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FRAGMENTED AND SUBSIDIARY UNIVERSALISM: THE ITALIAN CASE

by Angela Genova

The study analyses health inequalities concerning the maternity and reproductive sphere for ethnic minority women in Italy, offering an overview of their health profiles, their access to health services and the policies addressed to them, at national and regional level. In the framework of universalistic health services, the Italian regulatory context guarantees access to health service for both documented and undocumented migrants in need of health care. Nonetheless, ethnic minority women face relevant inequalities in accessing pre and post maternal care. Regional implementation of the national regulatory framework is characterised by several regional differences, bringing to the light a fragmented system of regional, specifically targeted policies to tackle health inequalities faced by migrant women, and a crucial role played by civil society organisations introducing innovative services.

Lo studio analizza le disuguaglianze di salute nella maternità e sfera riproduttiva per le donne che appartengono a minoranze etniche in Italia, offrendo una panoramica sui dati relativi al loro profilo di salute, all'accesso ai servizi sanitari e alle politiche a loro rivolte, a livello nazionale e regionale. All'interno del sistema sanitario universalistico, il contesto regolativo italiano garantisce l'accesso ai servizi sanitari sia per i migranti regolarmente residenti che per quelli non regolari che necessitano cure. Nonostante questo, i dati mostrano notevoli disuguaglianze nell'accesso alle cure legate alla maternità per le donne immigrate. L'implementazione regionale del quadro regolativo nazionale è caratterizzata da diverse differenze regionali, che portano alla luce un sistema regionale frammentato di politiche specifiche per contrastare le diseguaglianze di salute delle donne immigrate e il ruolo centrale assunto dalle organizzazioni del terzo settore nell'introduzione di servizi innovativi.

In Italy, immigration is a relatively recent phenomenon. Starting in the 1970s, and increasing during the 1990s, it has since become an important socio-demographic element. Studies conducted so far show that foreigners regularly residing in Italy present health needs quite similar to those of the Italian population, and that their health conditions are on average better than those of Italians (ISTAT, 2008). This has to do with the selection of those that move to Italy and remain. They are mainly healthy people with working projects, who tend to return to their country of origin should their health conditions deteriorate. However, there is some evidence that they might face more health risks (Malmusi *et al.*, 2010) and/or more difficulties in using health services (FRA, 2013; Jiménez-Rubio and Hernández-Quevedo, 2011). This study analyses health inequalities concerning the

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maternity and reproductive sphere for ethnic minority women (EMW) in Italy, offering an overview of their health profiles, their access to health services and the policies addressed to them, at national and regional level[1].

1. The provenience and migration processes of ethnic minorities women

In 2011 (ISTAT, 2011), there were 4,570,317 foreign people, which equates to about 7.5% of the population. In 2010, Italy had the fourth highest foreign population in the EU, after Germany (7,1 million), Spain (5,7 million) and the UK (4,4 million). Nonetheless, looking at the percentage of foreigners out of the total population, Italy is in tenth position (Vasileva, 2011). However, this can be also partly due to a 'measurement underreported effect'. Indeed, statistical data is based on residence, and therefore does not include foreigners who do not have legal residence. Undocumented immigrants are estimated to be about 420,000 (Blangiardo, 2009). In 2010, foreign births were 13.9% of all total births (ISTAT, 2010).

Immigration to Italy is composed of different ethnic minority groups. In the last years there have been an increasing number of immigrants from Eastern Europe, exceeding the number of people from North African countries (which made up highest proportion of immigration during the 1990s). The number of people from Romania doubled in 2007, from 342,000 to 625,000, becoming the main immigrant community in Italy. In 2010, there were around 1 million Romanian residents in Italy, constituting 21.2% of the total foreign population. After Romania, the other main countries of provenience are: Albania, Morocco, China, and Ukraine. By January 2010, about half of the immigrant population were from Eastern Europe and a quarter from countries that entered EU between 2004 and 2007. Around one fifth of immigrants come from the African continent, mainly from northern countries, notably Morocco and Tunisia. Asian immigrants make up 16% of the foreign population, coming mainly from India, Sri Lanka, Bangladesh, Pakistan, Chine Popular Republic, and the Philippines. 7.7% of immigrants come from Central and South America (Ecuador and Perù) (ISTAT, 2010; 2011).

The proportion of immigrant women has increased. In 1991, the female foreign population in Italy was 361,137. At the end of 2010 this had risen to 2,370,000 (51,8% of the total number of foreigners in Italy). The increase in female migration flows is also proved by the higher number of women with legal residence status: 26% in 1990 and 45% in 2002. At the end of 2005, 46% of the women acquired the permission of residence because of their job, and 45% because of the reunification initiative. The employment rate of women in the domestic work sector (care for the house, children, elderly or people with disability) makes up about 90% of all immigrants working in domestic area (Ministero dell'Interno, 2007; Simonazzi, 2008). Also, changes can be observed in the most common countries of origin. The first migrant women who arrived in Italy during the 1970s, tended to come from Cape Verde Islands, The Horn of Africa, the Philippines, and South America, to work in the domestic services sector, in some cases owing to the network of religious institutions. During the last two decades the number of women coming from Eastern Europe countries

[1] The research is based on secondary analysis, literature review, regulative framework analysis and on interviews to relevant stakeholders. Interviews were conduct to select good national and regional practices and to collected the related data. For more information on the interviews, see the Italian report at http://www.bhbi.eu/sites/default/files/documents/Country_Report_IT_EN.pdf.

increased, while the rate of women immigrants from Muslim communities has been lower. From the 1990s women from Maghreb arrived in Italy mainly because of family reunification procedure, following their husbands.

The share of women varies across migrant groups. Some migrant communities are characterized by higher number of women, significantly among migrants from: Ukraine (81.5%), Moldova (68.8%), Peru (61.8%), the Philippines (58.7%), Nigeria (53.8%). By contrast, fewer women are present in communities from Senegal (23,6%), Egypt (29%), Bangladesh (30%), Pakistan (31,4%) (Caritas-Migrantes, 2011). Analysis on gender aspects of immigration brings to the light that educational attainment of immigrant women is generally lower compared to men (APRE, 2011). Moreover, women have lower occupational level, but their participation in the labour market is related to the country where they come from. Women from Eastern Europe and Southern America are mainly employed in the services sector and housework, most of them on the black market. A proportion of ethnic minority women are also involved in trafficking, exploitation and prostitution activities (Carchedi, Tola, 2008).

Differences can also be observed in the reasons behind migration. Analysing the process of feminisation of migration, two main ideal types of women emerge: first, women migrating to follow the breadwinner husband, mainly observed among from northern African countries); and second, women migrating according to an individual migration plan to became breadwinner of their family, in most of the cases from Eastern Europe and South America (Kofman, 2004; Kofman, Raghuram, 2012).

Literature on migrant women has mainly focused on their role as caregivers in the familialistic mediterranean welfare model or on their conditions as "mothers far away". Female migration flows contribute to the redefinition of complex transnational welfare social policies (Piperno, Tognetti, 2012) generating potential conflicts between migration experience and family life (Glick Schiller *et al*., 1992; Zlotnik, 1995, Zontini, 2010). Studies on transnational maternity highlight the conflicting conditions for mothers leaving their children in the countries of origins (Parreñas, 2001; Hondagneu-Sotelo, Avila, 1997; on Italian case: Caponio, Colombo, 2011; Bonizzoni, 2009; Fedyuk, 2012; Vianello, 2009) and the problematic redefinition of their role in relation to the husband and rest of the family and community members (Mahler, 2001; Pribilsky, 2004; Menjivar, 2006). However, few studies explore the link between health and migration, analysing whether these different profiles in terms of migration processes, motivations, new role experiences with connected tensions imply different health risks.

2. Migrants' state of health: general data

The age of migrant population is, on average, lower than those of Italians: in 2009, 22% of migrants were under 18 years old and 13.5% were born in Italy. Moreover, those that migrate are a selective group, mainly in 'young and in good shape' and able to work and adapt themselves also to new and stressful conditions. Also for this, generally speaking, migrants do not present pathologies that are very different from those of Italians according to age populations. Nonetheless mortality data shows some relevant inequalities. Mortality causes for women from countries with high migratory pressures is lower compared to women from countries with advanced development for cancers, endocrine and metabolic disease, circulatory systems diseases, digestive systems diseases, but it is higher for infec-

tious and parasitic, ill-defined diseases states and violent causes (26,7% for women from CHMP; 6,7% for DC)[2]. Also self-perceived health appears different (ISTAT, 2008). Generally foreigners fell healthy more often than natives: among foreigners, 85% of men and 75% of women think that their health is good or very good, against 76% and 68% among Italians. There are however areas or groups of migrants that appear disadvantaged. A worrying area is given by overweight, especially among women: obesity is registered among 20% of the Albanians and 13% of the Latin-American, against 7% of Italians. A peculiar group is given by Moroccan, who declare worse perceived health conditions with a specific focus on mental health, both among women and men (Spadea *et al.*, 2013). Nonetheless, worse health conditions are generally related to worse social economic conditions than to ethnicity or migration in itself.

In Italy there is no data concerning health needs of different foreigner groups. Indeed, data on health needs and use of services typically only distinguish between general socio-demographic characteristics and country of residence. Yet, *ad hoc* researches have shown that, overall, the foreign population has a lower access to health services compared to their Italian counterparts. The main differences concern access to secondary care, such as specialist consultant medical visits (18.4% foreigners-24.6% Italians in the last four weeks before the interview) and diagnostic tests (6.8% foreigners-9.6% Italians). However, as has emerged from relevant literature (Mladovsky, 2009; FRA, 2011) and interviews with stakeholders (Responsible for Health Inequalities Observatory Marche Region), this can be put down to communication and information problems in accessing Italian health services more than legal limits in accessing health services.

Also, the hospitalisation rate is lower for foreigners than for Italians with the exception of hospitalisation related to childbirth, as afore mentioned, due to the higher fertility levels among immigrants. Access to emergency services displays a higher rate for foreigners compared to Italians. Moreover, foreigners' access to primary care presents many critical aspects. Firstly, migrants access primary care later, or do not use primary care at all, applying directly to emergency services (such as first aid services in hospital). Finally, about half of foreign women attend prevention screening programmes (51.6% pap test; 42.9% mammography). However, the attendance rate for women from Morocco and Albania is lower (about 30% for pap test, while for Italians the rate is higher than 70%). Moreover, Moroccan women present the lowest data concerning physical, psychological, mental, vitality health index (ISTAT, 2008).

Given their average age and fertility, maternal and reproductive health services are the most used and relevant for ethnic minority women. Therefore, the next section will focus on the access to such services, underlining the level and type of services accessed and the problems encountered.

[2] Following ISTAT (2002) classification, in the analysis of health conditions of foreigners, two main groups can be identified: foreigners coming from country with a high migration pressure and foreigners coming from country with advanced development. The distinction is relevant since socio economic conditions of country of origin affect migration projects. Country with a strong migration pressure are: Northern Africa, Western Africa, centre-southern Africa, western Asia, with the exception of Israel, centre southern Asia, eastern Asia, with the exception of South Chorea and Japan, Centre –southern America, centre Eastern Europa (included: Czech Republic, Slovakia, Estonia, Latvia, Lithuania, Poland, Slovenia, Hungary, Cyprus, Malta, Bulgaria, Romania). Country with advanced development are: Europe 15 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Portugal, United Kingdom, Spain, Sweden), Andorra, Australia, Canada, Vatican City, South Korea, Japan, Iceland, Israel, Liechtenstein, Norway, New Zealand, Monaco, San Marino, Switzerland, USA (Carletti, 2009, pp. 17-8).

3. Ethnic minority women: data on sexual/reproductive health[3]

In 2008, in 16.9% of all children were born to mothers who did not hold Italian citizenship (Boldrini, Di Cesare, 2011). This figure increased to 18.8% in 2010 (Caritas-Migrantes, 2011) with some relevant regional differences: in Emilia Romagna 29.3% of new born children had a foreign mother. In Lombardy, the figure was at 28.5% and at 27.2% in Veneto. Africa (27.2%) and Europe (25.6%) represent the main continents of provenience of the foreign mothers, followed by Asia (17.8%) and South America (9.1%).

Migrant women also show distinctive socio-demographic profiles. They tend to have more children (2.13 children for each woman, compared to 1.4 for each Italian woman) and at younger ages (28.9 age at first child, compared to 31.8 for Italians) (*ibid.*). Considering education, foreign women who gave birth in 2008 had lower educational attainment than Italians. Moreover the rate of foreigner women not working is 56,6%, higher than Italians (Carletti, 2009).

Table 1. Number and % obstetric admission for women age 15-49 in Italy in 2006

	Women from Italy and developed countries		Women from countries with high migratory pressures		Undocumented migrant women	
	n.	%	n.	%	n.	%
Hospitalisation cause	480.968	49	67.718	40	8.014	20
Childbirth	98.006	10	29.487	18	11.436	29
Abortion	76.583	8	11.097	7	2.593	7
Miscarriage	326.776	33	60.150	36	17.721	45
Other	982.333	100	168.452	100	39.764	100

Source: Carletti (2009).

As shown in tab. 1, because of such higher fertility, the first cause of hospitalisation for foreign women is related to pre and post natal assistance. Yet, immigrants from countries with high migratory pressures access health systems mainly through emergency services because of difficulties in accessing health territorial services and general practitioners. Moreover, outpatient hospital access for immigrant women from countries with high migratory pressures is higher than those of women from developed countries, mainly due to abortion cases. Most cases of hospitalisation concern women (7 out of 10 hospitalisations) because of pre and post natal assistance. About half of hospitalisation cases for women from developed countries are due to childbirth, while for immigrant women from disadvantaged countries the number of hospitalisation cases for abortion is larger (*ibid.*). The percentage of female holders of temporary residence permits (*stranieri temporaneamente residente* – STP) with obstetric admission for abortion is higher (29%). This data warrants further investigation.

[3] The main source of data concerning this paragraph is the study coordinated by Patrizia Carletti by the Regional Inequalities Observatory in Marche Region (Carletti, 2009).

There are differences not only in the level of access, but also the type of services requested and used by Italian and foreign women. Caesarean operations are more frequent among Italians (39.8%) than foreign women (28.4%). This is partly due to the younger age of immigrant women. Identity and cultural factors seem to affect childbirth modality, as is proved by research conducted by the public health agency of the city of Reggio Emilia, in Northern Italy (*ibid.*). All indicators (examinations, ultrasounds exams, gestational age at first examination) show worse results for immigrant women, presenting more difficult access to pre-natal care. Moreover the percentage of migrant women having their first pre-natal examinations after the third month of pregnancy is higher than the percentage of Italians (*ibid.*).

Ethnic minority women are also more exposed to pre-term childbirth, compared to Italians. This is likely connected to their lower socioeconomic conditions and increased difficulties in accessing to pre-natal care. Moreover, analysis of child health conditions at birth show that children of foreign women have higher rate in resuscitation needs and a lower Apgar score. Higher rates are also displayed among migrant women in the birth of underweight children and neonatal distress. All of this data is also related to different socio economic conditions, but also to differences in health care during pregnancy (*ibid.*).

There is also a higher rate of abortion cases among ethnic minority women. In 2006, migrant women accounted for 31% of abortions in Italy. The abortion rate (Ministero dell'Interno, 2007) for Italian women is lower than 8 abortions in every 1000 women of fertility age (15-49). Obvious differences can be observed with regards to abortions among migrant women. The lowest abortion rate among foreign women is among Philippine women (19 in every 1000 women). Other available data shows the rate of abortions among women from: Albania (38 for every 1000 women), China (29 for 1000 women), Morocco (27 for every 1000 women), Romania (73 for 1000 women), and Ukraine (174 for every 1000 women). The abortion rate for Ecuadorian women decreased in 1996, 1997, 1999 but rapidly increased after 2002 reaching 229 abortions for every 1000 women of fertility age. In 1995 Nigerian women presented the highest abortion rate (182 for every 1000 women) that rapidly decreased to reach 72 abortions for every 1000 women in 2001. A quarter of EMW had already had abortions, 18% of STP had, had two or more. Women from Eastern Europe (Romania 23%) and Nigeria (36%) have higher risk of having multiple abortions.

Many features contribute to the higher abortion rate for immigrant women: the socioeconomic conditions, different use of contraception, but also because of prostitution, victims of trafficking, especially for undocumented women. Indeed, data shows that immigrant women in Italy have a higher abortion rate than women in their countries of origin. The abortion rate is also positively correlated with lower educational attainment, with the exception of women from Ukraine (13% with a university degree compared to 4% of Italians) and Romania. Moreover, occupational status affects the rate in a different way: more than 50% of women from Italy, Romania, Albania, Ukraine, Morocco, and Nigeria having an abortion are unemployed, while 78% of women from Ecuador, Peru, Chine, Philippine are employed. Some migrant women undergo the abortion procedure for economic reasons. More than 75% of women from Chine and the Philippines already have children and cannot afford the social and economic cost of another child. 63% of Nigerian women declared not having other children (Lauria, Andreozzi, 2009).

Miscarriage is similar in EMW and women from Italy and developed countries. Nonetheless if age is considered, miscarriage is more frequent for women from developed countries aged over 35, and for migrant women from disadvantaged countries aged 25-29, and for

undocumented migrant women aged 20-24. It might be supposed that conditions of social exclusion increase maternity risk, especially for young women. Moreover, miscarriage could also cover abortion, but this data needs more investigation.

In sum, even though with variations across different groups and types of migrant, ethnic minority women seem more at risk of pre-term childbirth, abortion, child health conditions at child birth and they seem to use less prenatal care such as ultrasounds, antenatal courses, and obstetric visits. Certainly this is partly due to different cultures of childbirth and motherhood, in particular the lack of importance given to external expertise in many of their countries of origin. But what is the role of policies? To what extent are the health inequalities observed linked to the absence of rights or difficulties in actual access to the existing services? How have policies, at national or local level, recognized and tackled such difficulties? Next section shall address this.

4. National and regional policies to tackle health inequalities

Legislative decree 286/1998, called the "Unified Text on Immigration" (*Testo Unico sull'Immigrazione*) (TU), and the related implementing regulation (P.P.R. n. 394/1999) regulates different dimensions of immigrants' conditions, including health rights. The law allows access to preventative, care and rehabilitative services for documented (and undocumented) foreign citizens in Italy (Direzione generale diritto alla salute e politiche di solidarietà, 2012).

The aim of this normative act was to guarantee full health services access for regular foreign residents. The right to health assistance has been extended also to undocumented migrants. They have the right to urgent and essential care, continuity and preventative health services. In order not to block access to health services, it is forbidden for health organisations to call or give information about irregular migrants to the police. To register health services for undocumented residents a specific code system was defined: STP (*straniero temporaneamente residente*). STP health services are free of charge for socioeconomically deprived people.

The regulatory framework guarantees access to health services for maternity care with regard also to undocumented foreigners (D.Lgs. 25 luglio 1998, n. 286, art. 35, c. 3. a.) and it does not allow the eviction of undocumented pregnant women or any women within the first six months after childbirth (*ibid.*, art. 19, c. 9).

However, while the national TU on immigration represents a crucial point of reference, regional implementation has been problematic and very heterogeneous. Moreover, law 94/2009 introduced the crime of illegal entry and stay and, according to this, public offices and people in charge of public services are required to denounce people in illegal conditions. The TU on immigration nevertheless forbids the denouncement of undocumented migrants. Therefore there is a conflicting juridical situations. Most regions approved regional acts supporting the "ban on reporting". Lombardy, Basilicata, Sardinia, Abruzzi, and Friuli Venezia Giulia are the only regions that did not follow up the law. Some regions updated regional laws on immigration to include indications of the national TU, while other regions implemented some aspects of the national law at local level. These developments were subject to differences in time, conditions and the deliberation of local administrations, and were incorporated as part of regional health plans or immigration regional plans.

Looking at health of migrant women, regions and autonomous provinces have different policies (Pasini, 2011). In 2010, research was conducted by Caritas (Geraci *et al.*, 2010) aimed at comparing regional health policies for immigrants. The main variables that were analysed were: regional acts concerning health service provisions for immigrants in order to guarantee coherence between national and regional services or within the region; the presence of a regional or provincial observatory for monitoring immigrants' health needs; intervention of or health promotion for immigrants (with specific focus on pre and post natal care and workplace health); the presence of specific training policies for health workers; the presence of cultural or linguistic mediators in health services; modality to guarantee health assistance for irregular migrants; and specific policies to guarantee health assistance for EU citizens without health insurance. Data confirms high heterogeneity of policies at regional level. There is low attention on guarantees on the application of national laws and ensuring equal access to health services: just 5 regions (Sicily, Veneto, Lazio, Umbria, and Puglia) have specific acts oriented to conform health services offers at local level and national level.

Immigrants' needs analysis is part of policies in half of the regions (Lombardy, Campania, Veneto, Emilia Romagna, Friuli, Liguria, Marche, Piedmont, Sardinia, Toscana, and Puglia). Prevention and health promotion play an important role in 10 regional policies, and in one of the autonomous provinces. Pre and post natal care also receives high levels of attention with specific local projects. Nonetheless 10 regions do not have any such provisions on pre and post natal care, while only 6 focus on these (in relation to maternity and abortion): Emilia Romagna, Toscana, Marche, Puglia, Sardinia, Trento Province.

Training of health workers is part of the policies in most of the regions. Only 3 regions do not mention it (Calabria, Campania, Bolzano Province). However, in most cases, indications are generic. Cultural and linguistic mediation is part of most regional policies, with just one region (Calabria) and one autonomous province (Bolzano Province) not dealing with this aspect. Mediation is articulated through different types of intervention: informative documents in different languages, cultural mediators within health services, and reorganisation of procedures and services.

Health assistance to illegal immigrants is mainly part of regional policies. Only in three regions (Lombardy, Calabria, Molise) it is not regionally planned for, and offered only through first aid services, non-accredited voluntary services, or accredited services. Health services access is guaranteed for EU citizens without health insurance in most of the regions, only in 5 regions (Valle d'Aosta, Veneto, Abruzzo, Molise, Calabria) and one autonomous province (Trento Province) do immigrant health policies not deal with this topic.

Looking at the aggregate index Puglia presents the policy frame that most addresses the health needs of immigrants because of the presence of regional guidelines to implement national regulations, national observatory to collect data on immigrant health needs, specifically targeted preventative and promotional health policy, specific training policies for health workers, mediators in health services, health assistance for undocumented migrants and from other EU countries. On the other hand, regulatory frameworks in Calabria and Campania are the least developed in relation to the health needs of migrant people.

In the National Health Programme 1998-2000, the italian ministry of Health introduced a project to improve maternal and child health. The *Istituto superiore di sanità* (the National Institute of Health in Italy) had the task of helping the local health units to implement the project recommendations for pre- and post-natal assistance and of evaluating its impact among foreign women. Thus two surveys (qualitative and quantitative) were conducted in

collaboration with 18 birth centres in 2009 (Lauria, Andreozzi, 2011). The results show that indicators of assistance at delivery are similar for foreign and Italian women, but pre and post natal assistance indicators differ. Foreign women seem to lack the necessary information and are less able to take advantage of assistance opportunities. Public family care services are more likely to provide assistance according to the project recommendations. These studies underline that assistance continuity, the presence of cultural mediators, adequate personal training in communication and information skills are important, in order for all services actively offered to be successful. Nonetheless the implementation of services to respond ethnic minority women needs has been very different in the Italian regions.

To sum up, the Italian regulatory framework concerning access to health services is quite advanced (Geraci *et al.*, 2010; Pasini, 2011). However implementation of its policy tackling health inequalities for ethnic minority women presents some limits. The research has brought to light a regional scenario characterised by fragmentation and heterogeneity of cultural mediation services. In most family health services in the Marche region, assistance continuity, cultural mediators, and adequate personal training in communication and information skills, are all absent.

Cultural mediator services (Baraldi *et al.*, 2008) are considered crucial for tackling inequalities in accessing health services at regional policy level. Nevertheless, their implementation has not been adequately supported at local level. In the Marche region, the province of Ancona is currently the only one offering cultural mediation in the form of structured services, owing to an agreement between the local cultural mediation association and the provincial health service. In the other provinces, cultural mediation is sporadic or absent. The presence of cultural mediation services is not related to the incidence of ethnic-minority women[4]. Cultural mediation services are offered by local non-institutional organisations, most of them have few members and are not involved in structured mediation services with local health authorities.

5. Some good practices

The above analysis of the regulatory context brings to the light a severe gap between national and regional policies that risk increasing health inequalities for ethnic minority women. Ethnic minority women suffer inequalities accessing maternal health services that need to be tackled. In the context of highly differentiated services at regional level, two good practices were identified specifically targeted to EMW: "Lo sapevi che…" in Torino, Piedmont region, run by a civil society organisation, and "Centro per la salute delle donne straniere e dei loro bambini" in Bologna, Emilia Romagna region, run by the public health services. These are interesting practices because they focus on the necessity to improve actual access to health services, to which they have formally right, through better information on their quality and location, and through cultural and linguistic mediation.

The first project, "Lo sapevi che" aimed to give information on health services to migrants through a peer information system (peer education) in the Aurora neighborhood in Torino. The project was funded by civil society organisation ("Comitato collaborazione medica – CCM") through regional funds targeted to voluntary associations, and by Torino

[4] Childbirth from ethnic minority women in the main city for province in the region: in 2008, Fermo 50%, Ancona 17%, Pesaro 17%, Urbino 25%, Macerata 27%.

municipality. It lasted 15 months and finished in July 2011. The main target were women from Morocco and Egypt communities in the Aurora neighborhood in Torino.

The project was articulated in different actions: 1. Training course for 10 women from "Spazi al femminile" association (local Moroccan women association), as (*animatrici sanitarie*) health/sanitary animators. 2. Peer education through 10 sanitary animators to disseminate information to friends and people of the same community in the area where they live. In order to evaluate the project, each sanitary animator was asked to take note of number and objects of meetings she had. 3. Information meetings on health services: 3 meetings (1st in November 2010 in the mosque, and 2nd and 3rd at local events). 4. Final conferences at the end of the project.

Between 700 and 900 ethnic minority women reached by sanitary animators were. It was a 15 month project, but its effects are not easily measurable in the short term. Nonetheless, knowledge and capacity acquired by sanitary animators remain part of the social capital of the Maghreb communities in the neighborhood. During the project implementation, sanitary animators identified the need for more specific information on topic not directly covered by the project; therefore, they promoted a small information project involving the local health authority. Sanitary mediators were supposed to offer the first contact with local EMW to give them information and contact with medical doctors of CCM organisations and of local family health services used mainly by immigrant women (90%).

The project did not plan a system to quantitatively measure its impact on the women in the Aurora neighborhood. Nevertheless, it might be assumed that the impact of the project has concerned women's empowerment and reduction of inequalities in accessing health services. Women actively taking part in the project increased their knowledge and their social capital in the neighborhood. The women reached by the sanitary animators (between 700 and 900 in number) improved their knowledge on health services and access to it.

The second good practice identified is "Centro per la salute delle donne straniere e dei loro bambini" (Centre for the health of foreign women and their children) in Bologna, it is targeted to foreign women, regardless of their condition and/or position in Italy, and funded by the Emilia Romagna regional health service. The necessity to identify a specific area in the context of regional family planning centres and paediatric supply system became urgent when the number of migrant women employed and/or migrated through a family rejoining process started to grow. They could not access public health services, not because there was a lack of them, but only because they had problems in identifying and reaching the places in which these services were provided.

The service aims to: 1. Give shelter to women and children during the first stage of the migration process and/or support them in severe personal, psychological and social conditions, through a cross-cultural approach. 2. Provide an introduction on how the SSN works, following the phase of care delivery and the connection between every stage of medical process. 3. Prepare inter-institutional connections to simplify the access to services. 4. Provide professional training for workers involved in the programme in order to promote a global daily care approach towards women and children. 5. Promote an organisational model based on team work, adopting a multidisciplinary approach from the early stage of migrant's care. 6. Facilitate the presence of mediators in every phase of the reception process to give constant cultural and linguistic support. 7. Research Development (about intercultural and corrective organization). 8. Assure information activities on specific themes.

In line with the aims, the main activities of the services are centred on: providing assistance for social and health problems for women and children, supporting migrant wom-

en in accessing public health services, intercultural mediation (Arab, Chinese, Russian, Spanish, and Romanian), paediatric visits (general health conditions, jabs), obstetrical and gynaecological visits (pregnancies, IVG, birth control, oncologic prevention, MTS), psychological examination and psychotherapy, general health examination, the creation of information brochures and forms in different languages, the activation of integrated care services, providing training of professionals who take charge of migrant patients, and participation in research projects and/or inter-institutional working groups.

The geographic provenance of service users is constantly influenced by migratory flows. Previously, the most common countries of origin for migrants coming to Italy were Morocco and China. However, changes have been observed in recent years. Nowadays, the five most common countries of origin for migrants are Moldova, Romania, Morocco, Philippines, and China. In 2010, health services have been used by 1730 ethnic minority women. Data shows that in last 10 years more than 25.000 people have accessed the service. The main innovative aspects concern the targeting of the services at all migrant women independently despite their legal status (documented and undocumented migrants). The project was able to offer health services to a target population which have not tended to access health services because of cultural and legal barriers.

6. Conclusions

Is the health of ethnic minority women worse than that of Italian women? Is this connected to unequal access to health services? This report has attempted to answer such questions through research based, on secondary analysis, literature review and regulative framework analysis on one hand, and interviews with stakeholders on the other.

Surely, in the framework of universalistic health services, the Italian regulatory context guarantees access to health service for both documented and undocumented migrants in need of health care. Nonetheless, ethnic minority women face relevant inequalities in accessing pre and post maternal care in Italy (Carletti, 2009; Zanconato *et al.*, 2011; Sosta *et al.*, 2008; Tognetti Bordogna, 2012) as in other context (Williams, 2002; Bollini *et al.*, 2009; Balaam *et al.*, 2013; Vissandjee *et al.*, 2013). Analysis of secondary data (Pasini, 2011; Geraci *et al.*, 2010) brought to light that just few regions have developed specifically targeted policies and services to overcome these barriers in accessing pre and post natal care, despite the national regulatory framework aiming specifically to guarantee access to maternal care health services for ethnic minority women, regardless of their legal status. Regional implementation of the national regulatory framework is characterised by several regional differences, bringing to the light a fragmented system of regional, specifically targeted policies to tackle health inequalities faced by immigrant women. In the logic of subsidiary, the reform process of the health system in the last two decades has increased the responsibility for health care at regional level, increasing the existing regional differences.

In particular, intercultural mediation services are not equally present in regional health services. The two selected good practices show, on one side, the important role played by civil society organisation in offering services to tackle health inequalities for migrant women applying a peer education approach, and from the other, the developed public health services offered in Bologna since 1991 specifically targeted at migrant women.

In the context of the fragmented regional regulatory context, civil society organisations play a crucial role in introducing innovative services aiming to tackle health inequalities in

accessing services, as in the case of the selected good practice in Torino. In most cases, civil society organisations are the only bodies offering intercultural mediation services.

The research highlights the limits of the fragmented and subsidiary Italian universalism that affect migrant women's health. Moreover it brings to the light the gap between the health needs of ethnic minority women and services to tackle inequalities in accessing health services. This gap not only generates health inequalities for ethnic-minority women, but also has an impact upon regional health financial systems, augmenting costs through the inappropriate use of available health systems (e.g., resorting to emergency services instead of primary care and recourse to the most expensive cost for maternal care due to the inappropriate use of maternal services). The lack of adequate intercultural mediation services and specific policies targeted at migrant women are the main barriers in tackling health inequalities which they face in the fragmented and subsidiary universalistic health system in Italy.

In the Italian context, civil society organizations are important in tackling barriers to accessing health services through intercultural mediation services. Nonetheless, the main challenge concerns the capacity of integration and coordination between local public institutions and civil society organisations. Indeed, regulatory and governance contexts play a crucial role in shaping inequalities in accessing health services. The research brought to light that ethnic minority women experience different forms of "institutional racism" (Coretta, 2011; Bartoli, 2012) within different regional policy frameworks because of differing envisaged and implemented policy. This issue needs to be adequately considered at both national and EU level.

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