Racism, Violence and Health: The Living Experience of Immigrant Women In An Italian City

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Introduction: gendering the 'immigrants, racism and health' question

Migration, especially economic migration, is characterized by the selection of populations that are young, healthy, as well as capable of and motivated to join the workforce. Notwithstanding this 'healthy migrant' effect, after some time in the host country, in most cases immigrant people present a prevalence of health problems higher than natives. Historically, this excess of bad health has been attributed either to genetic causes or to 'cultural differences', such as eating, hygiene or sexual practices. These explanations still persist, despite the lack of scientific evidence and more than a century of research exposing their limits (see Atkin and Chattoo 2006).

More recently, a number of studies have shown that not only social disadvantage, but also discrimination and racism, circumstances all linked to being an immigrant or a 'visible minority', are associated with an increased risk of mental and physical bad health (Krieger 2000; Nazroo 2006). The associations with health problems are observed using self-reported measures of discrimination or objective measures, such as difficulties in obtaining a bank loan (Gee et al. 2002; Harris et al. 2006; Velig et al. 2007). Unfortunately, the scope of most of these studies is limited by their lack of a gender perspective (Llacer et al. 2007). Generally 'sex' is not considered as an important, explicative variable, being instead only statistically treated as an 'effect modifier variable', missing the opportunity of exploring gender differences in the migrants' experiences, or in the associations between risk factors and health. Even when only women are studied, the risk factors considered do not include sexual harassment in the work place, sexual violence or intimate partner violence (Schultz et al. 2002), despite this violence being tragically common in women's lives. This omission is particularly striking, as this violence is likely to be even more frequent among women who are socially vulnerable: immigrant, and especially undocumented migrants, and minority, racialized women (Krieger et al. 2006). While the studies on racism and health tend to assume a gender-neutral approach, neglecting women's specific so-

cial position and experiences, the studies focusing exclusively on migrant women's health tend to reduce them only to two traditional feminine personifications: the mother and the prostitute. For instance, a traditional field in public health concerns migrant/minority women's reproductive life and functions, an important yet specific topic (Rash et al. 2007; Wolff et al. 2008; Lyons et al. 2008). More recently, a number of studies have focused on the health effects of being a trafficked woman, another important but hyperspecific issue (Zimmerman et al. 2008).

Interpersonal and institutional racism, discrimination and violence

There are different ways to conceptualize and measure racially motivated discrimination and violence. Most authors distinguish between interpersonal discrimination, which refers to discriminatory interactions between individuals, which usually can be directly perceived, and institutional discrimination, which refers to discriminatory policies or practices embedded in organisational structures, that tends to be more invisible (Karlson and Nazroo 2002). A Canadian document (CRIAV 2002) makes a distinction between overt and covert/subtle/polite racism: the first refers to explicit acts (or omissions), such as calling people names, attacking them physically, or excluding them on the basis of race or ethnicity; the second, to the various ways of letting people know that they are different, or that their only or most salient characteristic is race. In addition, racism may be 'structural', being so deeply embedded in every aspect of society, that most people 'do' it almost unconsciously (CRIAV 2002). Racist discrimination can be found in access to jobs and income, and is usually coupled with gender discrimination[1]. In Italy, among nurses, immigrants from outside the EU are paid 20–40% less than Italians; unfortunately, the data are not analyzed by gender (Bencini, Cerretelli and Di Pasquale 2008).

Other discrimination concerns housing: immigrants and minorities are concentrated in poorer and often segregated geographic areas and in poorer quality and overcrowded accommodation, and have more difficulties in obtaining a bank mortgage to buy a house (Nazroo 2006; Bencini, Cerretelli and Di Pasquale 2008). Still other discriminations can be observed in access

1 For instance, in Canada, in 1995–96, the average annual income for all Canadian men was 31,117 dollars; for 'visible minority men', it was 23,600 dollars; for all Canadian women, 19,200; for aboriginal men, 18,200; for 'visible minority women', 16,600, and for aboriginal women, it was 13,300 dollars (CRIAV 2002).

to health care and to justice. This latter aspect is particularly relevant for the issue of women and violence. In some countries, because of the racism of police forces, criminal justice system and prisons in the host country, immigrant and racialized women appear to be reluctant to call the police in cases of domestic violence out of loyalty to their family and community, not wishing to fuel racist stereotypes (CRIAV 2002; Thiara and Gill 2010; for a different picture, see the Italian data in the Creazzo et al. chapter in this volume).

Thus, interpersonal discrimination and violence are common in the lives of immigrant or minority people. In the UK, according to the Fourth National Survey of Ethnic Minorities, 13% of ethnic minorities reported experiencing racially motivated physical or verbal attacks in the previous 12 months (Karlson and Nazroo 2002). Similar figures were observed for Maori and Asian peoples in New Zealand (Harris et al. 2006). High discrimination in the workplace was observed among UK ethnic minority groups, with 19% of ethnic minorities reporting being refused a job in the previous 12 months, both for perceived religious and ethnic reasons (Modood et al. 1997). In these articles, figures are not presented separately by gender. Most of these studies consider the relationships between racist discrimination, violence and health for 'visible minorities', people who are citizens with, at least in theory, all citizenships rights. But immigrant people must struggle also with other difficulties: restrictive immigrant laws, abrupt changes in laws or policies, bureaucratic delays and harassment. Few studies have considered the effects of being an undocumented migrant on migrant women's health. A study in Geneva (Wolff et al. 2008), on medical care in pregnancy, showed that undocumented migrants have more unintended pregnancies, delay prenatal care, use fewer preventive measures, and are exposed to more partner violence during pregnancy. Authors conclude that not having a legal residence permit leads to a greater vulnerability for pregnant women.

Women' immigration in Trieste and Italian immigration laws

According to official data, in 2005 around 2.5 million immigrants lived in Italy, of which more than half (55.8%) were women. Internationally, Italy ranks 16 among the 20 top destination countries for international migrants (UNDP 2006). However, official statistics only count regular immigrants while many immigrant women and men are in Italy illegally, without the necessary documents. For instance, the Italian Catholic Unions (ACLI) esti-

mate that, in 2008, there were 500,000/600,000 illegal immigrant women working as nannies or house helpers[2] (around the same number was working legally). Available data show that, in the last ten years, the number of immigrants in Italy rose steadily: in the Friuli-Venezia Giulia Region (this study was carried out in its administrative centre, Trieste), from 1991 to 2001, their number has tripled. At the time of the study, 40,985 foreigners[3] (around 3.3% of the Region population) lived in Friuli-Venezia Giulia; 48% of them were women (Caritas 2002). More specifically, according to the files of the Trieste Register office, in 2002, 108,447 Italian women and 4,558 foreign women, mostly from countries of ex-Yugoslavia and Eastern Europe, were living in the city.

Notwithstanding the historical experience of millions of Italians as migrants, Italy seems ill prepared to become an immigration country. Immigration laws have been traditionally restrictive, considering immigrant people only as work-force, and treating them as a security, 'law and order' issue (Scevi 2004). At the time of the study, the law in operation was the 'L.189/2002', also called 'Bossi-Fini', from the names of two right-wing male Ministers who had drafted it. According to the estimated needs of the labour market, a fixed number of immigrants were accepted each year. Immigrants could enter Italy only if they already had a regular job, with the employer signing a 'contract of residence for work', an accommodation guarantee and the commitment to pay the return journey of the worker to the country of origin. With the 'residence contract', the immigrant could request a 'residence permit', lasting two years. An immigrant found without the 'residency permit' had to be expelled. The 'Bossi-Fini' was a tough immigration law: the residence status of immigrants was rendered precarious and totally dependent on the employer, with a heightened risk of blackmail and abuse; family reunification was deeply restricted; immediate repatriation of the ones who do not leave Italy after being ordered expulsion; and the crime of not compliance with the order of leaving Italy were also introduced. The process was made even harder by the gap between the law and its application. Due to the inefficiency of the Italian bureaucracy or to the racism of its officials, or both, even when the immigrant worker and her/his employer presented all the necessary documents, there were very long, and anxiety generating, delays: in the summer of 2009, many of the applications regularly presented in 2007 were still unanswered[4]. Sadly, in July 2009, the right-wing Italian government promulgated a new immigration law, which was even more restrictive,

2 '600,000 le badanti irregolari', La Repubblica, July 7, 2009, p.16.
3 Not all the foreigners are classed as 'immigrants'. In this case, 13% of foreigners were the US soldiers and their families, at the Aviano US Army base.
4 'I ritardi: Flussi bloccati e 311,000 domande respinte'. La Repubblica, July 6, 2009, p.9.

within which, among other measures, being an illegal immigrant became a penal crime.

On the other hand, Italian health policies concerning immigrant people have been more respectful of human rights. Between 1995 and 2000, and until now, several laws and measures have been promulgated, asserting that health is a right for every person living in Italy, independently from her/his status. Immigrants, regular or irregular, have the right to medical care, including prevention and rehabilitative measures. Those with a regular residence permit have the same rights to access the National Health System (NHS) as Italian citizens, while those without the permit to stay can be provided with a 'Regional card' by the Health Regional Agencies, which gives access to emergency care and to 'essential' care. As for Italians, all medical care concerning women's reproductive and childrens health, and the prevention of infectious diseases is totally free within the NHS. Health operators are forbidden to inform the authorities of irregular immigrants. In a first draft of the new law, the Italian government tried to cancel the forbiddance, but, in the face of a strong opposition from health professionals' associations, the measure was dropped, and, until 2011, irregular immigrants could still safely access health services.

The study aims and methods

The data presented in this chapter are drawn from a multi-method study on *'Health and health care of immigrant women in Trieste'*[5], a city of 210,000 inhabitants located in North-eastern Italy. The study, carried out between 2003 and 2006, comprised different parts: a secondary statistical analysis of the files of immigrant women's access to reproductive health services; a qualitative study, with interviews with women and 'key informants'; and a quantitative survey, with questionnaires to a sample of the women. In this chapter, we present only the results of the questionnaire survey.

The aims of the study were to analyze the health and health care of immigrant women, in order to facilitate their access to health facilities and to implement specific information and preventive measures. To meet these objectives, the study had to involve also those women who are often excluded both

5 The study was promoted by the Office for Women and Migrants policies, directed by Dr. Daniela Gerin of the Agency for Social and Health Services of Trieste (ASS n.1) and was funded by the Health Department of the Regione Friuli Venezia Giulia. Giuditta Creazzo was the principal investigator; Daniela Paci, the study coordinator; Emanuela Pipitone, the data manager and statistician: Patrizia Romito, the scientific advisor. The working group also included: Donatella Barbina, Iris Tekovich, and Imma Tromba.

from surveys and from health care: women who are undocumented immigrants, illiterate, or do not speak Italian. Constructing the sample and interviewing the women represented the main difficulty of the study, and was possible only with the involvement of twelve female cultural mediators working within the Trieste health services. They come from eleven countries[6], and were trusted by the women of their communities. They collaborated in the different parts of the study, contributing to defining the aims and constructing the interview guide and the questionnaire; translating the questionnaire or checking its translation; contacting the women to be interviewed; and helping the women, when necessary, in filling in the questionnaire.

The quantitative survey: sample, instrument and procedure

Overall, 465 immigrant women participated in the survey. We wanted to involve women living in different situations: legal and illegal/undocumented migrants, whether they spoke Italian or not, and whether or not they used the health service. Moreover, in constructing the sample, we wanted to respect, as far as possible, the estimated proportion of nationalities of immigrant women in the city. Most women were approached by the cultural mediators, among those contacting health services, NGOs, cultural or religious associations; others were recruited by the women themselves via a 'snowball sampling' technique. Mediators explained the study to the women (its aims, anonymity of the questionnaires and confidentiality of the answers), stressing that they were free to participate or not to do so, and that declining to participate was not going to affect in any way their health care. Informed, spoken consent was requested and, when obtained, an appointment for filling in the questionnaire was set; in some cases, and with the women's agreement, a group appointment was set up in a location chosen by the women.

The questionnaire was inspired by national and international literature, and by the content of the interviews carried out in the qualitative part of the study. It comprises 115 questions, including: socio-demographic information; migration history; physical and mental health; reproductive history; experiences of violence and discrimination; knowledge of rights; access to health services and experiences with health professionals; family and social relationships; comments and suggestions. An earlier version of the questionnaire

6 Albania, Romania, Serbia, Croatia, Hungary, Iran, Morocco, Senegal, Kenya, Venezuela, and Colombia.

was tested with a different sample of 50 women, and revised according to their suggestions. The revised version was translated by the Mediators, with the researchers' assistance, into 6 languages: Spanish, Serbian/Croatian, Albanian, Rumanian, French, and English. The questionnaire was intended to be self-administered. The Mediator explained to the women its content, and stayed nearby, available for help. In 43% of the cases, due to women's illiteracy, or bad sight or difficulties in understanding some questions, the mediators administered the questionnaire or helped the women filling in the answers; 73% of women answered the questionnaires in their mother tongue; 23% in Italian; and 4% in another language they knew.

Measures of women's health and experience of discrimination and violence

In the questionnaire, we asked questions about several indicators of physical and mental health: symptoms of common problems, symptoms of panic attacks, depression (measured with the General Health Questionnaire, Goldberg, 1972), medicine consumption. In this chapter, we present only the results concerning one indicator of mental health – that of panic attacks. Women were asked if, in the last year, they had experienced anxiety or panic attacks, described, according to the DSM-IV (1994) as occurrences of intense fear or discomfort, that might include rapid heart beats, feelings of suffocation, nausea, fear of losing control or dying. Answers were: no; yes, one or twice; yes, more often, and were re-coded dichotomously: no and yes.

Different types of indicator of discrimination and violence were used. Firstly, the indicators of institutional/structural discrimination were: having or not having a legal residence permit and, among those who had it, how much time they had to wait to obtain it; the partner having or not a legal residence permit; the fact that the children, or some of them, were living in the woman's home country; being insured, regularly or with a temporary card, or not to the National Health Services; subjective evaluation of income; characteristics of housing. Secondly, a number of questions were designed to produce indicators of interpersonal, ethnically based, harassment/discrimination. The woman was asked if, in the last year, someone did or said something against her as a foreigner, that hurt, offended, humiliated or deeply irritated her. A list of perpetrators was provided, including employers, colleagues, acquaintances, family members, or unknown people. Answers were: no; once; 2/3 times; more often. In the analyses, answers were re-coded dichotomously: no and yes. Women were considered as having suffered from ethnically motivated discrimination if they reported at least one occurrence of

discrimination from one perpetrator. In addition, the woman was asked if, in the last year, a health professional did or said something against her as a foreigner that hurt, offended, humiliated or irritated her. Among the women who had contacts with health services, answers were: no; once; 2/3 times; more often; and were recoded dichotomously: no and yes. Thirdly, two questions were put on the topic of interpersonal violence, on psychological violence and on physical/sexual violence. Women were asked if, in the last year, they had experienced psychological violence (defined as being offended, insulted, followed, controlled, impeded to do something or to see someone, having their belongings destroyed). In another question, they were asked if they had experienced physical or sexual violence (being physically attacked or beaten up, or being obliged or pressurized to have sexual contacts against their will). A list of possible perpetrators was provided, including a husband/fiancé or ex husband/fiancé, a family member, an employer, a colleague, acquaintances, and unknown people. Answers were: no; once; 2/3 times; more often. In the analyses, answers were re-coded dichotomously: no and yes. Women were considered as having suffered from violence if they reported at least one occurrence of violence from one perpetrator.

Strategy of analysis

After a description of the demographic and social characteristics of the women interviewed, we calculated the frequency of the different types of discrimination and violence suffered by them, and the bi-variate relationships between discrimination and violence and symptoms of panic attacks in the last year. We then carried out the Cochran-Mantel-Haenszel test to calculate the Odds ratios of experiencing a panic attack in presence of each type of discrimination and violence, controlling for age and ethnicity, as both may have an influence on discrimination/violence and on panic attacks. Migrant groups were categorized as: Europe, Central/South America, Africa and Asia. Preliminary analyses (not presented here) have shown that perceived income was strongly associated with all the health indicators. We, therefore, also calculated the Odds ratios of a panic attack, controlling for age, ethnic group and perceived income.

Demographic, health and social characteristics of the women interviewed

Among the 465 women who answered the questionnaires, 59% born were in Europe (36% in ex-Yugoslavia, 22% in Central-Eastern European countries, and 1% in other countries); 18% were born in Central and South America, 18% in Africa and 5% in Asia. Women's geographical origins correspond to the origins of foreign women in Trieste (although Asian women were slightly underrepresented in the sample). Most women came to Italy independently, to study (10%), work (33%), or financially help their families (25%); 16% migrated with their husband for a better life; 23% followed their husbands who were already in Italy; 9% said they were escaping war or social disorders; and 2% were escaping a violent partner or ex-partner (more than one answer was possible).

The women's ages ranged from 18 to 64 years, with most women being between 18 and 44 years old. Most were married or cohabiting (66%), and had children (68%). Educational levels of the sample varied widely: 18% of the women attended school or University for 15 years or more; 46% for 9–14 years; 28% for 6–8 years; only a minority (7%) was illiterate or with few years of schooling. As regards occupation, 41% had a regular job, 17% were working illegally, 11% were unemployed, 24% did not have paid work and 7% were students or in other situations. Among those who were employed, 87% had a blue collar or service job. Their knowledge of the Italian language varied: 38% said they speak and understand 'well', 30% 'fairly well', 24% knew only a few words, and 8% did not speak or understand at all. This means that the study had a broad coverage of education levels, Italian language proficiency, occupational status and family circumstances. Concerning women's mental health: in the previous month, 14% of them had experienced depression symptoms and 11.5% was taking psychotropic drugs. In the last year, 25.6% had experienced one or more panic attacks

Analysis of the frequency of discrimination and violence

Table 1 presents the frequency of institutional/structural and interpersonal discrimination and violence as reported by the women. At the structural level, 24% of women, and 17% of their partners, had an illegal immigrant status, as they lacked the residence permit; among those women who had the permit, 13.8% had to wait more than 1 year to obtain it. Among those who

had children, in 38.3% of cases the children, or some of them, were living away, mostly with other relatives in the country of origin. While most women (89%) had access to the NHS, 11% did not have this possibility, because they were not registered through the Regional card. As for social disadvantage, 38.8% evaluated their income as scarce or not adequate, and 16% were living in temporary accommodation: with friends, in the house where they were working as live-in nannies or house helpers, or in collective accommodation.

At the interpersonal level, sixty-two women (13.3%) had suffered racist harassment in the last year, in most cases (76%) more than once. Perpetrators were mostly unknown people (31%), otherwise employers and colleagues (34%). Among the 321 women who had some contact with health services in the last year, 9% reported occurrences of racist attitudes towards them or discrimination by the health personnel; the corresponding figure in the whole sample was 6%. In addition, 78 women (16.8%) reported occurrences of psychological violence in the last year, in 79% of cases more than once. The most frequent perpetrator was a partner or ex-partner, followed by another family member, then an acquaintance, an employer or a colleague; only in a minority of cases was the person unknown. In the same period, 30 women (6.5%) had experienced acts of physical or sexual violence, occurring, in 61% of cases, more than once. The most frequent perpetrator was a partner or ex partner, followed by an unknown person, and then by a family member. To have an estimate of Intimate Partner Violence (IPV), we considered the sub-sample of 303 women who were married/cohabiting with a partner or who were in the process of leaving him: 10% had suffered psychological violence, and 5% physical or sexual violence by a partner or ex-partner in the past year.

Relationships between institutional discrimination, interpersonal violence and panic attacks

Results of bi-variate analyses show that both structural/institutional discrimination and interpersonal violence negatively affected women's mental health (Table 2A). Not having the residency permit or having had to wait for a long time before obtaining one, living in temporary accommodation, and describing her own income as irregular or inadequate, were all strongly associated with the occurrence of a panic attack. There were no significant associations between the partner not having the residency permit, a child/children living away, the woman's working status, and not being insured at the National Health System and panic (data not shown), hence these variables were not

analyzed in the multivariate analyses. At the interpersonal level, having suffered racist harassment or discrimination, including during contacts with the health services, psychological violence, and physical/sexual violence were all strongly associated with panic attacks.

The multivariate analyses confirm most of the bi-variate results. Controlling for age and ethnicity (Table 2B), women without a residence permit or having had to wait for a long time were 2.3 times more likely to have a panic attack, and those with a scarce/inadequate income were 2.8 times more likely to experience panic than women who were not exposed to these factors. Living in a temporary accommodation almost doubled the probability of a panic attack ($p<0.05$). The impact of interpersonal, racially based discrimination on mental health was strong. Women exposed to racist harassment presented an odds ratio of having a panic attack almost three times higher than those who were not exposed. A similar trend was observed for women reporting racist discrimination in health services. The impact of interpersonal violence was even more powerful. Women exposed to psychological violence were approximately seven times more likely to have a panic attack, and those exposed to physical/sexual violence were 5.7 times more likely to experience panic than women who were not exposed.

Introducing income into the models reduced partially the strength of the associations between discrimination or violence and panic attacks (Table 2C). Controlling for age, ethnicity and income, being without a residence permit/having waited for one for a long time, living in temporary accommodation, and reporting racist discrimination in the health services were no longer statistically associated with panic attacks. On the contrary, racist harassment, psychological violence and physical/sexual violence all increased significantly the probability of a panic attack. More particularly, women exposed to psychological violence were just over four times as likely to have a panic attack. Women exposed to physical/sexual violence were more than five times as likely to have a panic attack; the impact of physical/sexual violence on panic attacks was reduced only very slightly by introducing income into the model.

Discussion

The immigrant women interviewed in this Italian city had experienced various types of discrimination and violence, both at the institutional/structural and at the interpersonal level. As women, they suffered psychological, physical and sexual violence, mostly perpetrated by a partner or another family member. As

immigrants, they were subjected to several instances of racist harassment and discrimination and to severe institutional/structural violence. Almost a quarter of the women were without a residence permit, a frightening situation to have to endure. Among those who had the permit, many had to wait more than one year to obtain one, a period filled with financial hardship and anxiety. Eleven percent had no national health insurance, unaware that, even if they were living illegally in Italy, they had the right to the Regional health card, without any risk. Thirty-eight percent of those who had children, their offspring had remained in their country of origin. Around 40% had an inadequate income, and 16% lived in poor, often shared, accommodation. While many had a good level of education, 87% of those who were employed had a manual job, often in the service sector. Several qualitative studies have described these experiences and the suffering they may entail (Macioti 2000; Ehrenreich and Hochshield 2004). A full analysis of the links between these various types of violence and discrimination is beyond the scope of this chapter. However, these figures illustrate how the situation of an immigrant, or minority, woman can best be understood through the lens of intersectionality, a key methodological tool allowing us to read the deep connections between various systems of domination – gender, race/ethnicity and social class/poverty – in the lives of many women and their effects on health (Crenshaw 1994).

In the bi-variate analyses, all types of discrimination and violence were significantly associated with having panic attacks. More than one third of the women without the residency permit, living in temporary accommodation, or having a poor income, reported the occurrence of panic attacks, compared with 18–23% of respondents without these institutional discriminations. The impact of interpersonal violence was even stronger: when exposed to racist harassment, also in health services, half of the women had panic attacks, as against 23–28% of those not exposed. Other studies have shown the same trend (Gee et al. 2002; Schultz et al. 2006; Williams, Neighbors and Jackson 2003). In the New Zealand Health Survey (Harris et al. 2006), experiencing any type of racial attack or discrimination by a health professional, in the workplace or when searching for housing, was associated with poor or fair self-rated health, lower physical functioning, poorer mental health, smoking, and cardiovascular disease. Not surprisingly, the impact of violence was even stronger than the impact of discrimination. Among women reporting psychological or physical/sexual violence, respectively 59.2% and 67.8% suffered panic attacks, compared with 18.8%–22.8% among the not exposed women, a trend confirmed by previous studies of this relationship (Campbell 2002; Golding 1999; Romito, Molzan Turan and De Marchi 2005).

In multivariate analyses, the strength of some of these associations was reduced. The association between housing conditions and panic was non-

significant when controlling for age and ethnicity (OR 1.88, CI 0.97–3.62), and was slightly lessened adjusting also for income. The associations between the 'residence permit' variable and panic attacks was significant when controlling only for the demographic factors (age and ethnicity; see Table 2B), but become non-significant when adjusting also for income (Table 2C). This suggests that its impact on health lies in the intersection of institutional discrimination – and the additional inequities and anxiety that it generates – and financial difficulties. However, it is possible that with a larger sample, these associations would have been significant.

Interestingly, the associations between the indicators of interpersonal violence and panic were only slightly reduced after adjusting on age, ethnic groups and income (except for racism in health services that becomes not significant). Women exposed to racist harassment were 2.3 times more likely to suffer from panic attacks than those not exposed. Those exposed to psychological violence, mostly by family members and by partners, and to physical/sexual violence, mostly by a partner or ex-partner, had even higher OR (respectively of 4.53 and 5.44) of a panic attack than women not exposed. Notably, the impact of physical/sexual violence was almost unmodified after adjusting also on income.

Having a child or children living in the woman's country of origin was not associated to experiencing panic attacks. This was a common situation for the women in this study, concerning the 38.3% of those who had children, a proportion similar to that found among immigrant domestic workers interviewed in California: 40% of mothers had at least one child 'back home', usually in the care of relatives (Hondagneu-Sotelo and Avila 2005). These authors stress that 'being a transnational mother means more than being the mother to children raised in another country. It means forsaking deeply felt beliefs that biological mothers should raise their own children and replacing this belief with new definitions of motherhood' (p. 312). Other authors have described the suffering of the children, often separated from their mothers for many years (Salazar Parrenas 2004). However, there are different models and different experiences of motherhood. From the qualitative data of the Trieste study, it appears that many women were deeply aware of their crucial role in providing for the whole family and were proud of it, even if this meant being temporarily separated from their children. This could explain why this factor was not associated with worse mental health.

There are multiple theories explaining how racism may affect health. These include differential exposure to determinants of health (e.g. socioeconomic, professional, environmental and behavioural), differential access to health services, and the direct effects of racism such as trauma and stress (Karlsen and Nazroo 2002). Krieger (2003) identified five key pathways:

economic and social deprivation; exposure to environmental hazards; socially-inflicted trauma; targeted marketing of harmful products such as tobacco and alcohol; and poor health care. While these theories are good in grasping the main factors that affect minority people health, they do not fully consider the effects – direct and indirect – of being an undocumented immigrant, a 'risk factor' also for the health of male immigrants. Nor do they consider the risk factors attached to being a woman, such as psychological, physical and sexual violence, mostly inflicted by partners and family members.

Our sample was reasonably heterogeneous and, differently from other published studies, it included also undocumented women immigrants. Also for these reasons, comparing our results to those of other studies is risky, as the methods, the sample composition and the social context vary. We cannot assume that similar results mean that similar facts or experiences have been measured, nor that different figures imply a different reality. Still, and with this precaution in mind, if our results are in the same range of those of others, we can be at least partly reassured on the validity of our data. Among the women interviewed in Trieste, 13% reported racist harassment in the last year, the same percentage reported by ethnic minorities in Great Britain (Karlson and Nazroo 2002) and in New Zealand (Harris et al. 2006). In these studies, figures are not presented separately by gender, although in both cases the authors state that these attacks were more common in young males. In our study, 9% of the women who had contacts with health professionals in the last year (6% in the whole sample) reported being discriminated against within the health care system because of their ethnic origin. This is higher than the 2% of Maori and Pacific peoples and 1.3% of Asians who reported unfair treatment by a health professional because of their ethnicity in New Zealand (Harris et al. 2006). Even if Harris et al. calculated the percentage of discriminated people on the whole sample, women in Trieste reported more occurrences of bad treatment. One explanation could be that minority people in New Zealand were citizens with all the citizenship rights, while the women interviewed in Trieste were immigrants, and in same cases irregular immigrants.

Studies in Europe have shown that immigrant women report more IPV than natives (Condon and Schrottle 2007), also around pregnancy (Saurel-Cubizolles and Lelong 2005; Romito, Molzan Turan, Lucchetta and Scrimin 2007). In the present study, 10% of the interviewed women reported psychological and 5% physical/sexual IPV in the last 12 months: these figures are almost identical to those found in two studies involving Italian women of similar age and using similar questions on IPV (Romito 1998; Romito, Molzan Turan and De Marchi 2005). It is possible that immigrant women in this

study had underreported violence, especially when they filled in the questionnaire with the mediator's help. However, as regards their national and cultural origins, they were a highly heterogeneous group, sharing only the status of immigrant women: there is no reason to expect a homogenous experience concerning IPV. With regard to mental health, the rate of depression reported by migrant women in Trieste (15%) was the same as that found in two other studies, involving Italian women in the same age range, and using the same instrument (the General Health Questionnaire) (Romito 1998; Romito, Molzan Turan and De Marchi 2005).

The main limit of this study lies in the fact that ours is a convenience sample. However, a representative sample of immigrant women in Trieste, including also illegal immigrant was – and is – impossible to achieve. Moreover, the sample was rather small, precluding the possibility of doing more complex analyses. Strengths of the study, however, lie in the inclusion of women who were illegal, illiterate and not speaking Italian, and in its gender perspective, allowing us to describe the living experiences of the respondents as immigrants and as women. In addition, this study is the first in Italy, and one of the few internationally, to show that racism and discrimination are bad for women's psychological health. Further studies, with larger samples, will make it possible to analyse more thoroughly the intersections of the different systems of gender, class and ethnicity, and their impact on women's health. We feel that such an approach will be useful also in order to gain a better understanding of the experiences and health of male immigrants.

After this study was completed, a new, harsher, immigration law was passed in Italy, which considers being an irregular migrant as a penal crime, making the life of migrant people even more difficult. The right-wing government, and especially one political party, the Lega, support anti-immigrant policies also at the local level, and foster a violent racist ideology (Volpato, Durante, Gabbiadini, Andrighetto and Mari 2010). Unfortunately, most Italian media seem to follow this stream (Morcellini 2009). International surveys report that contemporary Italy ranks high among EU countries for hostility and racism against immigrants (EU-MIDIS 2009; Horowitz 2010). In 2009, the day before the new Italian immigration law come into force, a young Moroccan women, Fatima Aitcardi, killed herself. According to her family, she was terrified and depressed because she had not been able to obtain a residence permit[7]. This tragedy reminds us that the health impact of racism is not only a scientific topic nor a theoretical human right issue: for many women and men it is truly a question of life or death, their life or death.

7 La Repubblica, August 7, 2009.

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Table 1: Discrimination and violence experienced by the women

At the institutional/structural level			
		(N)	%
Has a residence permit			
Yes, waited 1 year or less		(280)	62,2
Yes, waited more than 1 year		(62)	13,8
	No	(108)	24,0
Partner has a residence permit*			
	Yes	(209)	83,0
	No	(42)	17,0
Children living abroad**			
	No	(190)	61,7
	Yes	(118)	38,3
Insured at the NHS			
Regularly insured		(325)	72,3
With a Regional card		(75)	16,7
Not insured		(49)	11,0
Income			
Good/adequate		(279)	61,2
Poor/not inadequate		(175)	38,8
Housing			
Owned accommodation		(107)	23,3
Rented accommodation		(278)	60,7
Temporary accommodation		(73)	16,0
At the interpersonal level, in the last 12 months			
		(N)	%
Racist harassment			
	No	(403)	86,7
	Yes	(62)	13,3
Racist discrimination in Health			
Services***	No	(292)	91,0
	Yes	(29)	9,0
Psychological violence			
	No	(387)	83,2
	Yes	(78)	16,8
Physical/sexual violence			
	No	(435)	93,5
	Yes	(30)	6,5

* Among those who have a non-Italian partner
** Among those who have children
*** Among those who had contacts with the health services

Table 2: Discrimination and violence at the institutional and interpersonal level and symptoms of panic attacks in the last year

	A) % of women with panic attacks		B) Odds Ratios** (95% CI) of panic attacks adjusted for age and ethnicity		C) Odds Ratios (95% CI)** of panic attacks adjusted for age, ethnicity, income	
At the institutional level	%	(n)	OR	(95% CI)	OR	(95% CI)
Residency permit						
– Yes, no waiting*	19.3	(52)	1		1	
– Long wait, no permit	37.1	(59)	2.32	(1.46–3.67)	1.57	(0.94–2.63)
	p < 0.001		p < 0.05		ns	
Housing						
– Owned or rented*	23.1	(86)	1		1	
– Temporary accommodation	37.3	(28)	1.88	(0.97–3.62)	1.86	(0.91–3.77)
	p < 0.05		p < 0.05		ns	
Income						
– Good/adequate*	18.0	(49)	1		/	/
– Scarce/not adequate	37.3	(63)	2.78	(1.70–4.54)	/	/
	p < 0.001		p < 0.001			
At the interpersonal level, in the last 12 months						
Racist harassment						
No*	22.6	(91)	1		1	
Yes	50.0	(25)	2.99	(1.53–5.82)	2.32	(1.16–4.66)
	p < 0.001			p < 0.05		p < 0.05
Racist discrimination in health services°						
No*	28.3	(81)	1		1	
Yes	50.0	(14)	2.63	(1.10–6.27)	2.21	(0.92–5.31)
	p < 0.05			p < 0.05		ns
Psychological violence						
No*	18.8	(71)	1		1	
Yes	59.2	(45)	6.95	(2.62–18.40)	4.53	(1.89–10.82)
	p < 0.001			p < 0.001		p < 0.001
Physical/sexual violence						
No*	22.8	(97)	1		1	
Yes	67.8	(19)	5.72	(3.20–10.21)	5.44	(2.61–10.17)
	p < 0.001		p < 0.001		p < 0.001	

* Reference category. ° Among women who had attended health services.
** logit estimates (Woolf, 1955; Haldane, 1955).

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