individuals, who bring sunshine and light into the lives of the less fortunate' (p. 9) and highlights how this view can be highly problematic. We remain aware of the power asymmetry inscribed in this relationship along with Smith (2000) who argues that altruism as 'service to others' is hardly possible when personal satisfaction is achieved as part of this process. This critique is further extended by Dean (2020) who reminds us of the workings of charity humanitarianism which can hide forms of economic exploitation. This work refers to the symbolic capital of charities (p. 12) defined by social status and prestige of charity work whose symbolic power is firmly embedded in existing social order and obsequiousness paid to the state. Another poignant critique is proposed by Sirryeh (2018) who refers to the rise of cultural and political script of humanitarianism predicating compassion for undesired migrants. She warns that the emotion of compassion is often mobilised by both implementers and opponents of immigration policies. Tracing the origin of compassion for the racialised other in colonialism, she points to the power of disparities, control and subjugation inscribed in compassion. Compassion as a racialised emotion is further explored by examining the social distance in compassion relationships, where the voices and needs of those directly affected become diminished while attention is focussed on the 'saviours'. In the context of contemporary Italy however, SaMiFo staff powerfully speak against dominant anti-migration narratives, where several dimensions of the Ethics of Care identified by Tronto (2013) could be identified and discussed. Caring for SaMiFo staff meant abolishing the fictitious barrier between the domestic realm and the public sphere, in this way speaking against dominant discourses of autonomy and self-sufficiency typical contemporary neoliberalism.

Care-based interventions to alleviate injustice and suffering can be seen as a form of political participation in that there is a sustained attempt at limiting the processes through which suffering is created and reproduced (Peterie 2018). Our research traces the contours of a combined health and welfare framework showing the deep-rooted implications of care for societal transformation. For professionals, experts and activists it is important to use this framework as an orientation and as a source of inspiration. However, the reproducibility of this very experience depends on personal and professional values of the people involved.



## Conclusion

The interviews with health professionals and social workers at SaMiFo discussed values and factors affecting everyday work practices. Research participants made sense of their experience of working at SaMiFo by mobilising ideas of care and responsibility for forced migrants. Mutual care and recognition of their joint efforts in supporting people in vulnerable conditions were also discussed by several interviewees, especially with regards to the need for a coordinated strategy in supporting people with complex needs. When opening up about their working practices in the context of the interviews for this study, health professionals and operators highlighted their commitment to overcome structural barriers posed by external factors through innovative service provision approaches, uniqueness, and refusal to standardize practices.

Over the last years (or decade?) several health systems across Western Europe have introduced processes of patient involvement in service design in order to improve the quality of the services offered and at the same time respond to various types of welfare crises (Cervia 2014). In some countries, such as the UK incisive reforms for the modernization of public healthcare service agenda aimed at promoting community commitment approaches have been undertaken particularly in the mental health domain (Mantovani, Pizzolati, and Gillard 2017). Healthcare and welfare professionals working with forced migrants at SaMiFo responded in an articulated and competent way to the practical and ethical needs to implement appropriate methods and create the connections designed to improve users' access to the services on offer. On this basis, a future development of SaMiFo's work could potentially involve a systematic inclusion of the patients/ service users not just in a process of transformative co-production of the services, but also, learning from third sector organisations, in a gradual inclusion of migrants themselves as volunteers and ultimately social workers within the service. This would represent an opportunity to attempt a redefinition of the inevitable power asymmetries inscribed in the relationship between practitioners and service users we analysed in the course of this article.

## Acknowledgements

The authors are indebted to Emanuela Limiti and colleagues of Centro Astalli for their priceless cooperation during the fieldwork. We also acknowledge research assistant Isabella Cordisco for her role in data collection. Finally, we sincerely thank the organizers of the AtGender Conference 'Caring in Uncaring Times' (due to take place in London in May 2020 and cancelled because of the COVID-19 pandemic) for selecting an earlier version of this paper and providing the theme which has inspired it.

## Funding

This study was funded by Fondo Asilo, Migrazione e Integrazione (FAMI) 2014-20 as part of the project Forced migrant women: assistance and integration policies across Europe (PROG-307).

## References

Ambrosini, M., F. Campomori, 2020. "La controversia dell'asilo: politiche di accoglienza e solidarietà contro i confini." *Politiche Sociali* 2: 181-200.

- Bazurli, R., F. Campomori, and M. Casula. 2020. "Shelter from the Storm: Virtuous Systems of Urban Asylum Governance Coping with Italy's Immigration Crackdown." *Politiche Sociali* 2: 201-224.
- Bolzoni, M., E. Gargiulo, and M. Manocchi. 2015. "The social consequences of the denied access to housing for refugees in urban settings: the case of Turin, Italy." *International Journal of Housing Policy* 15 (4): 400-417.
- Campomori, F. 2018. "Criticità e contraddizioni delle politiche di ricezione dei richiedenti asilo in Italia." *Politiche Sociali* 3: 429-436.
- Caponio, T., T. M. Cappiali. 2018, "Italian Migration Policies in Times of Crisis: The Policy Gap Reconsidered", *South European Society and Politics* 23 (1): 115-132.
- Cervia, S. 2014. *La partecipazione dei cittadini in sanità. Italia ed Europa a confronto*. Milan: FrancoAngeli.
- Datta, K. C. McIlwaine, Y. Evans, J. Herbert, J. May, J. Willis. 2010. "a migrant ethic of care? negotiating care and caring among migrant workers in London's low-pay economy." *feminist review* 94 (1): 93-116.
- Dean, J. 2020. *The Good Glow Charity and the Symbolic Power of Doing Good*. Bristol: Policy Press.
- Fisher, B., J.C. Tronto. 1990. "Toward a Feminist Theory of Caring." In *Circles of Care. Work and Identity in Women's Lives*, edited by E. K. Abel and M. K. Nelson, 35-62, Albany: SUNY Press.
- Fraser, N. 2013. *Fortunes of Feminism: From State-Managed Capitalism to Neoliberal Crisis*. London: Verso Books.
- Gillian, C. 1982. *In a Different Voice. Psychological Theory and Women's Development*. Cambridge (Massachusetts): Harvard University Press.
- Held, V. (2005). *The ethics of care: Personal, political, and global*. Oxford: Oxford University Press.
- Kofman, E., P. Raghuram. 2015. *Gendered Migrations and Global Social Reproduction*. Basingstoke, Hampshire: Palgrave Macmillan.
- Maestri G., P. Monforte, 2020, "Who Deserves Compassion? The Moral and Emotional Dilemmas of Volunteering in the 'Refugee Crisis'" *Sociology* doi:10.1177/0038038520928199.
- Mantovani N., M. Pizzolati, S. Gillard. 2017. "Engaging communities to improve mental health in African and African Caribbean groups: a qualitative study evaluating the role of community well-being champions." *Health and Social Care in the Community* 25 (1): 167-176.
- Martin, N. 2014. "Spaces of hidden labor: Migrant women and work in nonprofit organizations." *Gender, Place & Culture* 21 (1): 17-34.
- Mesaric A., E. Vacchelli. 2019. "Invoking vulnerability: practitioner attitudes to supporting refugee and migrant women in London-based third sector organisations." *Journal of Ethnic and Migration Studies* doi: 10.1080/1369183X.2019.1635002.
- Midgley, J. 2018. "'You Were a Lifesaver': Encountering the Potentials of Vulnerability and Self-care in a Community Café." *Ethics and Social Welfare* 12(1): 49-64.
- Nguyen, M. T. N., R. Zavoretti, J. Tronto. 2017. "Beyond the Global Care Chain: Boundaries, Institutions and Ethics of Care." *Ethics and Social Welfare* 11 (3): 199-212.
- Peterie, M. 2018. "Personal care as political activism: Refugee and asylum seeker friendship programmes." *Australian Journal of Social Issues* 53 (4): 400-415.
- Pizzolati, M., D. Sterchele. 2016. "Mixed-sex in sport for development: a pragmatic and symbolic device. The case of touch rugby for forced migrants in Rome", *Sport in Society* 19 (8-9): 1267-1288.
- Santone, G. (eds). 2018. *Pregiudizi. Quaderni del SaMiFo - n. 2*. Rome: UOSD Centro SAMIFO ASL Roma 1.

- Schmid, S. 2019. "Taking Care of the Other: Visions of a Caring Integration in Female Refugee Support Work." *Social Inclusion* 7 (2):118–127.
- Schmid, S. 2020. "Same same but different. How the play of difference intersects female refugee support workers' constructions of a common identity." *Social Identities* 26 (2): 186-202.
- Semprebon, M., G. Pelacani. 2020. "Dispersal and reception in Northern Italy: comparing systems along the Brenner route." In *Geographies of Asylum in Europe and the Role of European Localities*, edited by B. Glorious, J. Doomernik, Springer Open - IMISCOE Research Series, 15-44.
- Sevenhuijsen, S. 1998. *Citizenship and the ethics of care: Feminist considerations on justice, morality and politics*. London: Routledge.
- Sirriyeh, A. 2018. *The politics of compassion: Immigration and asylum policy*. Policy Press.
- Smith, D. H. 2000. *Grassroots Associations*. Thousand Oaks: Sage.
- Tizzi, G., S. Albiani, G. Borgioli (eds). 2018. *La crisi dei rifugiati e il diritto alla salute*. Milano: FrancoAngeli.
- Tronto, J. C. 1993. *Moral boundaries: A political argument for an ethic of care*. London: Routledge.
- Tronto, J. C. 2013. *Caring democracy. Markets, equality, and justice*. New York: New York University Press.
- Vacchelli, E., A. Mesaric. 2020. "Diversity as discourse and diversity as practice: critical reflections on migrant women's experiences of accessing mental health support in London". *Identities: Global Studies in Culture and Power* doi: 10.1080/1070289X.2020.1785181.
- Vacchelli E., M. Peyrefitte. 2018. "From a/topia to topia: towards a gendered right to the city for migrant volunteers in London" *Cities* 76: 12-17.