Inclusion and health in transition: the case of midwifery services for migrant women

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This study examines the provisions of health services for migrant women in Italy, focusing on midwifery and childbirth care. It analyses the challenges posed by demographic transitions within the Italian healthcare system. Conducted in Calabria between October and November 2024, the field-research has involved migrant women, midwives and reception operators in order to grasp personal experiences and systemic issues. Findings reveal critical gaps in reproductive health services, especially regarding cultural differences, legal barriers, and institutional inefficiencies. The medicalization of childbirth, as standardizing care, often marginalizes migrant women's experiential knowledge, emphasizing the need for more inclusive practices. This study underscores the importance of culturally sensitive policies and practices to ensure equitable healthcare access and bridge gaps between formal health services and informal community support.

Keywords: health services; migrant women; reproductive health; diversity; transition; body.

Introduction

The issue of diversity is a fundamental aspect of current research on social, technological and environmental transition. In order to be inclusive, transition governance must implement policies and practices ensuring the progress of increasingly heterogeneous societies, not only in terms of its composition (gender, age, ethnicity, class, sexual orientation, cultures, affiliations, and personal conditions), but also considering the diverse demands stemming from this heterogeneity. These demands are challenges, but also forms of resistance that question the processes of transition. (Preuß *et al.*,

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While the article is the result of a shared experience of researching and has to be considered the outcome of a common understanding between the authors, par. 1 and 5.3 have to be attributed to Luca Benvenga, par. 2 and 5.2 to Valentina Fedele, par. 3 and 5.1 to Sabrina Garofalo. Introduction, Methodology and Conclusions have to be attributed to all the authors.

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2021; Caro-González *et al.*, 2023). Building on this premise, the article seeks to contribute to a broader reflection on diversity in transition by analysing, from an intersectional perspective, the relationship between health services and migrant women in Italy, with a specific focus on obstetrical services in childbirth management. It is based on research conducted between October and November 2024, involving women, midwives, and reception operators in Calabria, focused on direct experiences of childbirth, its accompaniment, and management.

The growing presence of women within migratory flows, articulated in demographic, social, and cultural terms, raises specific challenges for health services, particularly amidst the ongoing transition of the national health system. Given the complexity of health service demand and supply, models of care and treatment must be reconsidered in light of ongoing demographic and epidemiological transitions. The increase in average age, which also affects migrant women, is accompanied by a growing chronicity, to which are added social inequalities and conditions of vulnerability that modify health needs and the health system's responses (Ingrosso *et al.*, 2020). In particular, the encounter between migrant women and reproductive health services is specifically reflected in obstetrical services and the childbirth experience, which are deeply influenced by cultural elements. Childbirth places at the centre of health care actions migrant women's bodies, which, following Bourdieu (1998), are socially determined as socialized nature and thus possible objects of symbolic, physical, and institutional forms of violence. As such, migrant bodies pose specific challenges, questioning transitional models and practices of health services in Italy.

1. Health transition and migrant services

Health promotion is an intersectoral process involving not only the health system, but also those sectors related to the distribution of health determinants. In Italy, the right to health is enshrined in Article 32 of the Constitution. Law 833 of December 23, 1978, introduced the National Health System (SSN), reflecting two decades of profound changes that reshaped the country through new welfare policies.

In broader terms, the establishment of the SSN is aligned with the basic principles of the *Global Strategy for Health for All by the Year 2000*, a strategy launched by the World Health Organization in 1977 to promote universal access to essential health care (WHO, 1984). This strategy was created in

response to member countries' demands to democratise long-term access to health care.

The egalitarianism introduced by the SSN has been fundamental for ensuring the social protection of the most vulnerable, with the aim of reducing inequalities and strengthening safeguards for socially disadvantaged groups. Among these, migrants are particularly affected, as regular access to prevention and care services is not always guaranteed, negatively influencing the health profile of growing segments of the population.

In Italy, a focus on migrants' health emerged between the 1980s and 1990s, when migratory flows began to spread throughout the country, as a countertrend to the previous decades characterised mainly by mass emigration. This resulted in new regulatory measures and public policies. In 1998, two measures-oriented health policies for the foreign population in Italy were adopted: the first was an organic regulatory intervention, the Turco-Napolitano Law; the second, more vertical, was contained in the National Health Plan (PNS) 1998-2000, that extending to migrants the vaccination system, ratified the need to standardise their access to health care (Geraci *et al.*, 2024). Despite these two references, subsequent health measures, in terms of regulatory actions and operational tools, have been very fragmented, exposing foreign population to various vulnerabilities and violations. Reproductive health, understood as «a state of complete well-being concerning all aspects of the reproductive system, its processes and functions» (UNFPA, 2004, p. 52), was recognised as a fundamental right at the Tehran Conference (1968) and formalised at the Cairo Conference of 1994 (Meo, 2021). The specific link that this right has with both socio-cultural – as gender inequalities – and political-institutional aspects – as barriers to access to health services – determines its different articulation and guarantee in different countries (Lombardi, 2020), especially when specific structural and personal conditions are raised in relation to marginalised groups. In this sense, reproductive health can be considered as straddling two levels of equality: the first formal, typical of the liberal state, and the second substantial, prerogative of the welfare state. It represents, therefore, a specific indicator of women's well-being and of the same social development in the perspective of the global demographic and epidemiological transition (ibidem).

In Europe, many countries have approved strategies to support reproductive health (Lombardi, 2020) with this transition in mind. The Italian health system, which is universal, ensures standard reproductive health care for migrant women. This is made possible by public support aimed at the foreign population and health policies (Gieles *et al.*, 2019; Fair *et al.*, 2020; Paříz-

ková *et al.*, 2023), with reference to high levels of monitoring of health conditions in the prenatal and postnatal phases. This attention potentially extends to broader areas of childbirth and reproductive health care, leveraging new health welfare, focused on health care and community care (Ingrosso *et al.*, 2020), which tries to intercept the needs coming from new specificities, to include them within the strengthening of territorial services, and of prevention activities. However, this perspective encounters several problems, as migrant women's care paths in the context of services related to childbirth and maternity still encounter criticalities related to the *management case*, to the construction of alliances between the territory and the hospital and to empowerment practices for recipients.

2. Gender, migration and health

In Italy, female migration became a specific object focus of analysis only in the 1980s following the phenomenon of the so-called feminisation of migratory flows (De Haas *et al.*, 2019), i.e. «women migrating alone in search of employment» (Vianello, 2014, p. 23), giving rise to a recognized female migration system (Cvajner, 2018). Previously, women had mostly been invisible in migration paths, both in the countries of origin (Garofalo, 2012), and in the receiving countries, whereas, in the face of the closure of the borders of Northern European countries in the 1970s, they had been involved in the process of migration linked to family reunifications. In this case, although they represented an important point of connection with the host society and a specific instance in accessing its institutions, especially through their children (Favaro, Omenetto, 2009), they were generally considered in a complementary role to male migration.

The increase of female first migrants within migration flows determines a specific focus on gender in migration, especially concerning their employment in private care sector, usually genderized as an activity «socially constructed as feminine» (Vianello, 2014, p. 33)[1]. In this sense, special attention has been given to the chain of care, i.e. the replacement welfare that often accompanies the economic migration of mothers to their countries of origin. In this sense, once again, it is the dimension of motherhood, traditionally constructed as a form of female labour, that is highlighted, while those paths

[1]Cf. Zanier (2006). Vianello (2014) points out that the nursing sector, the sex industry, the hospitality industry and the agricultural sector were also research environments, showing strong national, class and gender segregation.

illuminated possibilities of autonomous choice. A second area of investigation is that of gender-based violence. The latter, often ethnicised, traced back to the culture of origin (Pinelli, 2019), crosses the entire migratory process, in the countries of origin, through the journey and in host countries, taking on different normative, social, cultural, political, and communitarian declinations. This perspective emerges above all in relation to the increase of asylum seekers and refugees due to the multiplication of international, political, economic and climatic crises, determining different types of violence in the precariousness of the migratory path itself. This also reflect the heterogenization of the composition of migratory flows, from a demographic – with the presence of younger, minor, urbanised people, with a higher level of schooling –, normative – diversifying, in the face of stricter regulations, both the entry and permanence modes –, geographical and, consequently, cultural and linguistic point of view. Migrant women's demands to institutions and services and the criticalities possibly connected to them are consequently diversified, making it necessary also from an analytical point of view to take an approach capable of grasping their multidimensionality.

Health services represent a specific space of encounter, intersection and conflict between the public dimension and subjective and collective experience. States of health, in fact, interact with inequalities in a context of social and environmental complexity characterised by a spatial dimension (living places) and a temporal dimension (the unfolding of social relations) (Vingelli, 2016). In the last ten years, in-depth studies on the relationship between migrant women and health have been focused on three main areas: mental health (Redini *et al.*, 2023; Tognetti Bordogna *et al.*, 2020), health and gender-based violence (Bartholini, 2020; Rubini *et al.*, 2024; Gentile *et al.*, 2023), reproductive health (Delli Zotti, Urpis, 2020; Altobelli, 2021; Lombardi, 2018)[2]. Concerning the latter, Della Puppa, Pasian and Sanò (2020) propose a specifically culturalist approach. The latter allows to takes into account migrant women's subjectivities, culturally informed, in order to grasp the multidimensionality of the phenomenon; at the same time, it gives space to the intersecting of regulatory issues – as women's uncertain legal status may discourage their recourse to services – personal skills – educational backgrounds, language skills, family conditions, cultural orientations – bureaucratisation of procedures, and information's fragmentation, often

[2]These studies examine the reasons that inhibit access to services themselves, the public health repercussions of these, and possible overcoming practices (Quaranta, Ricca, 2012; Terraneo, Tognetti Bordogna, 2018; Tognetti Bordogna, 2012).

conveyed by third parties (reception centre operators, compatriots) (Lombardi, 2005; Mangone, Masullo, 2013; Tognetti Bordogna, Rossi, 2016; Terraneo, Tognetti Bordogna, 2018).

Given the medical specificity of reproductive and obstetrical services, in fact, migrant women's body – culturally and socially constructed (Bourdieu, 1998) – represent a field of articulation of narratives and hetero-narratives, linked to practices and conceptions, challenging the very approaches of the national health system.

3. Migrant bodies and obstetrical services

Women's bodies, in health studies, have often raised reflections on the pervasiveness of medicine and medical normalisation, in relation specifically to reproductive health. This derives from the very specificity of procreation in the reflection on women's bodies, which places specific demands on medical power. Following feminist reflection, the female body is to be understood as socially constructed, according to culture, gender and social class, representing (Lombardi, 2005). The processes of social construction of the (female) body, are closely linked to the processes of medicalisation of the body itself[3], with particular reference to the management of pregnancy and childbirth. The latter, traditionally regarded as exclusively female generational knowledge, are, through medicalisation procedures, colonised by male technical-scientific knowledge (Meo, 2012). In this sense, the medicalisation of childbirth occurs, firstly, by the very transfer of the action to a place other than home (the hospital) and proceeds through the masculine declination of the procedures, driven by (male) doctors, instead of (female) midwives. The hospitalised woman's body is increasingly considered the biological envelope of the fetus, while technological devices have entered the management of childbirth, problematising the experience of practical knowledge traditionally linked to the field of female perceptions (Pizzini, 1999). It is precisely for this reason that the medicalisation of childbirth cannot totally remove it from its natural feminine dimension, making it particularly significant within the multiple dimensions of obstetrical services, as a space «revealing every society» (Pizzini, 2001, p. 244).

[3]In the words of Conrad (2007, p. 4) we can consider medicalisation «to define human problems in exclusively medical terms (and language), to adopt a medical approach to understanding such problems and to intervene with specific instruments to treat it».

These reflections emerge specifically in the experiences of migrant women, who often bear conflicting conceptions that determine different forms of interaction with services. Thus, depending on personal conditions and belongings, the medicalisation of childbirth and pregnancy can be detected as a moment of reassurance (Carabini *et al.*, 2011). In fact, analyses emphasise that periodic and standardised medical check-ups, provided for by health protocols, can represent an experience of control over one's own body and therefore a new mode of narration from the outside of the pregnancy in a specialised language (Giuffrè, 2018; Marabello, Parisi, 2018; Quagliariello, 2018). From this point of view, in the articulation between medical knowledge and women's knowledge «mothers not only receive prenatal training, but at the same time produce a certain knowledge about motherhood» (Bonfanti, 2012, p. 7)[4]. In the case of migrant women it produces forms of hybridisation and contamination between different knowledge, and systems (Quagliariello, 2018), even more diversified in the face of the heterogenization of migratory paths. In this sense, therefore, migrant users not only tend to reconfigure the health system of the arrival societies (Pasini, Pullini, 2003), but also shape all sectors of social life (Cattaneo, Dal Verme, 2005). As several studies point out, migrant women's bodies bring «to light political dynamics of construction and deconstruction of subjectivities (...) mechanisms of production of a certain type of social order, to denounce inequities and exclusions» (Meo, 2014, p. 85). Pregnancy and childbirth by placing a socially constructed migrant body in a transnational reference space at the centre, poses specific challenges, complicating the already conflicting articulation between medicalised knowledge and female subjectivity, and raises elements for broader reflections on the possible inclusiveness and protection of diversity in health services. The experience of migrant women highlights the «polysemy of meanings attributable to pregnancy», linked to personal history, origin, family model and migratory path/project, employment and networks in host countries (Kaes, 2002 in Giarelli, Venneri, 2009, p. 126).

4. Methodology

The research has been carried out between October and November 2024, involving 10 migrant women (2 asylum seekers and 8 arrived following fam-

[4]see also Ketler, 2000.

ily reunifications) and 9 midwives and gynaecologists, in the territories between the province of Cosenza and Lamezia Terme. In addition, 3 operators of the SAI (National Reception and Integration System) were interviewed as privileged witnesses, as they are often directly involved in mediating between women and the institutional system, with three different professional profiles: psychologist, social worker and health worker. The methodology adopted is qualitative, with the main objective of emphasising the interviewee's position by creating the best conditions for its expression, with an open approach to both the way the interview is conducted and the setting (Bichi, 2002; Cardano, 2011).

Experiences were collected through free discursive interviews, in the case of migrant women and midwives and gynaecologists, and the semi-structured interview in the case of the privileged witnesses. A convenience sampling has been adopted: through personal networks, contacts with the reference sample, migrant women and health professionals from the departments of Gynaecology and Obstetrics, have been implemented. The interviews have been structured to give relevance to the subjective experiences of the interviewees, their impressions, opinions and motivations. This focus made it possible to articulate the reflection beyond their different cultural affiliations and origins.

The interviews were transcribed verbatim, and, together with field notes, organised for analysis. This has used a phenomenological approach, mainly referring to Interpretative Phenomenological Analysis (IPA), which Smith (2005) defines as the articulation of the relationship between participants trying to make sense of their world and the researcher trying to make sense of the participants' actions: from this perspective, the meaning of individuals' personal world is highlighted (Smith *et al.*, 2009). Although this generally uses the semi-structured interview as the main instrument, it has been considered to be the best method to open a breach in the personal experiences of the interviewees, and at the same time, to bring out relevant themes from small sample sizes (Sasso *et al.*, 2015). Over time, IPA has become particularly valuable in different disciplines, especially psychology, sociology and healthcare. Concerning the latter, it has been utilized to examine the experiences of both patients and healthcare providers, concentrating on how individuals perceive and interpret illness and their interactions within the healthcare system.

The transcribed interviews have been read and reviewed by the authors multiple times and discussed. This common discussion has been useful, also in order to limit the influence of researcher's subjective experiences, feelings and bias, that is one of the main risks involved in the IPA.

Initially, distinct experiences of each participant have been analyzed, coding line- by-line themes arising from the data. This initial codes have been then organized in emerging themes, i.e. themes that illuminate central elements compared to research objectives (ibidem). The interviews have been subsequently divided in three groups, mirroring the "point of view" of the subjects interviewed: migrant women, midwives/gynecologists, SAI operators. For each group, common patterns of meaning among the participants have been highlighted, and then confronted within the groups in order to highlight overarching themes, i.e. themes crossing all the transcripts. The analysis of the results is organised accordingly: emerging themes are underlined inside the structure of three specific overarching themes, bodies; subjectivities; practices.

5. Analysis of results

5.1. Migrant Bodies in Childbirths

Childbirth experience, as underlined, is a moment of exceptionality within obstetrical services that escapes attempts at medicalisation, transcending more general reflections with respect to the standard methods of health services' access and management. In the specific case of migrant women, the importance that midwifery service workers attribute to the pre-birth and postpartum periods are particularly questioned: prenatal diagnosis, fundamental in the medicalisation of childbirth, is often absent, as are preparatory tests. The management of the three phases of reproduction – pregnancy, labour and childbirth – therefore represent culturally constructed and socially determined situations.

From this point of view, the interviews with midwives reveal, first of all, the relevance of linguistic knowledge, differently experienced depending on women's nationality and personal status. Midwives themselves receive people who are followed by the reception system's operator, respecting the stages provided by the pregnancy management model, or by their husbands, if they are outside the reception system, but have little language skills, or that are perfectly capable of handling common language tools. OIf, on the one hand, preparation for childbirth is considered inadequate by the practitioners and midwives encountered, compared to the intensive parenting practices

(Fargion, 2021)[5] that are already activated at the moment of pregnancy in the Western hegemonic model; on the other, the moment of childbirth itself cancels out any normative reference, as well as any linguistic difficulties: the fast and instantaneous communication that it requires, makes the communicative relationship between health workers and women unmediated, fluid, corporal, according to the level of freedom and self-determination given to the woman.

In most cases, the way in which migrant women experience childbirth is accepted but constructed as *other* by midwives, who, while acknowledging the value of a bodily naturalness – often not recognised in the experience of non-migrant women – emphasise differences in behaviour related to actions, gestures, and words linked to the acceptance – as reported by the midwives – of the level of pain. An example of this is the thematization of the presence of the veil, which can be perceived as an obstacle for the normal process of labour. In the cases encountered, practices vary according to personal sensitivities, in terms of symbolic violence, where midwives act by undressing the woman, «so they are free», to forms of bargaining «we ask the women if they want to undress, (....) that they be exposed to the male gaze as little as possible, that there be conditions for them to be comfortable», to the acceptance of free choice. The otherization of the migrant body, however, is evident where the way women act while giving birth, determine a value judgement on their adaptability, brought back into specifically cultural terms.

As one midwife points out:

> I have noticed that these are women (...) who allow themselves to be accompanied in labour, they are very calm in labour. Many times they manage to endure many hours of pain, even in silence, I noticed, compared perhaps to an Italian woman. (....) but for example with Nigerian women we have noticed that they are a bit less cooperative. Nigerian women are the ones who throw themselves on the ground, they are the ones who shout, they are the ones who bang their heads against the wall. You may say "no, you get hurt", but they don't listen to you, they are a bit more disobedient in that sense. (....) Nigerian women I have noticed that compared to other ethnicities, it is as if they want to self-inflict pain.

[5]Silvia Fargion (2021, p. 1) defines the western model of intensive parenting as a real «performance, with targets to be reached, and necessary competences to be learned».

Language barriers, however, emerge as a specific problem when the culturalized naturalness of childbirth is disrupted and women's bodies forcefully become the object of medicalising devices. The need for a caesarean section, which in the words of a midwife is culturally considered "a non-birth", becomes difficult to communicate, in the face of a hospital relationship that excludes the possibility of other mediation. This sometimes results in violent dynamics of opposition to the procedure. Medicalisation is, in fact, considered by women as extraneous to a condition – that of childbirth – which, regardless of its declinations, is not recognised as pathological. The negative reaction to C-section, however, is not only due to cultural reasons, but also to the lack of useful communication tools to convey awareness of the risks one would face, within the complex dynamics of fear management (Sanò *et al*., 2024).

The reference to the cultural dimension of childbirth is accompanied by specific declinations highlighting the transnational dimension of migrant families. The absence of family ties on the territory can represent an opportunity in the words of both midwives – «basically they give good deliveries, because there is no interference from family members (...) you can manage better according to guidelines, because no one bothers you, so you really follow recommendations to the letter and in the end they almost all give good deliveries» – and migrant women, who have the possibility to experience the moment of delivery individually, as protagonists of specific decision-making areas. This offers the possibility of co-constructing female-maternal knowledge (Giuffrè, 2018; Marabello, Parisi, 2018; Quagliariello, 2018).

As emphasised elsewhere, the lack of physical presence in the migrant experience does not take away from the symbolic presence, which is more or less important depending on the personal paths that pluralise diasporic relations. Some testimonies, thus, return the activation of co-presence mechanisms (Baldassar, 2008) that allow families to affect not only the dimension of childbirth, but also the first moments of motherhood. Mothers, sisters, husbands, thus, even at a distance, can guide women's choices perpetuating a community dimension of cultural definition of the experience.

5.2. Female subjectivities in childbirths

The specific relationship created between the woman and the healthcare team during labour emerges, therefore, as a relationship of care, but also as a relationship between bodies (Barazzetti, 2007). The time of labour is shared by women and workers, who are forced into a relationship, within

which mutual knowledge is produced. It is in this time that women's subjectivities can be acted upon, in an autonomous way, triggering processes of hetero – and self-recognition starting from individual positioning, leaving women the possibility of expression «of the unspoken, sometimes of the unspeakable, of the contradictory, of the non-identical» (Barazzetti, 2007, p. 69).

As underlined by a gynaecologist:

> A girl came in, very young, in a serious situation. In the operating theatre we didn't understand what was wrong with her, we weren't told anything. Then the terrible discovery: she had undergone a manoeuvre as soon as they realized she was pregnant to have an abortion. A very serious situation, but we tried everything possible to save her uterus. Because we knew that for them, reproduction is the most precious commodity.

Midwives and gynaecologists often find themselves dealing with narrated bodies, acting out other subjectivities, telling of choices and practices that may or may not be accepted and recognised. Women and workers interviewed, tell of plural migration paths, in which childbirth can be experienced in different places, in different countries and with different approaches, one linking to the other as a form of co-constructed knowledge, that influence the way women deal with subsequent births, but also their perception of themselves and their own bodies. In this sense, migration and childbirth open up a new space, or in the words of a social worker: «medicalisation makes a difference in their experiences».

Thus, depending on the specific histories, experiences and paths, the outcome of the encounter with the health service and of the negotiation with different forms of medicalisation, can be an obstacle or an opportunity. Midwives underline how, in more dramatic cases, it was not possible to activate postnatal control mechanisms, in the face of specific difficulties in accessing and reaching territorial welfare services. Thus, in some cases, the process of subjectivation, in the face of difficult life experiences and inescapable cultural role expectations, has particularly dramatic outcomes, precisely because of the lack of territorial intervention tools:

> A woman from Sub-Saharan Africa comes to us and is diagnosed with an extrauterine pregnancy. We reconstruct that it was not the first time, so in the previous event the woman had had a tuba (fallopian tube) removed. This procedure had to be repeated in this case as well, because there could have been very serious consequences. The woman did not authorise the procedure, reit-

> erating her wish to keep the baby. From a clinical point of view, this is impossible. She was also called by her husband and family members who told her not to have the operation. In the end, she signed and left. We were OK from a medical-legal point of view, but it is not the signature that protects women, the signature protects us. We never heard from her again.

At the same time, the shared space of childbirth and the knowledge co-produced in that context, can activate specific practices of conscious management of reproductive health, hitherto not taken into account, also fostering women's autonomy.

5.3. Professionals and migrant women: formal services and informal practices

Health professionals interviewed show how, in the clinical-hospital structures and in the proximity networks, processes of negotiation of assistance and care practices related to childbirth are activated from time to time. These processes constitute the generative element of interactions with migrant women, influenced by the perceptive patterns of all the actors involved. They are often accompanied by interventions within a context of informal practices, based on an experiential regime rather than institutionalised norms of intervention. One SAI psychologist, for example, emphasises the importance of negotiation processes, which are culturally informal, in making women accept any new social identities in the face of contact with the health service.

> (...) Nigerian women do not conceive the word *disease*. So much so that if you ask why she takes the medication, she doesn't say that she is ill, she doesn't say that she has a disease, because she doesn't accept it! (...) so, she does not accept this illness and it was difficult to make her understand that she had to take the therapy and if she did not take the therapy it would put her and her family, the child, her husband at risk and especially if she wanted to have another pregnancy. So, we went through the process of accepting the illness because they do not conceive it.

In this case, the woman's identity is redefined from the rejection of the institutional recognition of the disease – sickness – and of a biomedical paradigm, to acceptance and therapeutic obedience, by deactivating certain subjective resistances that emphasised major differences in the social, cultural and behavioural dimensions of the disease. Refusing the role of a patient, as someone in need of care and assistance, disrupts the continuity of medical processes. When migrants decline to follow a therapeutic plan, they may face

increased health risks due to delayed medical interventions. On one hand, this refusal reflects cultural differences in the perception of health, illness, and treatment. On the other hand, it underscores the need for a negotiation framework between institutional actors and the immigrant population to foster mutual understanding and trust.

From this point of view, mediating institutions, which include reception centres, offer often a useful tool in the negotiation of health services in general. The intervention of the operators can break down language barriers, facilitate the development of health education and health culture, favouring the recognition of health needs and increasing the users' knowledge of health services. While this possibility is generally recognised by all the midwives encountered, recourse to mediation tools is not always possible, due to personal conditions, but also to objective difficulties. One midwife emphasizes how, for example, the presence of cultural mediation is not an effective guarantee of accompaniment: mediators are generally men, sometimes belonging to different religious systems. From this point of view, the accompanying services are often solicited on the basis of a process of essentialisation, assuming migrants as monolith from the point of view of culture, language and belongings.

The greatest challenges come precisely from the practical management of migrant women's biographical diversity, which have to be taken into account, both in patient care and in the transition from informal to institutionalised healthcare. The experience of labour and childbirth is affected by individual paths of women who are also heterogeneous in terms of the different ways in which they encounter the healthcare institution. The hospitalisation of incoming migrants after a disembarkation, for example, is always framed as an emergency, where it is not possible to be aware of the woman's clinical past, for which standardised protocols are activated; women coming from reception centres are generally taken care of in a direct and personalised way; women who came as family reunification, who have already had previous pregnancies, move independently, and the management of the medical-obstetric pathway varies according to personal opportunities and skills. In other words, the experiential element, pluralising the relationship with services, underlies the formalisation of the patients' ties of interdependence with the professionals (micro level), with the context surrounding them (meso) and with the structure (macro). This is found both in the management of simpler births and labour, and in particularly dramatic situations, such as in the case of women who have undergone genital mutilation, causing a greater exposure to psychophysical suffering during childbirth. In the interviews it emerges that this specific condition is often only highlighted because of a

gynaecological examination, often, as pointed out, very close to childbirth. This determines that women acquire full awareness of their situation in a context of suffering, and that health workers need to quickly react, resorting to their own personal resources, to their unofficial competences, in order to deal with unprecedented and non-standard situations, determining specific conditions of vulnerability.

Conclusions

Health services constitute a critical element with respect to the governance of the transition in terms of inclusion. In Italy, as the right to health is enshrined in the Constitution, changes affecting the SSN, in the face of a society with increasingly diversified demands, have generally led to practices aimed at limiting hospitalisation and expanding territorial services and proximity welfare. The interventions and policies envisaged in this sense, however, only partially succeed in including those segments of the population that, due to personal conditions, find themselves on the margins of the most common social and regulatory dimensions. (Delli Zotti, Urpis, 2020). Specific challenges to transition governance in general, and to healthcare services in particular, come from migrant populations: in fact, they are articulated not only with respect to the axes of differentiation (of needs and demands) concerning the whole population (ageing, digital literacy, poverty, etc.), but raise also socio-cultural issues, calling for specific interventions with respect to transition governance of diversity. In additions, it is important to focus on the sense of insecurity due to the precariousness of the legal status related to the condition of migrant (ibidem).

The case of migrant women and midwifery services, particularly with respect to childbirth, is particularly significant: childbirth in itself represents an experience that straddles medicalisation and the articulation of subjectivity, because it crosses women's bodies, bodies that, following Bourdieu (1998), are socially constructed, and as such crossed by self and hetero-narratives. In the case of migrant women, the discursive references of these narratives are inevitably transnational, they challenge transnational regimes and institutions, and control devices that act on the naturalness of child-birthing. Often, the process of medicalisation of childbirth is located in the midst of a rupture of the perceptual schemas that govern migrant women's reality, in which the very need to go to hospital represents a traumatic and new experience: they have to re-conceptualise the event, in order to adapt to a service

that is formalised through specific delivery procedures, in the contexts of a transitional health care.

The experiences gathered highlight how migrant womens' biographies and paths are diverse and difficult to address or treat using standardised procedures (Venneri, 2008). When they do exist, the same mediation tools available turn out to be insufficient, unsuitable for every subjectivity, and can even lead to failure to protect women's right to health. In this sense, the forecasts of strengthening the tools to encourage proximity medicine, which are part of the SSN transition government policies, seem to go in the right direction of providing an alternative to hospitalisation, where a more complete accompaniment of the different phases of pregnancy can be guaranteed, by more easily recognisable figures.

Nevertheless, the collected experiences underline that the possibility for these practices to give rise to an effective process of inclusion, allowing diversity to be managed not only in health services but in transitional societies in general, depends, in the first place, on the full recognition of the demands and challenges posed by the heterogeneity of contemporary societies (Delli Zotti, Urpis, 2020).

In conclusion, addressing the healthcare needs of migrant women requires a multifaceted approach that encompasses cultural sensitivity, technological innovation, and policy reform. Cultural sensitivity requires healthcare professionals to understand and respect the cultural contexts and lived experiences of migrant women. This can be achieved through comprehensive training programs that focus on building empathy, awareness of cultural differences, and strategies to foster trust in clinical relationships. Additionally, integrating cultural mediators into healthcare settings can facilitate more effective communication and reduce misunderstandings, ensuring that migrant women feel seen and heard. An important contribution comes from the approaches of narrative medicine, capable of creating the conditions for starting an effective and shared therapeutic project. In this case it is possible to know the frames of meaning of the meanings they attribute to their health and disease, also considering the integration of additional information for the benefit of clinical practices (Casella Paltrinieri, 2011).It is possible in this direction, to go beyond the doctor-patient relationship and the strictly diagnostic-therapeutic moment, to govern the entire path from the reception and the taking charge: in this perspective, it is not only the doctor or the cultural mediator who mediates, but the entire healthcare system (Marceca, 2008).

Technological innovation offers significant potential to bridge existing gaps in healthcare accessibility. Digital tools such as telemedicine, mobile

health applications, and online educational resources can provide critical information in multiple languages and formats, tailored to the unique circumstances of migrant women. These tools can enhance healthcare continuity, improve maternal and reproductive health outcomes, and empower women to take control of their healthcare decisions by offering greater access to information and services regardless of geographical or institutional barriers.

Policy reform is essential to dismantle structural barriers that hinder equitable access to healthcare. Policymakers should prioritize the removal of bureaucratic and legal obstacles that limit healthcare access for undocumented or economically disadvantaged migrant women. Effective policies must be grounded in intersectional frameworks that consider the compounded vulnerabilities experienced by migrant women due to their gender, migration status, socioeconomic position, and cultural background. Cross-sectoral collaboration between healthcare providers, social services, and community organizations will be critical to creating a safety net that ensures no one is left behind.

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