



*MMG Working Paper 12-20* • ISSN 2192-2357

LORENZO ALUNNI

“After all, they are nomads, aren’t they?”:  
Roma transnationalism and health issues

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Max-Planck-Institut zur Erforschung multireligiöser und multiethnischer Gesellschaften,  
*Max Planck Institute for the Study of Religious and Ethnic Diversity*  
Göttingen

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ISSN 2192-2357 (MMG Working Papers Print)

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## Abstract

For Roma groups living in Italy, nomadism is a trait that is simultaneously externally attributed to them as a “cultural typical characteristic” and shaped by the state, while also determining groups’ transnational dynamics as an internal response to the power technologies that Roma encounter in the field of healthcare. In this context, medical transnationalism plays a role in the personal networks of Roma citizens who prefer to travel to the countries of their families’ origin for healing purposes rather than rely on the Italian public health system due to their problematic relationships with it. This configuration leads subjects to a forced integration of multiple complementary and incomplete medical approaches (the Italian health system, that of their origin country, their cultural approach to the body, etc.), resulting in a medical fragmentation directly shaped by the Roma’s precarious forms of citizenship and the public policies developed to address their issues. The aim of this text is to analyse, through an ethnographic case, how health policies participate in the construction of a state of permanent exception nourished by the forced mobility of people engaged in a settling process.

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## I. ELEMENTS FOR A POSSIBLE SPECIFICITY

In January 2010, when several Roma settlements in Rome were being closed down, the important newspaper *La Repubblica* published a cartoon by the famous Italian cartoonist Altan in which one person tells another: “Roma are deported here and there.” The other person answers: “After all, they are nomads, aren’t they?”

In this simple but powerful cartoon, the paradox of the Roma’s situation was significantly condensed: their effort to settle, in a context of rejection displayed by mainstream society, is expressed through strategies of transnational dynamics related to fields where the same rejection takes action. The medical field is one of these fields. If we think about the contemporary tendency in legal practice to recognise the ill body as the ultimate evidence for claiming legal residence and citizenship rights (Fassin 2011), the medical field may even be considered the main arena in which this rejection occurs. State technologies of marginalisation find powerful tools in processes related to health, and they include the use of healthcare actions – carried out by the public health system – to limit a group’s presence in the national territory to a temporary period of time as opposed to supporting an effective settling process. Attributing nomadism to Roma allows states to formulate a healthcare approach intended for migrants who are only temporarily present in the national territory, while the acquisition of full citizenship would require the systematisation of the relationship between these groups and the healthcare institutions.

Before presenting the following ethnographic case, and before starting a discussion on what the Roma issues can add to the larger debate on transnationalism and medical integration, we have to clarify why this population presents elements that lead many scholars to consider them a challenging and particularly interesting case study. Challenging, because there are many situations when Roma do not seem to fit into the theoretical models, and interesting, because exceptions to the models do not confirm the rules, as the saying goes, but call them into question.

The last decade has been characterised by an exacerbation of the unequal treatment of Roma groups living in Europe, both in the public space and in institutional policies (for the Italian situation see, for example, Clough Marinaro 2010 and Daniele 2011). A first approach to the problematic presence of Roma in Italy can be derived from a comparison with what Giorgio Agamben has argued about the condition of refugees (Agamben 1995). According to him, refugees throw into crisis the relationships and continuities between human and citizen and between birth and nationality, unveiling the original character of the fiction constituting sovereignty. Following this

argument, Roma populations in Europe participate in illuminating the gap between nation and nationality, whereby the concept of human life as the prerequisite for claiming politic rights becomes the main focus.

In this framework, the question that arises is how we can usefully articulate these theoretic and preliminary considerations in relation to the need to understand the dynamics underlying the marginality and the extremely precarious life conditions of Roma living in legal and illegal settlements. The focus might be on the micropolitics composing larger technologies of power that provide the government with practical tools in defining and maintaining the margins of the state (Das 2004). As Roma individuals and refugees are not simply a “concept-limit”, as Agamben defines them, we need to observe the process that simultaneously determines and is determined by the state of exception in which Roma groups are involved. Agamben (2003) discusses the “states of exception” as spaces (and not only topographic spaces) in which ordinary legislation is suspended in order to face contingencies considered exceptional and particularly serious for the safety of the nation. Agamben’s theories seem to fit particularly well in the field of studies on the situation of Roma in Europe, particularly in Italy, where the peculiar existence of the camps (“*campi nomadi*” or “*campi rom*”) dates back to the 1970s (Piasere 2004).

Health issues are directly concerned as essential principles of contemporary forms of citizenship, resulting from the integration of medicine and politics. Before referring all this to a further observation of biopolitical dynamics, as formulated by Michel Foucault, for the purpose of this text we need to assume as a central focus the strategies that subjects adopt to “draw the medical gaze in the first place, or how their resistance to biomedical intervention both invites and deflects control” (Ong 2004, 92). The starting point of this analysis therefore is the reality of the indiscernibility of healing and controlling, in the framework of the politicisation of the biological and the biologicisation of the political in Roma camps in contemporary Rome.

## II. SUPPOSING TRANSNATIONALISM

As evoked by the Altan cartoon previously described, the persistence of the appellation of Roma as “nomads” is an element that deserves close observation. For the analytical purposes of this text, even though I acknowledge the complexity of this category, I will refer here to Roma as the Romani (or “Gypsy”) people, whereby I do

not distinguish between the different entities composing this group, and I consider as Roma those living in the “*campi rom*”. Moreover, while I will be referring to the subjects concerned as Roma (*Rom*) – also because this is the term used by all the actors involved in my fieldwork (institutional figures, healthcare personnel, activists, citizens, etc.) (Cossée 2010) – we need to look more closely at the institutional uses of the denomination most diffused in the public space: “*i nomadi*”, “the nomads”. This name refers to the wandering of the Roma groups, but today we can clearly consider it a misuse, if not a form of linguistic abuse. Talking about the “settling process” – as I am doing in this text – while affirming the non-existence of Roma nomadism may appear paradoxical: it is not, if we consider the “settling” as an effort by Roma to be fully recognised as citizens, in this case, Italian citizens.

Roma have been involved in a settlement process for years. Important ethnographic works in many parts of Italy and at different moments of the last decades show that the wandering has never been claimed as a “cultural” need, a will or, more largely, a choice by the Roma themselves. Possible exceptions excluded, the reality of the Roma is one far from the supposed “nomadic instinct”. Political and economic contingencies outside of the Roma groups’ control have always determined this movement. Actions stimulating the creation of the conditions for the Roma to settle – and become citizens – are not encouraged. The refusal by governments to enable Roma remain in the national territory seems to take the form of an instrumental, false but commonly accepted knowledge about Roma and their supposed “innate” and “irresistible” need to travel. This conception seems to shape the current politics in all the Central European countries. In order to reflect on the dimension of the external attribution of nomadism to Roma, we need to explore how it corresponds to a supposed public desire more than to a social reality. The misuse of denominations such as *nomadi* results not only from a certain degree of ignorance about this population among institutional representatives and citizens (many of whom still always and automatically identify Roma as Romanians, for example), but also constitutes a tool for rejectionist policies. The transnationalism of the Roma seems more hoped than supposed by their host societies.

One example among the many possible helps to clarify this point: Italian municipalities still include among their offices a service dedicated to “*Stranieri e nomadi*” (“Foreigners and nomads”). Local authorities very often still name Roma settlements “*campi sosta*” (“lay-by camps”). The very existence of camps – “our national infamy”, as anthropologist Leonardo Piasere defined them (Piasere 2004) – is strong

evidence of a government mentality that never moved away from the idea of a transitory presence.

If we consider the ways in which the attribution of nomadic characteristics perfectly fits with mainstream society's will to consign Roma to an eternal state of exception and extreme marginality, we also need to observe the micro-strategies adopted by governments to take action in this framework. The issue of healthcare provides fertile soil for such strategies, and in this regard I will examine a case in which transnationalism produces a form of medical integration that is not only determined by the dynamics of a forced mobility (Alunni 2011), but also corresponds to the same political causalities determining the vicious circle of a condition of exception that continually feeds itself. The efforts to include Roma in mainstream society and its normative system paradoxically lead to actions of rejection, and the body is the ultimate field where all these processes take place.

If we consider that biopolitic modernity expresses itself through the administration and control of individual bodies, the processes of normalisation involving biomedicine evidently need to be observed through a lens which is able to describe the different ways of promoting values and categories linked to health matters. The particular interest of the Roma case lies in the ambiguity between healthcare provision and the participation of health institutions in the political technologies of the rejection of this group. In the situations I will describe, what emerges is a context where this ambiguity produces the simultaneous will to impose normative attitudes on individuals and the constitution of one of the elements marking a state of exception. In this case, the tension between healing and rejecting is directed towards Italian citizens, which Roma subjects born in Italy or who have lived there for decades (even if in "transitory" camps) are. This reality directly shapes the form of transnationalism involving the dynamics of the characteristics of nomadism attributed to Roma.

Taking this configuration into consideration, can we identify a specificity of Roma situations determined by their health issues? Anthropological literature shows how the body is a crucial arena for Roma's relationships and boundaries with the larger society (Gay y Blasco 1999; Pizza 2005; Trevisan 2004). The body is considered not only a principle that provides a metaphor for social organisation (Okely 1983) in general, but the corpus of ethnographic works shows the ways Roma and other Gypsy groups specifically manage their bodies to mark their difference from the non-Roma, the *gadgé*. Moreover, Roma are paradoxically (as these works refer to undocumented migrants and refugees) but completely included in the current tendency that considers the ill body as the ultimate resort for rights (Fassin 2011). Furthermore,

for Roma the body is the ultimate and most important field for expressing purity/impurity dynamics (Gay y Blasco 1999), which makes the medical encounter even more delicate than the problematic political context and relationship already do. In light of this context, we need to produce efficient accounts of the articulation of all these aspects, from the ways Roma construct the concept of the person through the relationships with their bodies, to the ways local and national authorities produce an image of Roma that fit with their political exigencies.

Body issues are related, in this text, to transnational dynamics. Being more specific about the concept of transnationalism, beyond the need to place this paper in the forest of possible definitions of this analytical and descriptive category, it helps us approach the reciprocal determination of health actions and mobility dynamics in the framework of transnationalism, which produces specific therapeutic paths. Through the term “transnationalism”, we can indicate a variable phenomenon able to account for both individual and group dynamics. From this starting point, in the ethnographic cases that follow, the conception of transnationalism derives from episodes – in the life of healthcare units (such as the medical consulting room and the *équipe* I will present) – that represent technologies of regulation composed of both official policies and laws and micro practices permitted by the fluidity of that system of norms. This regulation system, declined in everyday spaces of interpretation and agency, while formally attempting to make Roma patients learn how to use and what to give to the healthcare institutions, determines a type of transnational healing we can read as a particular dimension of the strategies of resistance from patients, the Roma, who are perceived as travelling to circumvent the factors that prevent them from stopping their travelling and settling permanently. Considering this framework, it is worth pointing out that one of the key expressions used during the numerous meetings of social workers I attended, was “*educazione sanitaria*” (“healthcare education”), which, as a rhetorical device, combines a humanitarian approach with the intervention and the will to instil in the patients normalizing and normalised values and knowledge.

The paradox affecting such a situation is that in this process, a kind of declared will is regularly combined with interventions set up through emergency approaches and forms of interventions employed on a daily basis. The existence of these very same emergency services – with all the bureaucratic and financing dynamics and interests they involve – is part of a configuration whose perimeter is marked by elements determining the current condition in which Roma are stuck. In this framework, it is hard (and not very useful) to identify the nexus of causality between transnationa-

lism, healing needs and policies. We need instead to observe what we gain and what we lose in referring to a concept of transnationalism shaped by Roma efforts to counter it, and going in the opposite direction: the settling process the Roma are engaged in, without forgetting the possibility of healing as a fundamental part of this process. Therefore, in the dynamics of going and coming back for healing purposes, an error would evidently be that of considering the health-seeking actions undertaken in Italy as comprehensible from a political perspective and the healing practices effectuated in the countries of origin as “more cultural”. It would be the same error as analysing global flows through an approach that sees the global as political and the local as cultural (Ong 1999).

### III. VANISHING PATIENTS

Before starting the ethnographic account I wish to present, we need to take a look at the current situation of Roma groups in Rome. This city has the largest population of Roma citizens in Italy (around 12,000-15,000 people, according to rather problematic different censuses, even if informal estimations talk about a much greater number). Rome’s current right-wing mayor, Gianni Alemanno (a former member of the nationalist party *Alleanza Nazionale* and then of Silvio Berlusconi’s party *Popolo della Libertà*), was elected in 2008 after a campaign that focused on the Roma population as a key factor for insecurity and crime in Rome. This argument gradually turned into discourses focusing on the imperative of ensuring that Roma do not live in precarious conditions: this discourse was soon translated into a humanitarian register (Clough Marinaro & Daniele 2011).

In May 2008, the national government declared a state of “Nomads emergency” for three (and then five) regions – among them the Latium, where Rome is located – and an Extraordinary Commissioner was nominated to deal with this issue. In July, Mayor Alemanno announced the “*Piano nomadi*” (“Nomads plan”) for Rome. A first step was the carrying out of a census of all the settlements in the city, including the personal identification of Roma subjects (photos and fingerprinting, mostly effectuated by the Italian Red Cross, interestingly). The result was that only about 7,000 people (half of the estimated total number of Roma currently living in Rome) were identified and more than 80 illegal settlements were found (to be added to the 14 “tolerated” and the 7 “authorised” camps), plus 310 micro-settlements. The plan

proposed that all the illegal settlements be demolished and that part of the people documented in the census (the “sustainability” of the town is estimated by the City Government at 6,000) would be lodged in new special structures, under new and restrictive rules (video surveillance, camp doors closed at 10 pm, special ID for the inhabitants, guards 24h/24, etc.) (Daniele 2011). At the time of the final editing of this text, this project is currently underway.

In one of these camps – an illegal but tolerated one (considering the distinction in “legal”, “illegal” and “tolerated” camps) –, I met the patient I am going to introduce and whom I will call Adriana. This encounter was one among others that occurred during ethnographic fieldwork conducted on a daily basis in 2009 and 2010. I observed the activities – visits, meetings, informal discussions and the other moments composing the service’s life – of a healthcare unit called the “sanitary camper” that operated every day in the camp of the south and south-east area of Rome. It was a medical mobile unit run by the local Public Health Service and specifically dedicated to Roma groups living in this area. According to a weekly calendar, the “sanitary camper” went to one, more often two or three Roma settlements, parking there and offering its services on a daily basis. The personnel included a doctor, a nurse, and a “cultural mediator”, employed as the camper’s driver. The camper looked like a common touristic motorhome, except for the inscription “Farmacap” on its side, the name of the organisation that manages the municipal medical pharmacies and dispensaries. Its interior was like a consulting room similar to other Italian common medical spaces (with a bed, a little desk for the doctor to write his prescriptions on and for the nurse to update the registers, and some other medical furniture).

Some of the interesting points in the ethnographic observation of such a unit concern the ways in which the medical authorities manage the diseased bodies of Roma patients, thereby shaping campaigns of prevention and sanitary education. From this perspective, even if there are aspects of mediation and advocacy we cannot ignore, we can consider the sanitary camper’s personnel as figures that pragmatically translate the issues and will of the authorities and, more largely, of the government into everyday micro-politics, choices and forms of moral positioning.

As previously announced, it is in this context that I met Adriana, a young woman of twenty years of age. She had been one of the regular visitors of the “sanitary camper” ever since she was a little girl. When she stepped into the camper, both the doctor and the nurse almost screamed “Look who’s back!” They were both very surprised to see her again, in that place. Later on, they told me that Adriana had left for

France some months before, where some of her relatives lived. Just a moment after stepping into the vehicle, she said she was back in the camp to live there again.

The nurse, before the medical consultation started, asked why she had decided to come back to the squalid situation in Rome, despite the fact that in France the social services had provided her with an apartment in which to live in a dignified way. The answer, declaimed in a happy and somewhat infantile way, was: “It was so boring over there!”

Even though Adriana was well aware of the very bad living conditions in the camp, she considered the camp’s forms of sociality and the need to live with her relatives to be more important. These relatives did not renounce the settling process in which, even if in a problematically passive way, they were engaged. It is one of the cases I found during the fieldwork where the prospect of better living conditions and resources was not considered a sufficient reason to leave the place, in this case Rome. But it is a migratory path without migration: the paradox is that parameters normally used for migrants are susceptible of being applied even to Roma born in Rome or who have been living there since they were children or young. In this way, both in the bureaucratic management of their healthcare and their everyday relations with the personnel of medical services, the current policies and measures, such as the sanitary camper, perpetuate the exclusion of Roma citizens from the moral community of individuals deserving civil rights reserved to the locals, including the bureaucratic and practical dimensions of healthcare treatment in public structures.

Adriana was born in Rome to Bosnian Roma parents and she has always lived in the camp where I met her (at least before leaving for France, where she remained for only a few months). When asked why she had decided to try the French experience (more precisely in Marseille), she told me that in Rome she did not even know where she could go for a medical screening or to fill a medical prescription.

It was interesting that a young Roma girl gave a need related to health services as the main reason for leaving. I asked for other information about the factors behind her choice, but the results were poor, as Adriana became evasive when confronted with such questions. After the short and cordial conversation with the personnel and myself, Adriana told us what she needed. She asked for a prescription for a painkiller and, when the doctor asked for her medical card, Adriana extracted from the pocket of her large and colourful skirt a document of a colour and format different from those the staff were used to seeing. It was neither the Italian medical card (“*tessera sanitaria*”) nor the STP card (“*Straniero Temporaneamente Presente*”, “Foreigners temporarily present”) or the ENI card (“*Europeo Non Iscritto*” – “European not

inscribed”), the last two being types of cards normally reserved for migrants waiting to be regularised or to citizens coming from countries recently integrated into the European Union but still waiting for regularisation and clarification of the new regime of communitarian law. Instead, the document that Adriana presented was the certification of her pending request for the status of refugee in France. She believed it possible to use a similar paper as a way to have access to healthcare resources in another European country.

The doctor and the nurse analysed the document and, after trying to summarily translate what was written, they told her that it was not a valid card for them. After having scolded her, with a paternalistic tone, about the need to respect the rules for matters as important as health, they suggested she should go to her parents or some other relative and ask them to use their medical card, to obtain the requested prescription. But Adriana did not seem to understand why a document so important was not valid for a medical prescription.

This relatively banal situation summarises several key elements of the issues analysed in this text. Usually, obtaining prescriptions is a primary aim for Roma patients when seeking healthcare, especially considering that with these documents, they gain free access to many kinds of pharmaceuticals. For the majority of the Roma who accessed that medical space, it was clear that showing relative respect to the camper’s personnel was an effective way to negotiate strategies to be accepted in the healthcare services and other public spaces. In this regard, behaviours expressed in the “sanitary camper” were a significant representation, in a micro-scale, of forms of resistance and proportional opposition to an institutional space, here the public healthcare sector, where invisible and visible (when not striking) actions of rejection are regularly expressed toward Roma. These actions of rejection are the principal elements used to determine the distance between Roma patients and institutional medical spaces, spaces which Roma are constantly discouraged from using and where the conditions for the education on the use of these same services are absent.

A key element of what we can temporarily define as “resistance” is the transnational mobility linked to single medical operations. This form of travelling is articulated with strategies to interpret and use the camper as a protected space (a protection offered by the intimacy between the doctor – the same for eleven years – and the habitual patients), where the medical service is a gateway to other forms of civic service. Roma’s attention to the right to healing apparently seems to arise distinctly only when the claim to that same right is combined with an accentuated tone of denunciation (for example, after every episode of discrimination against Roma that

has occurred in the hospitals). But when the right to health is to be related to other aspects of citizenship, including obligations on the part of citizens (for example, the regularisation of personal documents, or the paying of taxes), Roma resist these aspects of citizenship through forms of international mobility.

Coming back to the case of Adriana, her following visits to the “sanitary camper” made it clear that her main health worry was contraception (a practice usually hardly accepted by Roma men) and, more significantly, abortion. During the following conversations with Adriana, she showed an important interest for an event that had just happened in another camp in Rome (one of the targets for the local authorities’ new policies of security). A young woman had died from internal bleeding (a haemorrhage) provoked by an abortion method that the camper’s personnel had discovered with the help of another patient who had witnessed the procedure. This is a frequent occurrence in Roma camps when women discover an unwanted pregnancy and try to avoid travelling to their original countries (mostly the Balkans or Romania) for the abortion by using a dangerous method. Many Roma women knew from relatives living abroad about a pill, normally used to treat stomach problems, that, if taken simultaneously orally and vaginally, produces a haemorrhage in the womb that provokes the abortion. This method, as it soon became clear, was being repeatedly utilised in the camps and is extremely dangerous because the haemorrhage it provokes can easily be fatal. This is exactly what happened in the young woman’s case that attracted Adriana’s interest.

“You see? In Italy you cannot do abortion and these things happen!” she told me, reflecting on the news of the dead woman. “Why isn’t it possible to do it at the hospital? I went to France because my cousins told me that over there it is possible to do stuff like this, abortion and so on, here all is so complicated, and when they see us in a hospital they refuse to treat us!”

During the months that followed the discovery of the misuse of the pill, the camper’s staff often talked about it to women regularly attending the clinic and who could have been familiar with that method. The recommendations given by the doctor and the nurse resulted in a hyperbolic case of a particular form of sanitary education to be evaluated in relation to the way it crossed the security policies and the citizenship problematic. The case of the dead woman was used as an example and warning for other patients. More generally, daily encounters between Roma patients and the healthcare personnel consisted, in this case more than ever, in lessons of bodily behaviours referring more to the patients living in a state of exception than to routines of screening, vaccination, consulting and so on. This is one of the situations

that make visible how a healthcare approach constantly conceived and constructed on an emergency basis nourishes the same regime of exception and marginality that it is supposed to counter.

Adriana's interest in this event provided the main clue to understanding her decision, revoked after some months, of leaving for France. "Even before leaving to France, I often went over there for the hospital." She claims that in Marseille, where she then went to live temporarily, it is easier than in Rome to obtain consultations and free prescriptions. For her, it was an easier solution to travel to France than to obtain information, money or authorisation for medical consultations and healing in Rome. When I asked the reasons for travelling so long just for visits she could have attended directly in Rome, she refused to explain the kind of medical consultation she needed, but she provided interesting comparisons to defend her choice: "Don't you know that, in all the other camps here in Rome, people go and come back all the time for these things? Romanians [she refers to Romanian Roma] do that all the time! They have a problem with teeth? They go to Romania. They want a gold tooth? They go to Romania. Women are to give birth? They go to Romania. They want to be healed? They go to Romania, and so on. And not only them. For those whose families are in Bosnia, Macedonia and Kosovo, it is the same thing. When they really need to be healed, they go."

When asked what she considers issues that "really need to be healed", she explained that she was referring to kinds of illness that would force the patients to be hospitalised or to attend medical examinations considered too invasive or for which the doctors and nurses in Italy are not sufficiently trusted. The problem of hospitalisation is discussed or at least mentioned in many ethnographic works on Roma (Trevisan 2004). When forced to be hospitalised, subjects are never left alone in the hospital room and are continually visited by relatives and friends, which makes the situation similar to a mourning wake. This kind of action is confirmed by other data arising from my fieldwork: the use of the first aid service even in cases that would not require it. First aid service seems to be considered by Roma as a way to avoid both hospitalisation and the bureaucratic procedures (including circumstances such as the line at the sanitary camper, for example), related to processes that do not involve emergencies.

In her interpretation of mobility and health, Adriana added judgments on the effectiveness of healing in the countries where the Roma are used to travelling, in this context. "They go over there and there are no good doctors, just their relatives and their magic stuff! And they think the people are better healers over there than here.

But only rich people can be really healed over there, in hospitals they always ask for money...”

Adriana’s words about Roma travelling to avoid struggling with the Italian health system were an interpretation of dynamics that were evident in many cases I observed in my fieldwork. While the activity of the “sanitary camper” was built on the relations with a relatively reduced number of regular patients (who were therefore more familiar with the idea of negotiating the local medical and bureaucratic procedures), other government projects of sanitary intervention also had to handle the direct effects of transnational mobility linked to healing processes, as we are going to see in the next ethnographic sketch.

#### IV. NORMALISATION WITHOUT NORMALITY

The case I am going to briefly present concerns the healthcare of an important Italian organisation called Caritas, directly linked to the Catholic Church.<sup>1</sup> In 2010, the Rome section of Caritas started a project of field intervention dedicated to the small and hidden illegal Roma settlements, composed of a reduced number of barracks and inhabited mostly by Roma recently arrived in Italy. The residents are mostly Romanian, as a consequence of Romania’s entrance into the European Union, in 2007, and of Romania’s weak economy. As a result of European integration, Roma-

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1 From Caritas Italiana’s website: “Caritas Italiana is the Pastoral Body created by the Italian Episcopal Conference in order to promote, in cooperation with other bodies as well, the charity commitment of the Italian ecclesiastical community, in the forms that are appropriate considering time and needs, for a complete development of man, social justice and peace, with particular attention to the poor and with a mainly pedagogical function. [...] Caritas Italiana has to carry out the following tasks: [...] coordinating initiatives, charitable actions and assistance interventions of Christian inspiration; [...] cooperating with other bodies inspired to Christian principles: – carrying out studies and research on the needs in order to identify the causes, preparing both preventive and curative intervention plans, within the common pastoral programming and in order to stimulate the action of the civil institution towards an appropriate legislation; – promoting voluntary service and encouraging the training of the pastoral charity operator, as well as those people, voluntary and professional workers inspired by Christian principles, committed to both private and public social services and in human promotion activities [...]” (from [http://s2ew.caritasitaliana.it/pls/caritasitaliana/V3\\_S2EW\\_consultazione.mostra\\_pagina?id\\_pagina=964](http://s2ew.caritasitaliana.it/pls/caritasitaliana/V3_S2EW_consultazione.mostra_pagina?id_pagina=964), consulted in December 2011)

nians no longer need a visa to travel to EU countries, and the number of Romanian Roma in Italy suddenly increased. A large number of them arrived without the possibility to draw on a network for housing. They generally cannot speak Italian at all and their knowledge about local social and health structures was virtually non-existent. Romanian Roma arrivals were accused by other Roma groups of creating conflict and imbalance in their communities and their relationships with the host society (Solimene 2011). As a result, Romanian Roma often had neither access to nor provisory reception in these camps, so they chose to live in small and hidden settlements, like the ones for which the Caritas project was planned.

The project consisted of interventions effectuated by a staff composed of one or two volunteer doctors, normally two other assistant volunteers, one Roma cultural mediator and translator, and often one of the project coordinators. Wearing a jacket showing their affiliation with Caritas, the teams went to the small settlements to deliver brochures with information about the location and functioning of healthcare services in Rome, plus medication for emergency needs. The principal aim of the project was what is called “sanitary education” and to assist the Roma in orientating themselves in the public health system by providing information about its laws, the rights to be claimed and the related networks.

After a first period of weekly interventions in the settlements, the staff decided to initiate the second step of the project. The idea was to choose a limited number of Roma families and focus on them as a small nucleus for sanitary education and orientation. The team would instruct them on how to obtain regular documents and IDs for themselves and their children, how to properly start a process to obtain medical procedures, and how to adhere to the regular legal conditions needed in order to benefit from their right to health as EU citizens. When asked about the parameters used to choose the “familiar nucleus” for the project, one of its coordinators answered: “We opted for a young couple, with only a few and young children, someone with some willingness to work, that is to say, who demonstrated that they had done a few small jobs when they had the chance, and that they had some knowledge of how to introduce themselves correctly, in sum, you see?” While it would be interesting to analyse the links between the choice of these parameters and the ideological principles and the social context inspiring and shaping the project (the idea of which families to privilege, whom to exclude and whom to include in the selection, etc.), what is striking within the framework of the main theme of this text is the relative failure and the deception that occurred after the first months of the second step of

the project. The project manager considered that they had found only people who “moved between two countries, even if they live in the settlement in Rome.” Another coordinator added: “They go and come back... they heal their toothache in Romania... here, they don’t know how to do it and so they go there... it’s all a here and there... here they don’t have reference points, you always find people who don’t speak a word of Italian, who live closed in barracks, without any competence to live in our world...”

The project coordinators hoped to find subjects who showed interest in the perspective of stability and of being correctly introduced into the ordinary Italian medical process. They found, instead, people struggling on a daily basis for minimal subsistence and without any knowledge of how to use the public healthcare services, even if their status as EU citizens might assure benefits in this area. Their mobility was determined both by their lack of knowledge about using the healthcare services and the lack of state action to provide solutions for this situation. Regarding the latter, the authorities seem to appear in this kind of context only when solutions concern eviction and security-related actions.

Within the Caritas approach, healthcare interventions would constitute a sort of training ground for Roma aiming to live in Rome. Foucauldian studies show how medicine is a field in which the disciplining of everyday behaviour has prominent power in establishing the parameters of normalised citizens. But the case of Roma in Rome shows how this process can also be expressed in a negative form: the lack of medical disciplining of undesired groups has the same effectiveness, in terms of state strategies of surveillance and rejection, of the medicalisation of social control. In this context, is the Roma’s travelling for healing to be read as a form of resistance to these technologies of rejection or as a sign of renunciation of a “proper” settling process, or maybe neither – rather a very pragmatic and socially reproduced way of assuring healing?

Anthropological literature on this subject shows how the body is a crucial arena for Roma for the articulation of what we can define as resistance, including the strategies of constructing the boundaries with the larger society through bodily symbolism. The main question that arises, in the case described, concerns the bodily regime that results from this forced integration between a number of different health systems. Roma subjects receive occasional medical consultations through organisations such as Caritas, they try to obtain emergency care from hospitals through the use of first aid centres (which provide help only in an emergency and are therefore an occasional

intervention and not part of an efficient therapeutic path), and respond to this situation through a mobility that, considering the conditions of healing in the countries involved, remains an extremely precarious form of healing. The result of the sum of these different forms of healing is not enough to assure dignified body conditions; instead, Roma's physical well-being is threatened by serious disorders. A significant and somewhat sadly ironic case is that of the woman who, after receiving a recommendation for a vaccine from the doctor, told me that she no longer knew which vaccines she had to take, because every time she travelled for healing, doctors gave her some vaccine, and now she had lost count of the "hundreds of vaccines" (as she ironically told me) she had in her body.

Within the Caritas project, another interesting case was reported. In a settlement built inside an abandoned and dangerous factory, the team met a woman who asked for their help in order to remove a subcutaneous contraception system. She had put it in out of the sight of her husband and her family, who otherwise would not accept it. The system was giving her problems. She asked for assistance because no one in the hospitals and emergency ward she had gone to knew how to remove it. The reason for this was that she had gone to France to have it inserted, but in Italy this is not used as a method of contraception. Here, medical transnationalism was again emerging as an obstacle to a correct procedure. On top of all this, the woman admitted that she had tried to remove it by herself, which represented a serious danger in the same way as the abortion strategy I described before.

After hearing about this case, I met with Adriana again and connected the two similar problematic configurations linked to health and family planning. I had multiple conversations with Adriana and other patients of the "sanitary camper" regarding the extremely dangerous misuse of pills by Roma women through which a system of circulation and a trade in abortive pills among Roma emerged. Some Roma men asked women of the camps in Rome for large amounts of money (one hundred euros just for a pill, in one case) in order to bring them abortive pills from France, charging them very high amounts for the transportation. This trade seems to translate one transnationalism (the circulation of people trying to be healed) into another one (the circulation of pharmaceuticals), but the result of such dynamics doesn't seem to change, and these dynamics must not distract our attention from their political determinants.

## IV. CONCLUSIONS

For Roma in Rome, living in the “*campi nomadi*” is evidently neither the result of a desire nor the “cultural incapability” to live properly in houses. The observable signs of nomadism as a cultural trait among Roma must be placed within the context of the relations between Roma people and the larger society. Identifying these relations is crucial to understanding not only the dynamics of their mobility, but also their place in society.

When transnationalism arose as an important paradigm to analyse the process of mobility of subjects and capital, the need to identify networks of social and economic relationships that transgress national borders was underlined (Brettell 2003). Not only must we take into account contingent structures and agency, but also the reasons that force subjects – beyond kinship relationships or what we can imagine as a sort of “affective tourism” in the families’ countries of origin – to maintain ties in order to have a secondary (or mostly always primary) reference for healing needs. Both home and host societies become a transnational territory for healing actions, even (if not mostly) when we are talking about basic and relatively simple health-care needs. In this framework, we need to identify and situate the political elements that make this situation possible, their consequences in everyday life, and the actions undertaken by the state to maintain this situation.

According to Benedict Anderson, the efforts made by states aim to create social normalisation and alignment, but “modern nomadism” is challenging this approach in favour of disembodied forms of national belonging (Anderson 1983). What we are trying to understand in regard to Roma in Italy is the opposite of this process. Settling in a nation implies the possibility of healing in its geographic territory. But, considering the process I described, what seems to arise for Roma in Italy is the choice between a type of medical transnationalism and the complete renunciation of the settling process, namely by continuing to live in a condition of exception and to travel for healing, thereby leading to a fragmentation of both their therapeutic paths and their obtainment of civic rights. This choice would be a form of refusal of citizenship in the same way that, for example, the non-schooling of children, the refusal to pay taxes or to respect certain laws, can be considered.

In order to identify the forces and the behaviours that shape the described transnationalism, it seems more important to evaluate these from the perspective of racialisation (Fassin 2010) and political and everyday discrimination, focusing on

the cultural meanings behind these frameworks. It is not the generic desire of going back to a country thought of as the place of “origin” that pushes Roma subjects to return there to be healed, but – through a paradox revealed in this text – the strong motivation to find a place in a society and a nation that constantly show signs of rejection toward Roma, even when supposedly trying to help them.

Health cannot wait and Roma subjects need to respond quickly and fluidly to the conjunctures determining the possibility or the impossibility of using the local healthcare services, according to their rights. In this regard, in the case of Roma, transnationalism can be seen as an expression of the tension in the relationship with the institutions, as it is this very tension and its effects that bring Roma back to a position that can be taken for the nomadism that fits the ideas about Roma held by the authorities. We could talk again of a vicious circle, if only this expression did not hide the possible ways of escape.

Citizenship is also composed of the capacity to imagine ways of finding a place for our own body in the society where we live or where we desire to live. Doing it can only happen if it is a body we constantly know how and where to heal, in the territory of that same society. Aihwa Ong talked about “flexible citizenship”, identifying it as new form of disembedded belonging to a national or even a precise urban space (Ong 1999). The case of Roma makes us wonder how legitimate it is to recover the adjective “flexible” and to compare it to the way it is used by Emily Martin when talking about “flexible bodies” (Martin 1994). The question we need to answer – through the observation of concrete practice, again – is if this particular kind of flexibility constitutes a tool with which to respond to conditions of bodily and political insecurity, or a product of a simple impossibility to choose. But, while the kind of situations involving the subjects of flexible citizenship described by Ong (mostly Chinese workers involved in the global flux of capital and travelling in order to manage it) allows us to evaluate ambiguities, losses and gains permitted by these kinds of transnational practices, health matters are powerful and inescapable constraints affecting the choices subjects have when it comes to shaping their ways of being citizens.

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