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BORN IN TRANSLATION: MIDWIFERY PRACTICE WITH PREGNANT MIGRANTS — BETWEEN STEREOTYPES AND EMPATHY

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The paper focuses on the concept of cultural competence and has as the main purpose to explore: a) the perception and representation of Italian midwives regarding the reproductive health and the childbirth cultures of immigrant women; b) strengths and weaknesses of their professional practices. Twenty midwives were interviewed. Data were analyzed using the grounded theory procedures of categorization and codification, integrated with template analysis. Findings highlighted eight thematic areas showing the presence of difficulties related to the relationships and communication between foreign patients and medical staff. The results also revealed the widespread belief that maternity, childbirth, and breastfeeding have a "universal grammar" linked to the female body and reproductive function can lead to an underestimation of the need for culturally competent services; on the other hands, an ideal-typical contrast appears in the participants' discourse between an apparently egalitarian position of the same service for everyone and a desire for differentiated attention to diversity.

Keywords: Cultural competence; Migrants' health; Maternity care; Midwifery; Template analysis.

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Complex political, demographic, and economic dynamics are changing our societies and health systems are dealing with a highly differentiated population. Since the beginning of the 21st century, a growing body of literature has explained the complex relationship between immigration and health, mainly on the basis of three theories (Im & Yang, 2006): *selective migration and health* (immigrants tend to be healthier than their peers and respond more positively to adaptation), *negative effect of immigration on health* (immigration is a stressful experience that leads to health impairment), and *acculturation and health* (acculturation is a desired health-related outcome of immigration). Despite the adopted point of view, research shows health disparities in migrant groups and ethnic minorities and demonstrates the need for

health systems to become more responsive to migrant populations by establishing appropriate and accessible health services (Degrie et al., 2017). Health services play a central role in promoting equity and amplifying or mitigating the impact of inequities (O'Donnell et al., 2016). In 2008, the World Health Organization (WHO) called for migrant sensitive health policies, practices, and health systems with the WHA 61.17 Resolution on the "Health of Migrants." In 2017, the WHO endorsed the resolution on "Promoting the Health of Refugees and Migrants" that urges member states to identify and collect evidence-based information, best practices, and lessons learned in addressing the health needs of refugees and migrants (WHO, 2008, 2017). Marmot et al. (2008, p. 1665) state that "health care systems themselves can also be considered a social determinant of health, interacting with migrant status to perpetuate inequities in health care access." Indeed, migrants experience barriers affecting access and quality of care when interacting with health services.

The "accessibility" of services refers to the ease with which people can make use of them when they need them. There is a risk of migrants underutilizing care provision when problems are more advanced, and symptoms are more severe (WHO, 2010). It is widely known that the utilization of health services by migrants differs from that by nonmigrants. Both migrants' needs and their access to health care are affected by a number of factors related to the process of migration, including health and socioeconomic status, self-perceived needs, health beliefs, health-seeking behavior, language barriers, cultural differences, trauma, and newness (Nørredam & Krasnik, 2011). In addition, migrants face legal obstacles in most countries when accessing health care and may receive poorer service quality due to discriminative attitudes of health staff. This can impact diagnostics, medication, medical follow-up, hospital visits and admission, and patients' adherence to treatment (Dell'Aversana & Bruno, 2017). However, many European countries have not reacted adequately to the international calls for action and there remain considerable differences between countries in the extent to which their health systems have adopted "migrant-friendly" policies (Mladovsky et al., 2012).

Cultural Competence in Health Care Services

A key concept in this field is cultural competence (CC) for professionals and organizations, defined as "a set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals, and enable effective work in cross-cultural situations" (Cross et al., 1989, p. 28). Culturally competent health care develops organizational commitment, empirical evidence on inequalities and needs, a competent and diverse workforce, access for all users, and responsiveness in care provision, patient, and community participation (Seeleman et al., 2015). Good practices in culturally competent health care often include the training of staff, diversification of the workforce, use of cultural mediators, and adaptation of protocols, procedures, and treatment methods (Fernandes & Pereira, 2009; Handtke et al., 2019).

For decades, the main aim of CC has been matching health services to the needs of migrant users to bridge "cultural gaps" (Ingleby, 2011). Over time, some authors criticized CC discourse. Narrow or static concepts of culture often conflate culture with race and ethnicity: they fail to capture diversity within groups and reduce the effectiveness of CC strategies by stereotyping health needs. Thus, using culture as a concept to reduce health inequalities for "diverse" groups entails risks such as categorization and overestimation of cultural dimensions at the expense of social, political, and biographical ones (Kleinman & Benson, 2006). Partly because of this criticism, the concept of culture assumed by health services researchers

has changed over time and now growing attention is attributed to the notion of intersectionality (Ingleby et al., 2019; Dell'Aversana & Bruno, 2018). Emphasis on its dynamic dimension recognizes that CC involves skills in intercultural communication, attitudes of respect and openness, and relevant knowledge (Ingleby, 2011). Another important dimension is professionals' self-assessment of their own culture and implicit assumptions. In this way many aspects of CC formulation are also central aspects of patient centeredness (Saha et al., 2008).

Over the last three decades, Italy has become a popular destination for non-EU immigrants and refugees, with the majority settling in Central and Northern Italy. Italian legislation states that all migrants in the national territory needing urgent or essential care have the right to access public health care services, such as inpatient and emergency care. Regular migrants, in line with Italian citizens, have access to services provided by the *Servizio Sanitario Nazionale* (NHS; National Health Service), while irregular migrants need to be identified as *straniero temporaneamente presente* (STP; temporarily present foreigner).

While legislation and policy may guarantee some form of entitlement to health services for migrants, they do not guarantee access to appropriate and high-quality services: for example, rarely needs of migrant users are considered when evaluating the customers' satisfaction or the quality of health-care services (Velasco et al., 2014). In fact, limited research on the Italian context attests that inequalities persist, mainly when migrants experience socioeconomic disadvantage (Giannoni et al., 2012). Indeed, it was only very recently that the first systematic study on migrants' health was published, reporting evidence of health risk conditions related to social inequalities for migrant groups and reaffirming the need for the health system to promote diversity responsiveness (Petrelli et al., 2017).

There has been little research conducted on this issue in the Italian context (Dell'Aversana & Bruno, 2018, 2020; Ripamonti et al., 2011). It is therefore an interesting context in which to further explore the development of culturally competent health services, as they are characterized by a relatively good health policy framework, but fragmented practices and research. The literature suggests considering and identifying barriers and incentives for organizational change, while organizational CC remains heterogeneously implemented and poorly sustained among health professionals (Chiarenza et al., 2015; Seeleman et al., 2009).

Women's Migration and Cultural Competencies in Maternal Care Services

Female migration is a more recent phenomenon than the male one, and radically changes the system of relations in the country of origin and the system of arrival. Women's immigration involves managing one's "remote" family life, which counterbalances the management of family care for Western families. Many immigrant women do not decide to immigrate autonomously, but because their husbands do (Bonizzoni, 2012; Tognetti Bordogna, 2004, 2008). Moreover, the consequences of immigration are not the same for all women. For some, emigrating and starting a family represents a life project. For other women, however, the departure takes place in more difficult conditions: they flee because they are in danger or because they have suffered violence; as a result, the migratory experience is perceived as a break.

It is only in the last 15 years that women's immigration and all that it entails have begun to be important. The first attention paid to services from a cultural perspective mostly referenced male migrants.

Theories adopted to explain the health–immigration relationship are not gender sensitive (Im & Yang, 2006) and do not consider that the combination of gender, young age, and origin from countries where fertility rates are often significantly higher than those in Europe — and in Italy in particular —

means that foreign women, even when they are healthy, might require several visits to NHS services related to aspects of reproductive health, such as pregnancy, childbirth, voluntary terminations of pregnancy, and miscarriage.

Therefore, if two of the theories previously introduced (negative effect of immigration on health and acculturation and health) can be taken into account for all immigrants, men and women, the third one — selective migration and health — which postulates that immigrants tend to be healthier than their peers and therefore access the NHS less, needs to be revised in face of women' health needs.

The need for attention to the reproductive health and pregnancies of immigrants includes aspects that prescind and go beyond the health dimension alone. Being pregnant and having a baby in a foreign country have consequences for these women, their families, and ethnic groups. A new birth is always a crucial moment for the transmission of knowledge and family culture. When this occurs in migratory contexts, it acquires a particular flavor: the traditions of the minority group meet the local reality with its health system, and if it is not possible to ensure that they integrate each other, the damage could be considerable (Balsamo, 2003). For example, for some women, childbirth can represent a double burden, while others may experience childbirth in the new country as a relief, feeling safer and better cared for than in their countries of origin (Wikberg & Bondas, 2010). This often depends on the CC of professionals and the flexibility of the maternity care services. In general, a positive experience at childbirth can enhance trust and favor adaptation processes for the whole family (Musumeci, 2018).

Research conducted in Western countries where the phenomenon of the feminization of immigration has grown highlights how migrant and/or ethnic minority status can be associated with low birth weight and increased infant mortality (up to 43% higher for low birth weight, 24% higher for pre-term delivery, 50% higher for perinatal mortality, and 61% higher for congenital malformations; Bollini et al., 2009), severe maternal morbidity (Higginbottom et al., 2012), and postpartum depression (Karl-Trummer et al., 2006). Research also highlights the complexity of reciprocal expectations between professionals and women in relation to maternal care (Callister et al., 2010; Wikberg et al., 2012), where the lack of language and cultural skills can lead staff to provide poor information (or not provide it at all) from the prenatal screenings (Fransen et al., 2012) and throughout the pregnancy until childbirth (Small et al., 1999). This can have a negative impact on the quality of perinatal services and the health of mothers and their children (Vaillancourt & Lacaze-Masmonteil, 2009).

These results are confirmed by most of the research conducted in Italy (Bona et al., 2001; Della Vedova et al., 2020; Lauria & Andreozzi, 2011), a country where more than half of the regular foreigners are women. There are far more women from Eastern Europe than from Africa or Asia. Within the wider group of Eastern European women, Romanian women, who work mainly as housekeepers and informal caregivers, have been EU citizens since 2007 and have lifestyles that are much more similar to those of natives than most other immigrant women. It is more common for them to migrate on their own than it is for Maghreb women, who, in most cases, come to Italy to be reunited with their husbands. Most of these women are younger than 40 years old and therefore of childbearing age. As a result of the growth in the immigrant population, the number of births of foreign children has increased from 1% of the total number of people born in Italy in 1986 to 13.6% in 2009 and 15% in 2019 (Italian National Institute of Statistics [ISTAT], 2020).

The total fertility rate of foreign women is much higher (Musumeci, 2018; Stranges, 2007), estimated at 2.43 children per woman compared to 1.34 for Italian citizens (ISTAT, 2017). This pattern of fertility associated with the young age of the immigrant population means that, in general, the average age of childbirth is lower than that of Italian women (28 vs. 32).

Aims of the Study

In light of the literature on CC and in order to explore the Italian professionals' experience in coping with different maternity habits, as well as their interpretation of migrants' representations and needs on pregnancy and childbirth, and to hypothesize strategies for improving the services offered, the main aims of the study were to analyze the perception that Italian midwives have:

- of the reproductive health of immigrant women;
- of childbirth cultures of immigrant women; and
- of the current strengths and weaknesses of the professional practices in their institutions.

Research Design and Method

Settings, Participants, Procedures, and Techniques

Two "third level" childbirth hospitals[1] were identified in a northwestern city in Italy, one monospecialist with the largest number of childbirths in Italy (more than 7,000), a second multi-specialist with more than 1,000 childbirths per year, both with a high annual rate of foreign women assisted for pregnancy and maternal care (30% of the total childbirths followed). Once authorized by the health directors of the hospitals, the managers of the departments were contacted in order to recruit participants. Participants were recruited based on some indicators related to the experience of the workers (at least 10 years of service) and a variety of departments (low and medium intensity of care, low risk care, childbirth room, birth support courses, and prenatal diagnosis). A total of 20 midwives with similar work profiles were interviewed (15 within the first hospital and five in the second one). Their mean age was 46 years, and their mean length of service was 18 years. Moreover, most of them had experienced in their working life different activities, corresponding to the various departments where midwives operate.

The interviews were semi-structured and included five areas of study:

- identifying the origin of the foreign women and estimating their proportion on the total childbirths;
- describing the peculiarities, based on their experience, of the paths encountered by foreign women in pregnancy, from the first contact to childbirth and management of the newborn;
- describing the different roles of the community, family, and partners in foreign women's pregnancies and childbirth;
- self-assessing one's level of CC and quality of relationships with foreign women; and
- identifying possible improvements and changes in services to adequately accommodate the care needs of pregnant foreign women.

All the interviews took place in a very serene, confidential, and participatory climate.

Procedures of Analysis

A thematic analysis has been carried out, based on inductive techniques of the grounded theory procedures of categorization and codification (Strauss & Corbin, 1998), and integrating them with King's proposal of thematic analysis of texts using templates (Hindrichs, 2020), that pursuits a dialectical interaction between deductive and inductive reasoning, outlining the active and intersubjective role of the analyst (Braun

& Clarke, 2006). The essence of template analysis is that "the researcher produces a list of codes (template) representing themes identified in their textual data. Some of these will usually be defined a priori, but they will be modified and added to as the researcher reads and interprets the texts" (King, 2004, p. 256).

The a priori codes (initial template) were constituted by the descriptive themes that guided the semi-structured interviews. They were organized in three macro-categories with several subcategories (hierarchical coding).

The transcribed interviews were read line-by-line and codified with the categories. During this process, attention was paid to new emerging aspects in the texts, so new categories could be constructed (open coding) until a final template was reached by saturation (Table 1).

TABLE 1
Analytical Template

Categories	Subcategories
Information about the participant	Information about the organization
Information and data about migrant women in labor	Numeric data about migrant women in labor Origins of migrant women in labor Traditions and particularities of the migrants (women in labor)* • Health system of the original country* • Social participation around migrant women in labor+ Problems and difficulties regarding the migrants (women in labor) • Health and wellbeing of migrant women in labor# • Difficulties for the migrants (women in labor)# (Pre)judices and stereotyping*# • How they should behave* • Attitudes of the migrants (women in labor)-work/service/personal* • Recognizing oneself: empathy*
Work experience with migrant women in labor	Competences and preparation to work with migrant women in labor# Practices with migrant women in labor • Institutional practices# • "Personal" practices# Difficulties at work with migrant women in labor# Needs and proposals for improvements

Note. * New analytic category emergent during the analysis; + Category that changed hierarchical level; # Categories with detailed subcategories to calculate frequencies.

Only a few new categories emerged: traditions and particularities of the migrants — with its subcategory health system of the original country — and (pre)judices and stereotyping —with its subcategories how they should behave, attitudes of the migrants (women in labor)-work/service/personal, and recognizing oneself: empathy. One category changed its hierarchical level: social participation around migrant women in labor. These changes allowed a better comprehension of the phenomenon beyond a simple description, since the new categories considered the participants' representations of the migrant women in labor

that they attended to. Furthermore, tables for various categories were built to enable numeric comparisons of certain aspects that emerged in these categories; some of them can be appraised in the Section "Results."

Guided by the principles of the *constant comparative method* (Strauss & Corbin, 1998) that involves continuous attention to comparing interviews and categories — comparing interviews with each other, comparing categories with each other, and comparing all of them with theoretical references (*axial coding*) — the template allowed for systematic data interpretation by using a graphic schema that oriented the writing-up of the results (Figure 1), organized further in eight central thematic areas, complementary and transversal to analytic categories, and beyond a their simple description. Narrative writing following central thematic areas (*selective coding*) was a reflexive exercise that re-defined the final template. King (2004, p. 267) explains this writing process as follows:

> [it] should not be seen as a separate stage from analysis and interpretation, but rather as a continuation of it. Through summarizing detailed notes about themes, selecting illustrative quotes, and producing a coherent 'story' of the findings, the researcher continues to build his or her understanding of the phenomena the research project has investigated.

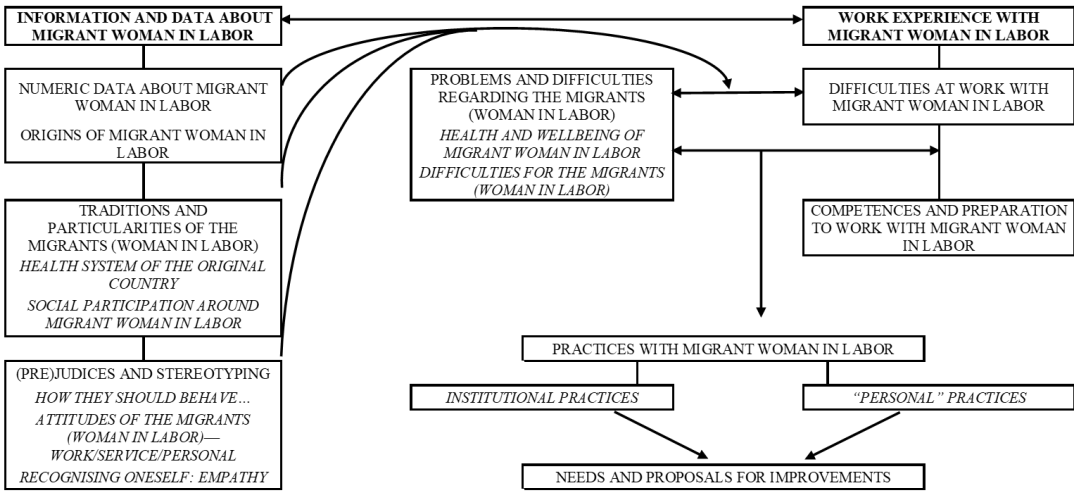

FIGURE 1
Graphic schema of categories' relations.

RESULTS

The narrative results are presented in eight thematic areas:

1. Migrant women: Numbers compared to native women, and their origins and social networks.
2. Health issues of migrant women in labor.
3. Problems and difficulties in the relationship with migrant women.
4. Midwifes' difficulties at work in facing linguistic and cultural barriers.
5. Professional development.
6. Specific institutional practices.
7. Personal professional practices.
8. Needs and proposals for improvements.

The thematic areas are complementary and transversal to the logic of the categories graphic schema (Figure 1) to reach a dialectical synthesis between the first axis on operators' representation on migrant labor on the left, and the second axis on operators' professional practices on the right side of the schema. Textual citations of the participants are between quotation marks and are referenced by the number of the cited interview, from Int01 to Int20, reflecting their chronological order.

Migrant Women: Numbers Compared to Native Women, and their Origins and Social Networks (1)

The participants gave quite generalized indications of the number of migrant women they attended to, overestimating — if compared to the official data — the proportion of foreign patients at around 40-50%. Participants reported that they assisted mostly women from Romany and Africa, followed by China and in fewer cases South America. The obstetrics gave different impressions of their foreign patients: on the one hand, *traditional representations* were emerging, especially about Muslim women, with references to combined marriages, controlling husbands who do not care about their wives, and so on.

"I'm not saying extremists since it isn't the right term, but …" (Int09)

On the other hand, they also observed the loneliness of the women, attributed to the fact that their families remained in their home countries, or their husbands were not present as they worked too much, a repercussion of economic problems. In both kinds of representations linguistic markers were found in most of the interviews: generalizations such as *the* Chinese, *the* Arab, *the* Africans as seen above and so on, as well as the even more generic "the foreign woman" (Int16) or "this kind of woman" (Int04), while in the opinion of one participant "the problem is to say 'foreigner,' thus that's various and variegated" (Int02). These markers were used even by the obstetrics who complained about superficial and stereotypical categorizations used by their colleagues.

Health Issues of Migrant Women in Labor (2)

Half of the participants observed a lack of prenatal visits, especially when migrant women give birth just after arriving in Italy; nevertheless, according to some participants, migrant women seem to attend fewer prenatal consultations even if they were already in Italy during their pregnancy. In addition, many cases of *hyperemesis gravidarum* were described, with participants attributing this to psycho-emotional causes related to *loneliness*. Furthermore, the obstetrics referred to health issues (e.g., more malformations in newborns) and specific pathologies such as sexually transmitted diseases.

Problems and Difficulties in the Relationship with Migrant Women (3)

When asked about the difficulties *for* the migrant women, it was interesting to observe that most of the interviewed centered more on *their* difficulties and problems in the relationship *with* them instead.

Midwifes report the *linguistic barrier* as the major problem in the relationship with migrant women (only one participant did not mention this). The communication problem seems to be related to practical difficulties such as being understood, as well as to affective implications: the obstetrics felt insecure since

they did not know if they were understood, and the shyness of some migrant patients made them feign understanding (Table 2).

Furthermore, there are *cultural barriers* for migrant women that midwifes relate to three issues: religious rituals and different food costumes; behavioral codes expected in the organizational context of the Italian health system; and the migrants' confidence in this system. A conflict between the value of health prescriptions and religious and food norms emerged: the participants attributed major value to the prescriptions by underlining the importance of following medical instructions. A conflict between behavioral codes expected and realized in the health context also emerged. For example, the participants saw a possibility of dialogue if "there are husbands … that understood that it's right to have a certain type of attitude" (Int01), implying that generally foreign husbands limit their wives' adherence to treatment. Some participants described the presence of husbands as a problem when they are invading and traditionalists.

TABLE 2
Frequencies of the issues emerged in the category
"Difficulties in the relationship with migrants (women in labor)"

Interviews	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Tot.
Language	X	X	X						X	X	X		X		X	X	X	X	X	X	13
Culture	X					X			X		X		X		X	X	X	X	X	X	11
Loneliness		X				X		X					X							X	5
Italian health system														X	X		X				3
Lack of trust				X														X			2
Economic problems														X							1

The obstetrics also reported a general *lack of trust* in the other, because of migrants' fear of being a priori victims of racism and prejudices.

In this sense, despite the barriers described above, various participants were convinced that the quality of health services was adequate and that the claims of migrant patients were not justified:

> A lot has been done for their pregnancies in these years, if we think just about the 'health balance' tool. They have their medical records; they have all the medical tests … it's sufficient if you explain it to someone who knows the language. After that, they have little to do, only to show up … they do not even have to stand in line … more than that … really … (Int19)

Midwifes' Difficulties at Work in Facing Linguistic and Cultural Barriers (4)

As can be observed in Table 3, obstetrics report as main difficulties at work the scarcity of resources dedicated to tempering language barriers (in other words, the lack of cultural mediators). In fact, cultural mediators are physically present in the hospital wards only during workdays and never at night, even though "Saturday and Sunday they give birth just the same … especially at night …" (Int08).

Furthermore, there are difficulties in managing the three above-mentioned cultural barriers (the relationship with different religious and food rituals; the behavioral codes expected by the organizational context; and trust in the Italian health system).

Midwifes report as a dilemma to manage culturally competent relationships with migrant women, and at the same time guarding health-oriented outcomes. Indeed, some religious and cultural peculiarities seemed to make the safeguarding of health more difficult, such as food issues that could conflict with health during pregnancy (e.g., fasting during Ramadan).

The same kind of dilemma is between the attention to specific traditions and the need to respect institutional rules: for example, food being prohibited from being taken into the hospital, visiting hours, hygienic norms, and medical indications.

One obstetric admitted that ignoring traditions was the problem, while another one claimed a lack of organizational commitment to training on religious and cultural differences.

As mentioned before, racism was also an issue: some obstetrics reported they have to be careful about what they say in order not to be labeled as racist while others recognized colleagues' use of superficial and stereotypical categorizations, which obstruct one from "get[ting] in touch with the woman's huge richness" (Int01).

TABLE 3
Frequencies of the issues emerged in the category "Difficulties at work with migrant women in labor"

Interviews	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Tot.
Language	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	19
Husbands	X								X	X		X					X				5
Religion/traditions					X	X			X												3
Not knowing the traditions																		X			1
Closeness, lack of trust, apathy, shyness	X					X									X			X			4
Rejecting male gynecologists						X															1
Food issues									X			X									2
Not respecting rules					X	X						X					X	X			5
Racism	X											X						X			3
Not knowing about pregnancy, lack of prenatal preparation, neglected pregnancies		X				X				X				X							4
Low educational level													X					X			2
Institutional problems	X		X	X			X		X	X				X			X	X			9
Absence of mediators			X	X			X		X					X							5
Lack of institutional interest	X									X								X			3
Same service for all as a problem	X									X											2
Orienting not regular migrants																	X				1

Professional Development (5)

Generally, it did not appear that the participants believed that they had trained special competences to work with migrant women' different needs. Only four of them said they had specific training (two from each hospital). Two of them remembered a training program with cultural mediators about cultural

differences "more than ten years ago" (Int06), while the others mentioned individual and not institutional experiences: classes about cultures (in another region of Italy) and genital mutilation, and a "master in bioethics that included training about the different ethnicities" (Int20).

On the contrary, in the opinion of the few that reported they have never had problems with migrant patients or saw no differences between the pregnancies of an Italian and a migrant woman, training was described as not being useful, since the obstetrics obtain their "training in the field" (Int04) and through experience. Further, some were convinced that "training for attending to foreign women does not exist" (Int07).

Specific Institutional Practices (6)

The idea that there are no issues with migrant patients was reflected in the answers to the question related to institutional practices, where more than half of the participants affirmed that *the service is the same for everyone*, suggesting the absence of institutional practices that are specific for migrant women in labor. In most cases, this appeared to be a defensive discourse to prove the absence of discrimination. However, two obstetrics underlined that this is not an ideal situation and valorized attention to diversity: "it's not so recommendable … it would be necessary to investigate a bit about the culture, the tradition of this ethnicity, and adapt a little" (Int11).

Regarding the ad hoc practices, most participants mentioned the *cultural mediators* as an institutional intern or extern service offered to migrants, but as mentioned above, only on workdays and not during nightshifts. To mitigate this limitation, as affirmed by two obstetrics of the multi-specialist hospital, there was a new experimental service of immediate phone translation 24/7 for concrete matters ("Help Voice").

Only two other specific services for migrants were mentioned: differentiated diet for religious reasons, and the translation of the informed consent in English, French, Arabic, and Chinese in collaboration with the two hospitals. Some participants supposed that there were no economic resources for training or other institutional initiatives: "in such a difficult political and economic moment, I wouldn't say that training about this kind of issue is of lesser importance, but yes, it's a little overshadowed by immediate urgencies" (Int01). Otherwise, despite the rather poor organizational commitment and the near absence of formal training, at least a few participants observed improvements in the services for migrant women (e.g., the family counseling services).

Personal Professional Practices (7)

Regarding their daily relations with migrant women in labor, the participants mentioned their intentions to *overcome the linguistic barrier* perceived as a major problem. They leaned not only on the cultural mediators (and perhaps not principally), but also on those who accompanied the patients (mostly female relatives or friends) or other patients as interpreters: "a little of their experience, a little of our advice, we manage it" (Int08). In contrast, men and particularly husbands were mentioned as a possible inconvenience, when they did not allow direct relations with women in labor, so sometimes they were sent away in order to "know how much this lady is able to perceive" (Int19). Only two participants referred to speaking English or French themselves to communicate; another tool used by various obstetrics is *nonverbal lan-*

guage (mimics, gestures, corporal language), since "communication isn't made only by language" (Int16). Finally, a few simply affirmed that they were "settling in the best way" (Int13).

Another practice focused almost exclusively on the identification with the other, recalling a key dimension of the patient-centered approach, but revealing a naiver interpretation of such a competence. Some obstetrics *put themselves in their patients' shoes*, trying to "get in tune with the woman" (Int09), whether an Italian or a foreigner, "to enter a bit into what's their mentality" (Int19), and to be orientating in a context that is new for them. For these participants, it is crucial to "get in touch" (Int01) with the other, to show interest and compare religious beliefs, or to communicate and get in "tune" (Int10) beyond the spoken language: "sometimes it's possible to communicate not verbally, but to understand each other and work well the same … other times we are speaking the same language and don't understand each other …" (Int10); "nevertheless, I'm talking because I think that they are seeing that you're trying, so in my opinion it's something positive" (Int13).

This kind of identification seems to become a sort of *compassion* in terms of sorrow or displeasure, with participants imagining what migrants might be feeling in a situation where no one understands them. One participant explained this kind of empathy by the fact that she herself is a migrant from another Italian region:

> I'm not from here, so I have lived this thing in a very reduced way, because they changed their country, and I changed only my region. Maybe I'm more aware of what it means to be in a place that isn't your place. (Int13)

Further, some participants stated that they "pay attention to traditions and religious particularities" (Int07) as an opportunity to learn and a source of "personal satisfaction … to have succeeded a little because of my experience … to maintain their tradition" (Int05).

On the contrary, one obstetric explained her rather different approach, since in her unit they delegate the social aspects to *other specialists*:

> If we realize that there's a problem on a social level, we can report it to the social assistant, or to the psychologist, or to the family counseling service so that they do a follow-up during the puerperium and after they give birth. (Int15)

Needs and Proposals for Improvements (8)

When the participants were asked to mention needs and proposals for improvements, some obstetrics sustained that it would be necessary to adapt to the foreign women, but as mentioned above, "unfortunately these things do not exist and the service is the same for everyone" (Int01). In the words of another participant, "often it's us who feel the obligation that the women should adapt to us, but I believe that it should be us to adapt a little more to them" (Int11). In their opinion, this could be done in a very direct and simple way, working out "strategies to relate with [foreign women] by respecting their culture and religion" (Int01) or improving their knowledge of other languages, at least English.

Only a few obstetrics believed that it is the foreign women who need to integrate more, since "in the end, if we go abroad to give birth, there are no mediators for us…I don't think so" (Int03). In fact, some participants affirmed that migrants should learn "the language in the country they live in" (Int12).

Other participants outlined that *training on different cultures* could be useful, especially training on the traditions, customs, and habits of pregnancy and birth giving. Interesting in this sense is the proposal of the first participant to create interchanges between operators and foreign women about this issue.

Further, various obstetrics insisted that the *service of cultural mediators* should be improved. Their presence during nightshifts and on weekends is necessary. A more complete service from pregnancy to the postpartum period is also required, with the mediator as "a female figure that goes with them" (Int06).

In addition, the *networking between different health services* could be improved. In the opinion of some participants, this should be done starting at the level of family counseling by providing women with better and more precise information and establishing a major collaboration between these services and hospitals.

Finally, a few obstetrics pointed out that even if there were good proposals, they feared that there were *no economic resources* to realize them: "a pretty project without resources to invest in" (Int18).

Discussion and Conclusion

The results show that the meetings between midwives and foreign women, each carrying personal models, brings different experiences to the childbirth process. Foreign women can be forced to abandon their beliefs to adhere to Western models. Midwives can put habitual professional practices in crisis by wishing to share the cultural encounter in the unique experience of childbirth. Both can be read as mediation figures: the midwife attempts to mediate the needs of the organizational structure, its models in daily practice, and the needs of foreign women. Foreign women are driven toward the integration and assimilation of Western models, and toward the affirmation of their own cultural identity.

Moreover, the results show that the main criticism identified is the language barrier, a common topic among the participants. According to the participants, speaking different languages can cause difficulties for both patients and midwives, sometimes even representing a risk factor, because it can hinder decision-making at crucial times. Different strategies are adopted to fill the language gap, but nearly all the participants agree on the need for different forms of support for communication, even basic forms such as a telephone translation service.

Our research confirms the presence of difficulties related to the relationships and communication between foreign patients and medical staff that emerged in other research conducted in Italy and in other Western countries. It seems to be exceedingly difficult to develop adequate communication on childbirth in the absence of a mediator-translator or with low organizational commitment which allows the linguistic service to function effectively. The inability to speak the local language can give rise to stereotypes about the ability of these women to understand information "as well as indigenous women" (Callister et al., 2010), or to actively participate in the decision to have a caesarean (Wikberg & Bondas, 2010), and can lead to an underestimation of clinical risks (Curtozzi et al., 2007). In addition to language barriers, the difficulty of relying on more sophisticated institutional practices and processes emerges (e.g., collecting data of health inequities, trainings, interorganizational collaboration). Not much progress seems to have been made in 20 years, when the percentage of foreign women giving birth in one of the two considered hospitals was less than 10% (Converso & Dell'Olio, 1999). Considering the number of migrant women visiting the two hospitals involved in the study, it is alarming that most of the participants seemed not to attribute to themselves particular competences, nor had they received particular training to work with foreign patients. Further, a lack of specific proposals to improve these competences appeared. This absence of representations of training tools and institutional initiatives risks being reflected in limited possibilities to imagine innovative institutional practices that could overcome barriers to culturally competent services (Chiarenza et al., 2015; Seeleman et al., 2009).

On the one hand, the widespread belief that maternity, childbirth, and breastfeeding (although de-

termined by culture) have a "universal grammar" linked to the female body and reproductive function can lead to an underestimation of the need for culturally competent services. Despite several differences, the ideal of a universal language of childbirth is in fact present among both those midwives who demonstrate greater empathy for foreign women and those who are less prone to understanding the need for specific CC. This is reflected in the duplicity of midwives considering themselves as equal and diverse, competent, and incompetent in caring for foreign women.

On the other hand, an ideal-typical contrast appears in the participants' discourse between an apparently egalitarian position of the *same service for everyone* and a desire for differentiated attention to diversity. The migrants' diversity represents a problem that is minimized or stereotyped, and the wish for differentiation accompanies curiosity for the other and empathetic expressions. This duplicity does not necessarily represent different kinds of participants; rather, it is present in an ambivalent way in the discourse of most interviews. This seems to be connected to the debate between the categorical and the process approach to CC in the literature (Kleinman & Benson, 2006; Ingleby, 2011).

The categorical approximation appears to sustain a normative idea of *must be* and *should be*: further, from the value judgements encountered in the interviews, the expectation is that it should be the migrants who assume particular adaptive practices in health services (Dauvrin & Lorant, 2014).

In this sense, the tension between generalized stereotypes on the one hand and identifying and empathizing with a fellow woman on the other is reflected in a categorical perspective of CC that struggles to recognize the other's specificities beyond an ethnic vision of their diversity. Data show the need for a health cultural shift from a categorial approach of CC to a more process-oriented one where professionals could embody patient diverseness into their practice, also by shifting from a personnel-centered to a patient-centered orientation.

As pointed out in the introduction, recognizing otherness is not reduced to the ethnical component; it is a challenge to place oneself at the intersection between different sociocultural dimensions in meeting the other, in accordance to an intersectional perspective (Ingleby et al., 2019). It is important to support health providers and organizations in understanding diversity by fostering a culture that values differences and similarities to promote equity.

Limitations and Future Developments

The study has some limitations. Critical points are that the field work was done in a single city of Italy, not considering the structural and cultural differences of Italian regions, and the unequal number of participants from the two hospitals involved. We also consider that a deeper differentiation of both research techniques and participants should be realized.

As most research considers professionals' and immigrant women's perceptions separately, future research should consider them simultaneously and in the same service context: health professionals' and immigrant women's perceptions of health care related to pregnancy and childbirth. This would improve the knowledge on the common ground that has to be created in the ethnocultural and bio-medical belief system (Weerasinghe & Mitchell, 2007) to develop international maternity care in multicultural societies (Wikberg et al., 2012).

In general, research on immigrant women's health, including their reproductive health, needs to be strengthened, as the literature on immigrant health and CC in health care services is still androcentric (Im & Yang, 2006). Describing immigrant women's perceptions of childbirth can enhance professionals' abili-

ty to provide culturally competent services and care (Callister et al., 2010). As suggested by current literature and to a minority extent by some participants, it seems useful to develop trainings with the involvement of users with migrant background. Indeed, the birth path of immigrant women is now one of the biggest challenges in the world's health system. It firmly links basic topics such as the right to health, equality in treatment, the complexity of relationships between people of different languages, social conditions and the difficulty of combining religions and cultures very distant from each other.

Finally, at an institutional level, tighter collaboration between local hospitals and clinics and researchers should be planned to promote better health services for migrants, and especially women. In this way, research outcomes can lead to action. At a political level, the political agenda should be addressed to advocate for better public health services, especially since during the current worldwide pandemic, the limits of the downsizing in this sector in recent years have come to light (Verelst et al., 2020).

NOTE

1. The guidelines for maternal services (L.R. Piedmont Region n. 61 12/12/1997 and D.G.R. n. 4-270 April 1st, 1999) define as "first level" those hospitals where the number of childbirths is no lower than 400 per year, dedicated to "physiological pregnancies" ending at/after the 34th week; "second level" those assisting no less than 1,000 childbirths per year, medium risk pregnancies ending at/after the 32nd week; and "third level" hospitals those with neonatal intensive therapy wards that can host high risk pregnancies that can end before the 32nd week.

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