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Embodying difference.

Health care, culture and childbearing through the experiences of Moroccan migrant women in Italy

Irene Capelli*

Abstract

This article raises some questions on reproductive and maternal health among Moroccan migrant women in Italy. I will focus on women's experiences of childbearing in the framework of their immigration processes and in relation to some 'culturally sensitive' measures fostered by public health services in dealing with migrant users. In doing so, I will draw attention to the ways health services conceive, produce and deal with differences while providing health care. Nonetheless, conceiving the strategies for the improvement of the access of migrant women to reproductive health in a mere culturalist sense may oversimplify and discipline the women's needs. Indeed, the outcome of such approaches may consist in the differentiation of migrants' from non-migrant users' access to public health resources. At the same time, I shall argue that the socio-cultural construction of pregnancy and maternity for Moroccan migrant women is to be problematised in relation to biomedicine. In the context of immigration this may actually be seen as a social and symbolic framework within which women negotiate the meaning of such events.

Keywords

Moroccan immigration to Italy, reproduction, health, gender, culture.

Introduction

This article aims to question the experience of childbearing and maternity for Moroccan migrant women as public health users in northern Italy. Attention will be drawn in particular to the women's relationships with public health services, focusing on their access to reproductive health care in a small town in the Emilia-Romagna region. These services provide maternal and reproductive health care fostering 'culturally sensitive' tools: thus, I will seek to explore their role in shaping women's experiences as patients and as migrants from the Maghreb region. In addressing migrant patients, some measures and projects fostered by health services assume and are based upon notions of 'ethnicity' and 'cultural difference'. Yet, on one hand, this approach highlight that health services are not merely sensitive towards cultural 'otherness', but also aim to improve their organisation. On the other hand, reproduction, gender relations, care and maternity are contested arenas in which users redefine their subjectivity both as migrant citizens and as women who negotiate their scope of action within their context of immigration.

Relying on women interpreters called "linguistic and cultural mediators"[1] during consultations is the main and now deep-seated practice adopted by the health service I examined in order to improve the clinical encounter with migrant patients. Besides, in this town in the Emilia-Romagna region[2] health personnel and local women

* Ph.D. Candidate Social Anthropology Department of Anthropology - University of Torino; email: irene.capelli@unito.it

1 "*Mediatore/mediatrice linguistico-culturale*", or "*mediatore/mediatrice culturale*" in Italian; this term designates a professional who is meant to play the role of a 'bridge', for instance, in the communication between the patients and the health personnel, by translating and by giving multiple kinds of explanations both to the patients and to the health personnel.

2 This central-northern Italian region is well-known for the quality of the public services it delivers, among which the health sector is known for being sensitive towards the needs of the patients. Emilia-Romagna is also known for the social and civic engagement of its

associations organised meetings in which information about the services and other topics such as pregnancy and contraception is disseminated among migrant women with the help of mother tongue translators – the already mentioned 'linguistic and cultural mediators'. These professionals, with a work training in the health sector, are steadily employed some hours per week and are involved in specific projects, such as an antenatal class for Arabic-speaking women.

Conversely, discourses and practices addressed to migrant patients, by understanding their access to health services in culturalist terms, neglect the wider social context informing their access to and their use of health facilities. Nevertheless, 'culture' is sometimes singled out as a barrier in the therapeutic encounter or for the patients' compliance and, therefore, for the work and the productivity of the whole health system. I will seek to highlight how the meaning and the goals of projects aimed at providing reproductive health care for migrant women by addressing mainly – or solely – their 'cultural difference' intend to produce in clinical terms therapeutic efficacy and compliance. Thus, the emphasis on 'culture' responds to the attempt to spread the standardized model of medicalized pregnancy and prenatal care in a culturally diverse context: the goal was to make women of different cultural backgrounds stick to it, so that for instance none of them ended up in the emergency room while pregnant.

Indeed, the personnel of the emergency room had reported that pregnant 'Arabic speaking women' had often turned to it seeking care for reasons that were afterwards deemed 'banal' or 'trivial', and that allegedly caused waste of time and financial resources for the hospital. This is also one reason why an antenatal class was tailored for these patients and not for women from other migrant communities. However, these women were implicitly 'targeted' for this 'experiment' – it was the first time such an antenatal class was organised – and the participants actually perceived they were the objects of this peculiar sort of project. As I will show further on in this paper, my informants presented very heterogeneous migration pathways, biographies, background, even if all of them were Muslim; besides, they shared the conditions of being migrant from the Maghreb and of being distant from their close female kin. All women were in their thirties and – except one of them, who gave birth to her first child in Morocco – were experiencing pregnancy and childbirth for the first time in Italy; they all settled down in this town and became users of the same health centre.

I shall argue that so called culturally appropriate or sensitive measures in the provision of reproductive health care for Moroccan migrant women in these health services ultimately essentialize and reify notions as 'ethnicity' or 'culture', without engaging in a broader process of recognition of the intersections of 'differences' that determine women's access and relationship to the health services. Despite the commitment and the efforts of the personnel, in targeting migrant patients and their 'otherness', neither diverse conceptions of the body, of health, illness and care were actually called into question. Moreover, nor epistemological assumptions about biomedical knowledge and practices were interrogated, although they emerged as authoritative knowledge (Sargent and Davis-Floyd, 1996) of childbearing and birth and, hence, as the symbolic framework in which migrant women inscribed and gave meaning to their reproductive experiences, as most of them lacked of alternative socially significant relationships. Women's lived experiences were redefined as events to be managed in order to create clinical compliance so that they could not hinder the organisation of the whole health system. Although it resulted that 'culturally oriented tools' disciplined migrant patients, I will seek to highlight how – on the other hand – these women negotiated their own experiences of maternity within the health arena and as social actors in their immigration context.

Culture, reproduction, difference – Anthropological insights

Before dealing with the main questions raised by this research, I will introduce some key concepts, theoretical perspectives and some anthropological analyses of reproduction I drew on to frame the ethnographic material I collected in the field. Although it is not possible and I do not intend to present here a thorough literature review of the anthropological studies of reproduction, it can be said that these as a whole provide a specific perspective from which social processes can be observed. Looking at reproductive processes does not merely connect biological and cultural domains, but it articulates the reproductive sphere with the organisation of gender roles within a certain cultural and sociopolitical context, such as, in this case, Italy as immigration context for Moroccan women and couples.

Physiologic reproductive processes can be seen beyond their biological dimensions, in that they are experienced through cultural filters: thus, they are not neutral and fixed, rather they are situated in specific material conditions

citizens and for its well-rooted network of associations, some of which are set up by migrants and/or deal with migration too.

and social relations. Reproduction is therefore determined by a set of socio-cultural as well as political and economic processes. Through this kind of research, the 'paradigms' of maternity are investigated: it is explored for instance how social and cultural forces shape maternal and paternal roles, kinship, childbirth and connect certain – culturally defined – notions of femininity to maternity (Sargent and Browner, 1996). The focus is, thus, on the articulation of gender constructions with notions of maternity, in order to highlight how this process results from wider socio-cultural dynamics. Medical anthropology also explores how reproductive technologies, as biomedical knowledge, are socially and culturally constructed (Helman, 2007) and it examines how the distribution of technologies and their use are determined by power relations, how technologies come to be inscribed in individual bodies and to which extent these are informed by them. These insights also aim ~~at~~ to investigate the meanings technologies assume for the subjects and the ways they appropriate them in culturally specific patterns (Sargent and Browner, 1996).

With regard to the research I am illustrating, I did not focus on technologies as such: I dealt with them as I turned attention to all biomedical practices that make up prenatal care in public health in this Italian region and that compose the *authoritative knowledge* of birth (Sargent and Davis-Floyd, 1996; Jordan, 1993, 1997) as the main repository of the knowledge and practices dealing with reproduction and childbirth in this context, for these women. Such practices as a whole and their role in informing pregnancy for Moroccan migrant patients were discussed also by the health personnel such as gynecologists and midwives, who noted, in particular, the extent to which these patients' approaches to prenatal care and birth were more or less 'technological', also in relation to other patients – i.e. from other countries, or non-migrant patients (Lazarus, 1994).

Yet, the difference between 'native' and Moroccan migrant patients was often oversimplified and dichotomized, as the latter were portrayed as relying less on 'technology' than other pregnant women. This, however, was not seen in itself as a problem, as maternal health care – in the public sector – strives for a 'physiologic' model of pregnancy and birth. At the same time, some basic and routine tests, ultrasound and consultations are prescribed and – the health personnel claimed – this scheme is not always respected by their "Arabic speaking"[3] patients. According to the personnel this resulted sometimes in subsequent accesses to the emergency room and, ultimately, in further workload and expenses for the health system.

Given importance of the socio-cultural and political processes surrounding birth, reproduction will not be accounted for as a mere biological process modeled by culture: biological 'facts' in every society are also 'cultural facts', in that their consequences and meanings are socially constructed (Yanagisako, 1987, 1994). In this sense, local concepts and symbolisms of reproduction and birth, have not been the object of this research, for in this case the latter are produced by the process of migration itself and not only in a circumscribed local context. Cultural representations of childbearing and maternity have been produced and negotiated by the subjects through constant symbolic and material references to immigration and emigration contexts, whereby giving birth in their immigration country may be seen as a multiple *rite of passage* (Van Gennep, 1960) as women and as migrant citizens.

Basing my insights on the paradigm of *embodiment* (Csordas, 1990) means considering the body not just as a material 'support' on which culture is inscribed, rather as the ground for subjectivity. The body is therefore not the mere locus of reproduction of an embodied *habitus* (Bourdieu, 1992, 2000) the subjects are socialized to, but also the arena where the interplay between subjective and social dimensions is enacted. Besides Merleau-Ponty's phenomenology of perception (Merleau-Ponty, 1965) and Thomas J. Csordas' cultural phenomenology (1990, 1994), I drew on the paradigm of embodiment as elaborated by Bourdieu (1992, 2000) and by feminist scholars such as Moore (Moore, 1995) from a gender perspective. The analyses of authors such as Duden (Duden, 1994) and Foucault (Foucault, 1976) constitute a theoretical background for approaching biomedical discourses and the historical processes which lead to the medicalisation of the female body, pregnancy and childbirth. The work of Rapp and Ginsburg (Rapp and Ginsburg, 1991, 1995) on the politics of reproduction are also central in my reflection. The cultural analysis of reproduction elaborated by Martin (Martin 1987) by deconstructing its cultural assumptions and the power relations that inform it in the western biomedical context are also crucial in this kind of ethnography.

The interpretative-critical approach in medical anthropology by Lock and Scheper-Hughes (1987, 1990), furthermore, is necessary for a radical questioning of the categories of health and illness, in that it is based upon the problematisation of the body as the intersection of individual, social and political dimensions. This theoretical framework introduces the issue of reproduction in anthropological research and opens up the

3 By "Arabic speaking" patients, the personnel sometimes mean patients from countries other than Morocco, even if they are far less numerous. On the other hand, any "Arabic speaking" patient from the Maghreb region is often assumed to be Moroccan.

reflection on the construction of the experience of pregnancy in the discourses and in the practices of the different actors in the ethnographic case I focused on. In spite of heterogeneous features, regional and gender specificities I aimed to explore the centrality of emigration and immigration experiences (Decimo, 2005; Salih, 2003; Sayad, 1999). To interrogate the interplay between health, culture and migration, I drew on research conducted in the Italian context by Salih (Salih, 2002), Beneduce (Beneduce, 2003; 2006), Taliani and Vacchiano (Taliani and Vacchiano, 2006). The contextualization of reproduction into migration processes gave way to the core of my analysis, i.e. the questioning of the role played by culturally oriented tools for 'Arabic-speaking migrant women' and the insight into their ways of negotiating the meaning of their experiences of maternity within the frame of immigration.

Strategies and relationships in fieldwork

This article is based on my master's dissertation stemming from overall five months fieldwork including a stage at a local women association, participant observation at a health facility called '*consultorio familiare*'[4] and informal meetings at my informants' homes between the spring of 2007 and the winter of 2008. While carrying out my stage at a local women association I took part in meetings on reproductive health held by health professionals with the help of interpreters[5], whose addressees were migrant women, most of whom were Moroccan. This project introduced me to the issue of pregnancy through migration and to the role of so-called "intercultural approaches" in health services. I have subsequently explored this domain during my participant observation and through semi-structured interviews with the staff at the local '*consultorio familiare'*, whereby the personnel I interviewed included midwives, a gynaecologist and a psychologist.

I chose to start my fieldwork drawing my attention to this kind of health service which focuses on maternal, reproductive and new-born health, whereby the activities and the interactions surrounding it represented the core of my ethnography. This consisted first of all in attending an antenatal class addressed to Arabic-speaking women, most of whom – about ten women – were from Morocco, namely from the region of Chaouia-Ouardigha, Beni Mellal and Casablanca[6]. Out of about ten participants, one came from Tunisia and one from Algeria, but the ones who attended the class more frequently and with whom I developed stronger ties were Moroccan, for this reason I will always refer to my informants as 'Moroccan women'[7].

Mariam, a 'linguistic and cultural interpreter', an Arabic mother tongue woman who had earlier experienced immigration to the same town, was in charge of attending every class, supporting the doctors, the psychologists and the midwives by translating from Italian to Arabic dialect – '*darija'* – and viceversa. Besides, Mariam also collaborated with the midwives and with the gynaecologists during the consultations one day per week for a few hours, during which the service was exclusively dedicated to Arabic-speaking patients. By attending the health service on those days, I had the chance to conduct semi-structured interviews with Mariam – and sometimes to a colleague of hers – and to spend time in the waiting room with her and with the patients. So, I could talk to them informally, being always within their professional context, observing the interactions between them and the users of this health centre.

As I already mentioned, in parallel to this activity, I conducted semi-structured interviews with the health personnel in order to have a broader picture of the changes occurred in the last ten/fifteen years in health care policies and practices concerning migrant women in the maternal and reproductive domain. Moreover, exploring the health personnel's views provided some understandings about the organisation of specific projects addressed to Arabic-speaking patients. Focusing on their experiences as doctors and midwives, who had been building – or

4 The term 'consultorio familiare' designates a specific sort of health centre which has been institutionalized by the Law n.405 of the 29th July 1975 and which is aimed at supporting families and maternity at a social and psychological level. Information about family planning and contraception are also provided within this public health structures in the global perspective of the promotion of women's and newborn's health. These health centres also uphold the individual's and the couple's freedom of choice in what reproduction, contraception and abortion are concerned, in respecting the patients' ethical views. Voluntary pregnancy interruption is disciplined by the Law n. 194, 1978. According to each region's organization of the health system, the personnel working in these structures consist of midwives, nurses, gynaecologists, psychologists, social workers and pediatricians. Most 'consultori' dedicate specific times and spaces to youth for counseling and consultations.

5 Who were themselves migrant women, members of this local women association and who – as I will explain below - worked as interpreters for the local health services.

6 These are the regions of Morocco where emigration to Italy is most widespread.

7 However, some reflections regarding the experience of pregnancy in this immigration context and the women's relationship with the health services matter for women coming from other Maghreb countries as well.

had tried to build – relationships with migrant patients for some years, helped me question the measures which were currently put into being – which I could observe and participate in. This kind of insight had to be contextualized in relation to the changes and to the gender features of Moroccan migration to this region[8], given its influence on the patterns of utilization of health resources by Moroccan migrant women. Furthermore, I questioned the discourses on 'differences' which were produced and activated within the health service by the various social actors – the personnel as well as the users.

I met and talked to the participants of the antenatal class and to some users of this health service both in the '*consultorio*' and especially at their homes. The relational side of my fieldwork has actually played a key role, for building rapport and long-lasting trust relationships with my informants, provided me with their perspectives and, thus, with crucial insights on their biographies, on their experiences of childbearing and migration as well as on their use of health services. Yet, at the beginning of the antenatal class as I was introduced to the participants by Mariam – the 'linguistic and cultural mediator' – it immediately emerged that I did not share any feature or experience with them, being a childless and unmarried Italian student, who did not know their home country. Our biographic and age differences did not represent an obstacle in communicating, though; on the contrary, the women were also glad about the interest I showed towards them, their experiences and their insights on the project they were taking part into. This allowed me to meet them, but, since the time and spaces of the health centre limited our interactions, they suggested we met in different contexts – their homes, most of the time. Looking at the issues of reproduction and health care both in clinical and in informal or domestic settings lead me to problematise the subjective as well as the social dimensions of maternity as experienced by these Moroccan women in their immigration context.

Crossing and negotiating boundaries

I have previously discussed how reproduction can be seen as a socio-cultural construct far beyond its biological features and how it is to be contextualized and given meaning in the whole migration process experienced by the subjects. Migrant women's relationship with and attitudes towards public health resources play a central role in informing their experiences, given the absence of other social and kinship networks and the fact that their first contact with health services in Italy sometimes corresponds with prenatal care and childbirth. However, women are not only the addressees of medical discourses and practices, but also actively negotiate their role as migrant women, patients and mothers-to-be.

As I mentioned, I got to know my informants both in the health centre and afterwards in different settings – mostly their homes. As I visited them, I drew attention to the biographical dimension, which I could take into account only partially during my participant observation at the health service. While attending the antenatal class addressed to Arabic-speaking women, I got to know only a few biographic elements of the participants: this is also due to the fact that the topics the midwives or the psychologist dealt with most of the time were centered on the future baby, on the biological aspects of pregnancy and postpartum, rather than on women as subjects. Other features, such as their marital status or whether they had had other children or not, emerged, therefore, in some of the meetings but sometimes it revealed itself being painful. Some of the participants actually started crying as these topics were raised: for instance, one of them was not married – she had been left behind by her partner as she got pregnant[9] – and another had had to leave her older child in her home country and missed her a lot.

For Zahra[10], a thirty-three year old woman from Casablanca, with whom I built a relationship of trust and confidence, the fact of not having had children yet was linked to the history of her previous marriage. She had indeed immigrated to Italy with her first husband, with whom she had been married for eight years, although they had not had any children: she had always been blamed for this by her husband and by his family, especially by her mother-in-law – even if she lived in Morocco. Given this situation, Zahra had suffered a lot – also because she was desperate to have babies. As she was all of a sudden divorced by her husband, and had no other relatives or friends close by, she spent some time in the same town living by herself. Significantly, she remembered this as the worst and hardest time of her life, for she felt completely lost; she moved afterwards to the town she was currently living in.

8 Single-male immigration preceded female migration, which consisted mostly of 'family reunifications' – see fourth Paragraph.

9 It is not the topic of this article, but – as I will briefly sketch out further on – single-motherhood is a consistent, yet highly stigmatised social phenomenon in Morocco and in the Moroccan immigrant community, for instance in Italy.

10 I provided fictitious names for all my informants to protect their anonymity.

In the meanwhile, her family back home had arranged for her another marriage. So, on her following visit to Morocco, she got married for the second time and her current husband – the father of her son – could join her in Italy. Unlike most cases I came across during my fieldwork, in this case the 'family reunification' process had been activated by the woman, who already had all documents as a 'legal' immigrant. Thus, it is to be noted that pregnancy and maternity for this woman had multiple meanings. She could now make sense of her presence in Italy once again, by planning to raise her child there with her husband. Having come across hardship both during the first marriage and after having been divorced – as she lived alone – Zahra could finally legitimate her presence in Italy in the eyes of her family as a married woman who succeeded in setting up a new household and by becoming a mother as she had wished since she arrived to Italy. Moreover, she could now represent her immigration pathway as a successful one because her husband – who had no bureaucratic obstacles in obtaining a permit of stay – easily found a job and contributed to support the new household.

Having been blamed for not having children by the previous husband and by his family had been a very painful experience, she had been able to re-elaborate and to talk about to me, in the light of her joy for the baby she was still bearing as we first met. So, starting from an extremely distressing situation, in which she found herself isolated and stigmatized both in her immigration as well as in her emigration country by her husband's family, she drew on the resources that she still had – such as the support of her own family – and was able to start all over again, investing lots of energies and expectations on her baby and on their future. Nonetheless, it was not easy for her to evoke her past and she did so only as we were alone – she would not have approached such issues during the antenatal class, even if the expression of women's expectations was often elicited.

As I met Zahra at her home, she also often expressed her feelings about the situation in which Hasna – another fellow participant of the class – found herself, as an unmarried pregnant woman, who – moreover – had no documents and who, six months[11] after having given birth to her baby, would have been considered an 'illegal' migrant according to Italian immigration policies. She had arrived to Italy the previous year and had been living with her – fellow national – boyfriend, who decided to leave her as she got pregnant. She found herself without a shelter and without anybody to rely on; she could hardly speak Italian and was jobless. So she turned to a local association[12], providing support and in some cases – like hers – accommodation for migrant women experiencing distressing situations or gender based violence.

Hasna spent her pregnancy and several months after childbirth at the association, being supported and cared for; this association also addressed Hasna to local health services for prenatal care. For this reason, she was also integrated in the antenatal class with other Moroccan women. Nevertheless, this situation turned out quite stressful too, for Hasna was constantly confronted with other women who – unlike her – were married and whose pregnancy was therefore legitimated in the eyes of their family and of their community – both in their home country and in Italy. The father of Hasna's child had indeed refused to marry her – which would have made her pregnancy socially acceptable – and turned her out of home as she disclosed that she was pregnant. Hasna and her partner were already living as a married couple, which lead her to rely on their relationship and to hope for marriage or for her partner's commitment towards her and the baby. Moreover, she did not take the possibility of abandoning her child after birth into account, for she was determined to raise him in spite of adverse material conditions and of the stigma surrounding single-motherhood in her community even in her immigration country[13].

Unmarried couples living as if they were married are in itself not legally recognised nor socially legitimated in Moroccan society (Guessous, 1987, 2005). Sexual relationships outside the framework of marriage are not admitted, nor is pregnancy: this makes single-motherhood a highly-stigmatized phenomenon, even among Moroccan women living abroad. Stigma, therefore, has played a significant role in shaping Hasna's pregnancy and, even if she did not explicitly tell her whole history to the other women during the antenatal class, everybody was aware that she was not married. As I visited her a few weeks after the birth of her child, she told me that she had been happy with the antenatal class because it helped her understand some "medical terms". Yet, during the first meeting, as the psychologist raised some issues dealing with health and 'psychological well-being' during pregnancy, or as she sought to explore the participants' views about gender roles in the couple, about notions of motherhood and fatherhood, it was fairly evident she felt bad and, as she started to cry, she did not even try to

11 During pregnancy and in the six months following birth, undocumented migrant women are ascribed a permit of stay, according to the article n.19 of the Immigration Law (Decreto Legislativo n.286, 1998).

12 The one where I did a work placement.

13 She would have had the possibility to turn to health services to have an abortion within the first three months of pregnancy. As I met her she was already about eight months pregnant and I did not deal with this issue though.

hide it. Although Hasna was experiencing a harder situation in comparison with that of other women I got to know, she managed to obtain the support of an association, where she was steadily surrounded by other women – both the personnel as well as other users – who had been helpful towards her and her baby, especially at the beginning.
Nevertheless, her condition of single mother appeared to the other women attending the antenatal class extremely serious, as something which would have marked her and her child's life forever. Even if – in virtue of her condition of single mother – she had gained the support of an association, where her status was not stigmatized and where she was surrounded by other women – unlike most married migrant women – what mattered in the eyes of some other participants of the antenatal class was her position towards the Moroccan community, within which Hasna's history could merely be a cause of 'shame' for her and her family. So, during the meetings of the antenatal class the biographic dimension of the participants was sometimes left aside, while some other time it was raised instead without considering the most sensitive sides of it and the possible negative consequences that might arise, especially within a group of women who did not know each other at all and who had gone through – or were going through – troublesome experiences.
The addressees of the 'culturally oriented' projects put into being by this health practice were aware that such an antenatal class had been organised so far only for them and sometimes pointed out they actually felt targeted as the objects of an "experiment" – as Loubna, the most outspoken among them, claimed. She also pointed out that during these meetings no real mutual exchange between the participants and the health personnel was achieved, for in her opinion the latter wanted to gain the participants' insights, without engaging – for instance – in the discussion of the contrasting points of view which sometimes had emerged. Loubna, on the other hand, underscored that the doctors had not touched on issues such as religion and its meaning for these women, neither in general nor in this particular time of their life. She emphasized, instead, the role of Islamic religion in giving meaning to every side of her life, an aspect which she deemed sometimes at odds with biomedicine: however, this had not been taken into account by the personnel and the extent to which religious views shaped the participants' reproductive experiences had not been explored at all. Therefore – at least initially – the problematisation of the 'otherness' embodied by Moroccan patients had never been made explicit, although it was embedded in the organisation of that specific antenatal class.
Yet, during this project some controversial aspects had emerged, which lead one of the midwifes to rethink the approach they used as they made the women simulate some – breathing – techniques to be adopted during labour. The midwife had actually been "shocked" by the reaction of Loubna, who started feeling bad as she began the exercise: indeed, this participant had showed some resistances towards the activity and started panicking and feeling as she was choking as soon as she tried to follow the midwife's indications. This midwife disclosed subsequently that she took for granted that all women were "ready" to simulate labour and contractions, for at that stage they were supposed to be 'familiar' with all phases of childbirth and of their management in this medicalised model of birth. Whereas, Loubna – even earlier in the class – had stressed that she 'projected' those phases "outside her". In looking at this episode, I drew on some key concepts Emily Martin (Martin, 1987) used in questioning the technological model of birth (Davis-Floyd, 1987) in northern American contexts among women of diverse ethnic and cultural backgrounds. Using the metaphor of production and the mechanical metaphor of the body as a machine, she illustrates how cultural assumptions on reproduction embedded in biomedicine result in the "alienation" (Martin, 1987) of women in childbirth, which would be exclusively appropriated by the biomedical institution. Such insights provided me some understandings of the cases of resistance or flexibility towards biomedical models of birth and ŧ towards a clear fragmentation of the stages of labour also among my informants.

Migration pathways, gender and social change

Although this kind of class aimed firstly to connect women who – living in the same neighbourhood – often did not know each other, the utmost importance of the communication with the health personnel , rather than between the participants , was emphasized. In the personnel's view, one of the obstacles to these women's compliance in the domain of contraception was allegedly the communication with their peers as a vehicle of "mistakes" and "erroneous beliefs". Therefore, the different and sometimes diverging goals of this antenatal class, show how it did not always succeed in allowing women make meaning out of their experiences of pregnancy as migrants from a socio-cultural context they were supposed to share. Indeed, even if most of the

women – as I mentioned above – came from the same region or from neighbouring regions of Morocco and their migration histories shared some common features, their background was not as homogeneous as the health personnel often assumed.

Among the participants of this antenatal class – spanning the age range twenty-eight to thirty-five – some had been living in Italy already for about ten years while others for just two or three years; the knowledge of Italian was also heterogeneous. In regard to their marital status, only one participant was unmarried, only one had an Italian husband and only one was divorced and married for the second time. Some other women arrived to Italy in virtue of their marriage with an émigré[14]; some of my informants experienced instead labour migration, so they had reached Italy as single unmarried women with a work contract and only subsequently got married with a fellow national – in one case somebody from the same extended family, who had earlier immigrated to Italy too. All couples got married in their home country but their conjugal life began in their immigration country. In the case of the women who emigrated to Italy explicitly to reach their husband and to set up an household, the marriage was arranged by the families before the males returned to Morocco for their summer holidays. Most of the time it was on that occasion that the marriage act and the wedding ceremony took place. After having accomplished all bureaucratic tasks according to the Italian immigration policies, women were allowed to leave their home country to join their husbands in Italy. Given this kind of arranged marriages – strongly entangled to the peculiarities of the emigration/immigration process – husband and wife did not have the chance nor the time to get to know each other before getting married.

It is to be noted that migration from Morocco to Italy – and to this region as well – began as male labour migration ~~and~~ started being an enduring phenomenon, engendering chain migration, from the late 1980s[15] and early 1990s onwards (Decimo, 2005) the process of 'family reunification' followed this first stage of migration, during which only a few single women quit Morocco to seek a job in Italy and in the mid/late 1990s Moroccan immigrant women and children started becoming 'visible', in particular in the educational and health sector. It is actually thanks to the female presence in maternal and reproductive health centres and in maternity wards in hospitals that Moroccan migration to Italy clearly emerged as a stable process involving whole families and extended families. The imagery about Moroccan immigration also changed: besides the single male or female worker, who until that time represented the most 'visible' sides of immigration, the need to use health resources – or just to give birth – shed light on the presence of households and long-term immigration, with a subsequent demand for rights as citizens – such as the right of accessing public health[16].

One of the aspects marking most female Moroccan immigration is that it is more recent than male: marriages are frequent between men who immigrated even in the late 1990s and much younger women who came to Italy even ten years after their husbands. The latter in the meanwhile have learnt the local language and got to know the context they settled down into through work. Their knowledge of the local environment also explains why sometimes husbands go along with their wives to local health services and often play the role of interpreters, since professional women interpreters may be absent in the times and days patients are able to book a consultation. Thus, besides some ethnographic examples grounded in the biographies of some of my informants, I sought to sketch out some gender features of female Moroccan immigration to Italy, for they also contribute to the understanding of the changes occurred in the interactions and in the dynamics of the access and the use of public health resources by Moroccan migrant women in Italy.

Representing and dealing with 'otherness'

As far as I could observe in the health centre I focused on, discourses and practices based on reified notions of culture aim above all to promote the access to and to "integrate" migrants in the public health system. Nonetheless, this is due to organisational reasons and does not hinge just on the policies promoting the access to health, irrespective of the status of migrant or 'native' citizens. So, health services deal with migrants by stressing mostly some cultural and/or ethnic features, that are sometimes positively emphasized and upon which

14 French term that refers to a person who emigrated from his country – Morocco, in this case.

15 In the 1980s Italy ceased to be an emigration country and started being an immigration country. Immigrants did not need any visa to enter Italy yet, while other European countries had already closed their frontiers.

16 According to the already mentioned laws n. 405 and n.194 disciplining "equality in the social protection of pregnancy and maternity" for Italian as well as for "foreign" women.

'positive discrimination'[17] measures are planned. I will first outline the role of the Arabic mother-tongue professionals working at the '*consultorio familiare*': the definition of their role, its influence in gathering patients, in promoting the access of women to the health service and in determining the kind of clinical encounter is indeed noteworthy. Before becoming recognized and institutionalised professionals, 'linguistic and cultural mediators' simply offered their linguistic skills and their knowledge of the health services both to midwives and doctors and to other patients, i.e. migrant women with the same or with a similar linguistic background.

At the very beginning, they played their role mainly informally and without an official status; they are nowadays acknowledged as professionals and health services necessarily rely on them. Yet, they still carry out part of their tasks beyond the times and places of the health service. They are actually socially recognised for being themselves migrants from the same country or region[18] and for having experienced pregnancy and maternity as immigrants, just like the patients turning out to the '*consultorio*'. Therefore, their role and their work go far beyond solving technical and linguistic issues; their task is not just about helping and facilitating the midwives' and the doctors' work. However, although 'translation' is conceived of by all professionals in a broad sense – as a fuller understanding of cultural meanings and representations of health – due to the lack of time and resources, 'cultural mediation' to date has mainly been adaptive for the health service's organisational needs.

Such an outcome is to be ascribed also to the Italian context, where – until recently – immigration has been dealt with as extraordinary, rather than as a socio-economic process inherent to societies on a global scale. Then, also migrants' presence in health services has been initially dealt with as something extraordinary and organised in order to respond to immediate needs, without a broader scope of action. Only subsequently, 'otherness' within health services has started to be problematised. The service of linguistic translation-interpretation and its institutionalisation as 'intercultural mediation' within a "migrants' health practice" in this health centre – its personnel claimed – had never aimed to create "ghettos", nor to "exclude" migrant patients. It had always striven to "meet their needs" instead; this was motivated with the awareness that "everything for migrant women is more difficult than for any other woman". So a time and space has been exclusively dedicated to Arabic speaking migrant women[19].

Hence, in this case the two aspects I initially mentioned, i.e. improving the access to the health centre for migrant women and addressing migrant patients through positive discrimination measures are strongly connected. Initiatives addressed to patients with diverse cultural backgrounds are not merely motivated by the will of reciprocal exchanges nor by the desire of discovering 'different cultures': projects such as the antenatal class I dealt with are significantly based on the need of the health services to re-organise and discipline its migrant users' access. The personnel pointed out that it had been reported that several childbearing "Arabic-speaking women" had turned to the emergency room for reasons that had been afterwards deemed "trivial" or "minor" by the health personnel. This phenomenon had been ascribed to these women's lack of basic knowledge about pregnancy. It had also been stressed that for this reason information on maternal and reproductive health had to be disseminated among these women, both for them and because the hospital could not afford caring for 'unmotivated' and 'unnecessary' accesses, since – it was claimed – its financial and human resources were already scarce. This – crucial – issue was also explained during the antenatal class, in order to raise awareness among the women who might potentially use health resources in 'un-appropriate' ways.

Hence, the employ of female 'cultural mediators' has been functional to the needs of this health centre and to its goal of attracting and building confidence with Moroccan women-patients, while informing them on the 'correct' use of health services. Patients who do not speak Italian can access the health centre and do not need to wait for anybody else – usually their husbands – to accompany and translate for them. In spite of being one of the major goals of the personnel, promoting the "autonomous" access to consultations and health services for women did not solely aim to make the overall organisation easier, but had, according to them, a further meaning. Indeed, in the view of the medical staff, the presence of a women-only environment and the possibility of going for a consultation without one's husband or relative would be beneficial both for their work, for the improvement of patients' well-being and for their attitudes towards the health service.

Doctors and midwives claimed that – especially in the early years of Moroccan women's access to the '*consultorio*', as the patients were regularly accompanied by their Italian-speaking[20] husbands – they encountered obstacles in

17 I use this term, even if it was not used by the health personnel.

18 In this case, the Maghreb region.

19 Once a week; on other times and days other interpreters collaborate with the health personnel in dealing with other migrant patients.

20 As I have previously underscored, husbands in some cases have spent a longer time in Italy and have acquired good language skills, which enable them to communicate with doctors and midwives.

the contact with women as the communication was exclusively filtered by men, who – in their opinion – translated their messages partially, not allowing their wives to make choices about contraception, pregnancy and their health in general. The staff argued that those constraints were not due to mere linguistic misunderstandings, but pointed out that husbands sometimes purportedly avoided translating everything, so they allegedly answered – and took decisions – at their wives' places. Therefore, employing women translators was seen as a necessary step towards 'direct communication' with and a global care of their patients: this, they stressed, had allowed women to express themselves, to talk about their problems and to ask questions.

However, the personnel did not consider that male presence during prenatal consultations and birth was peculiar to Moroccan couples in the context of immigration, for most of the time in their home country men would not take part in these events and are not expected to do so. In some cases women explicitly argued their husbands stood by them just because they were obliged to; male presence during labour was not generally seen as reassuring, rather as making women more uncomfortable. I cannot discuss further the issue of local constructions and 'models' of birth here, but it is socially organised as a highly gendered sphere, in which men do not take part. In Morocco, the pregnant, labouring or newly-delivered women is surrounded mostly by her female kin – even in the case of hospital birth. So, while on one hand this Italian health centre focused on women, their 'empowerment' and strove for women-centred care, on the other, their husbands', presence was encouraged at birth and in the postpartum.

For instance, some women who took part in the antenatal class wished that at the moment of birth itself another woman stood beside them, instead of their husbands. Yet, most women could rely ~~just~~ solely on their partners and some even had to recur to them for translation when in hospital. At the end of the antenatal class, as a visit to the maternity ward was organised for the couples – and not just for women – none of the husbands participated, because they were busy or ~~just~~ not interested in this activity. Unlike the organisers of this 'guided tour', the female addressees themselves were not surprised and did not complain about male absence. Hence, given the lack of other female relatives in the couple's immigration context, male presence in these phases is necessarily called into question, whereby gender relations – far from being static – are necessarily rethought and redefined. Thus, both the experience, as well as the social organisation of the birth scenario in the context of migration, bring about multiple and novel questions about gender relations. Situating reproduction and birth in the context of migration of these Moroccan couples also highlights how the social and cultural construction of gender roles is not bounded to 'cultures' as monolithic entities.

These examples and reflections about the experiences of pregnancy and birth in this immigration context highlight, therefore, how processes of migration have a significant impact on gender roles and relations, that are constantly re-negotiated. Most of my informants stressed indeed that the dearth of social relations and a weaker – or absent – social and kinship network strongly marked their conditions of migrant women. In the absence of strong female relationships and of a female social network to rely on, conjugal relationships emerge as one arena within which one's subjectivity – as gendered subjectivity – is defined, especially during pregnancy and at childbirth. The couple – or its absence in the case of single-motherhood – is sometimes the condition that mediate any other social relation and, for some women, marriage may be the reason of their presence in Italy and of their status of migrants. As I sought to illustrate, within this framework, women are constantly confronted with situations that challenge both the gender construction they have been socialized to in their families and socio-cultural contexts of origin, and some widespread assumptions on gender roles and on 'cultural differences' in their immigration country – for instance, in regard with male presence and involvement during prenatal consultations and at birth.

Conclusion

By looking at childbearing and childbirth through the experiences of Moroccan migrant women in a northern Italian town and by choosing local health services as a research site, I sought, on one hand, to explore the social and cultural context that informed their access to and their relationship with maternal health resources. On the other hand, I sought to understand whether and to which extent some 'culturally based' health care projects contributed to shape the women's lived experiences of pregnancy within the framework of immigration. In doing so, I came across the pitfalls and the controversial aspects embedded in so-called 'culturally sensitive'

measures addressed to Moroccan[21] migrant women within maternal health services. Driven by the goals of contrasting migrant women's exclusion from health care and reducing the constraints they might face in accessing health services, these have progressively fostered and institutionalised strategies aimed at integrating and including them. Linguistic tools were necessarily the first to be employed, even if they were not deemed sufficient to respond globally to the patients' needs, for it soon emerged that broadly defined 'cultural' and not merely 'linguistic' matters were at stake in dealing with migrant patients.

So, by focusing on projects like the antenatal class for Arabic speaking women, I sought to illustrate how these initiatives targeted patients on a 'cultural' or 'ethnic' base, revealing a process of essentialization of the notions of 'culture' and 'ethnicity'. Such a strategy, at the same time, was functional to the health centre need of a time-efficient management of migrant patients' access. Culturalist approaches to health care, as a consequence, might objectify cultural processes, in that these are not contextualized within the heterogeneous and complex processes of emigration and immigration which mark the biographies of the patients. 'Cultural mediation' and 'culturally based' strategies of health promotion and care have emerged as ambiguous notions and practices, which need to be questioned along with the use of terms and concepts such as 'culture' and 'ethnicity' often used to interpret and explain, for instance, migrants' attitudes and relationships to health services and to biomedical knowledge and practices in immigration contexts.

Through my insights, I drew attention to the rethinking of the practice of 'cultural mediation' as a mere cultural 'de-codification' of the patients' representations and behaviours. As cultural mediators pointed out, their work should not be conceived of as a mere linguistic 'translation', rather as a complex way of communicating between doctors, midwives and migrant patients, whereby the relational side of health care should play a major role. Otherwise, as some of these professionals stressed, using cultural mediation solely as a strategy of disciplining migrant patients' accesses and as a tool for simplifying the doctors' work, might reproduce or reinforce stereotypes, implicit – or explicit – ethnocentric assumptions or even 'culturalist' forms of racism and discrimination in the health domain.

The argument underlying my research is, therefore, that culturally based tools, while producing therapeutic efficacy and compliance from a clinical point of view, symbolically reconfigure pregnancy for migrant patients as an event to be easily managed by health professionals in order to meet the needs of the overall organisation of health services. Such strategies contribute to make prenatal care for migrant patients adaptable to the efficiency and productivity of the health system, so that the needs, the demands of migrant patients and the multiple layers of 'difference' they embody, do not come into conflict neither with the management of health centres and hospitals nor with biomedical knowledge and practices.

I also sought to highlight how, managing health care through culturally based projects might result in the differentiation of the access to health care for migrant women – especially for Arabic speaking women – in that, due to the lack of resources, 'linguistic and cultural mediation' can be provided only a few hours per week in the health centre I dealt with. Most consultations for Arabic speaking women are booked during those hours, circumscribing, hence, their access to the health centre and precluding the encounter with other patients. Thus the question underpinning this ethnographic case is whether targeting patients according to notions of 'culture' succeeds in overcoming socio-cultural boundaries encountered by migrants, or whether such strategies include them according to different standards and procedures. It is to be brought into question whether this approach re-creates novel boundaries and processes of social exclusion, whereby institutions do not re-think their knowledge and practices by recognising they are cultural practices in their own right too.

Thus, one of the outcomes of the application of 'multicultural' tools to the health domain is that through the control and the regulation of the access of migrant patients to health services, less space and time is dedicated to the women's elaboration of their lived experiences. Indeed, as I have already stressed, most women suffer from the absence of their female kin and of a wider social network, in which they could inscribe and socialize maternity. As a consequence, pregnancy, birth and postpartum for the migrant women I dealt with ended up being – most of the time – circumscribed to the individual dimension. At the same time gender relations and gender roles within migrant couples are often re-defined during pregnancy and childbirth; for instance, I underlined how male presence and involvement before and at birth gave rise to contested views by the women, their partners and the health personnel.

Knowing and using public services 'correctly' meant for some of my informants also achieving a 'successful' status as migrant women and enjoying their right to health care irrespective of their being 'documented' or

21 And other Arabic speaking women.

'undocumented' migrants and irrespective of their marital status. In particular, they contrasted their chance of accessing this kind of health care to some structural constraints encountered by their relatives in accessing the public and the private health sector in their home country. So, even if they longed their country and especially the support of their female kin[22], they stressed they were satisfied with the care they were provided within public health in their immigration country and, in particular, they felt much safer than in Moroccan public health in respect with the care they might receive during labour and birth. Hence, notions of 'safety', 'risk' and 'health' are reformulated and situated in the context of immigration, while they were constantly given meaning in relation to their emigration country as well.

While being far from home and facing the obstacles of immigration policies that prevent – or preclude – their kin from reaching them, women also made meaning of hardship and difficulties by inscribing them within their whole immigration process. Thus, becoming mothers in their immigration context and benefiting from the right to health care meant to them that they were taking deeper roots in the country towards which they had been investing their energies, their expectations and their symbolic as well as material resources. Hence, biological reproduction and childbirth are included and given significance in the broader process of social reproduction. In conclusion, I shall argue that the medicalized model of birth and its management within public health structures, as a symbolic framework informing and culturally shaping childbirth, becomes ultimately a contested arena of negotiation for the patients, as women and as migrant citizens.

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22 Who in Moroccan families usually support women during pregnancy and the postpartum; it is in this context that these events are symbolically inscribed and experienced by women.

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