


# The embodiment of fear: Reproductive health and migrant women's choices, in Verona, Italy

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## Abstract

This article discusses the results of ethnographic research conducted in the municipality of Verona (Veneto Region, Northeast Italy), during 2018, aimed at analysing the reproductive health needs of migrant women, and their access to such services in the territory. The research highlighted that, in addition to many critical structural-organizational issues, there was an emotional obstacle to the use of services – that is, the feeling of fear. In this paper, therefore, we will try to reflect on the role exercised by fear in the relationship between migrant women and reproductive health services. We interpret this emotion not as the expression of an individual experience and feeling, but rather as an example of “embedded thinking”; the result of a social construction that reflects dynamics and power relationships, capable of transforming feelings into practices.

## Keywords

migrant women, reproductive health, emotions, fear, services, tactics

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## Introduction

Often the women who do not have a health card end up in the emergency room and either they or their baby die. Not having the necessary check-ups during pregnancy is a risk factor. Our gynaecology clinic is one of the few that can provide antenatal care, even if the woman does not have a health card. Once the woman comes in, we see her and we explain that she needs a health card and where and how to get one. We do not refuse to see anyone. The aim is to have a health card, but we never refuse treatment. [...] Our goal is that the mother and child do not lose their lives. Even for women who cannot get a card, at least we examine them and carry out the essential check-ups. Here, above all, we explain to the woman that if anything should happen, she can go to the emergency room; that in Italy the emergency room welcomes you even if you do not have the card. We had two women who lost their babies after the fortieth week because they did not have a health card and thought they could not go to the hospital. In such cases, we tell them that they can go to the emergency room: your waters break? Go there! You are bleeding? Go there! I still remember Jennifer, who has that little disabled girl. It is not just a matter of visits... many people pick up information, they are aware: if they have an emergency, they will not be turned away from the emergency room. But how many are afraid? And what are the consequences of this? (Michela and Giulia, professionals at Family Counselling Centre)

Taking a cue from questions posed by health workers at a gynaecological clinic for immigrant women – how many are afraid and what are the consequences? – in this article, we analyse how emotions guide the daily choices of migrants in their country of destination. We focus on how the feeling of fear – as an embedded thought – conditions relationships between migrant women and female reproductive health services, and often inhibits their access to such services.

From the analysis of ethnographic data and interviews collected to investigate the needs of immigrant women and compare them with the experiences of reproductive health services in Verona, Northern Italy, fear emerged as one of the feelings most frequently mentioned by the interviewees. We do not argue that fear is the dominant feeling, but rather that it is the most shared and, above all, the most clearly represented in their narratives. However, next to fear, in a more or less explicit way, other feelings emerge from our research, such as shame, frustration, and lack of confidence.

Starting from these premises, we explore what generates this particular emotion and how it is articulated and formed in terms of access and use of services. To achieve this goal, we consider it useful to recover the figure of Janus from mythological imagery – the god who represents the middle ground between oppositions such as life/death. Because of his nature, Janus has already been deployed by scholars who have investigated the field of feelings (Fortunati, 2008). What prompted us to resort to this image was the two-fold dimension of the expression of this emotion that emerged from our field of analysis, in which the feeling of fear seems to simultaneously reflect two positions concerning health choices: women and professionals. The fears expressed by the migrant women

interviewed constitute one half of the god, while the stories and experiences of the health workers compose the other.

As we illustrate below, just as Janus does, fear corresponds to an ‘in between’: a middle ground from which it is possible to grasp what fear produces in terms of practices, actions and choices, and to better understand what produces it. However, this ambivalent fear – figuratively represented by the mythological figure of two-faced Janus – is not limited here to embodying a rhetorical device capable of highlighting the differences or distances (Kleinman, 1988; Fadiman, 1997) between the experiences of women and health workers. On closer inspection, this ambivalence consists of a double aspect that puts fear at the core of a dialectical relationship, one we can exemplify by asking two simple questions: what is fear produced by? And what, in turn, does fear produce?

A theoretical overview of the role of emotions in social life and the contribution they can make to migration studies precedes a description of the methodological choices made and a presentation of the political, social and territorial context of the research. We then focus on the articulations of fear as a product of the combination of structural and individual conditions, as well as a driver of practices and tactics.<sup>1</sup> Thereafter, we present the voices of migrant women and those of service coordinators and operators to consider the role that fear plays in orienting the choices of migrant users of reproductive health services and, above all, the influence it exerts on their access to health services.

## Studying emotions in the migration field

Emotions may be conceptualized as a way of being and staying in the social world, a means of interpreting, categorizing, perceiving and, consequently, acting in the social reality (Pussetti, 2005); that is, they constitute an ‘embedded thought’ (Rosaldo, 1984) that foregoes, determines and directs action (Bourdieu, 1972). It is possible to read emotions as ‘acquired experience models’ (Pussetti, 2005), shaped by learning of certain socio-cultural, normative and historically-placed orders. In other words, emotions must be understood as both social and cultural constructions (Geertz, 1973), as well as super-structural reflections of the social structure that are expressed at the bodily level, based on the personal biography of individuals and which concern a ‘corporeal self’ (Rosaldo, 1984), placed at the intersection between individual dimensions, body and society (McCarthy, 2017; Thoits, 1996). On the one hand, emotions are the result of a specific ‘hegemonic discourse’ and system of social relations; on the other hand, they legitimize and reproduce this discourse and system (Abu-Lughod and Lutz, 1990; Lutz, 1988).

Of course, this does not imply that emotions, or the symbolic violence (Bourdieu, 1998) with which emotions are imbued (Toffanin, 2015), are rigidly determined, denying any possibility of individual agency, subjective resistance, emotional freedom (Reddy, 1999) or deviation from a linear socio-cultural reproduction and the possibility of historical change. As embodied, conceptual, moral and ideational constructs that place the self in a dynamic relationship with the social structure (Seremetakis, 1991), emotions have also been seen as tools to understand the intimate links between the self and society. Following the definition of Lutz and White (1986), according to whom emotions are

‘languages of the self’, capable of generating social structures, for Seremetakis (1991) emotions can therefore be included in what Foucault called ‘techniques of the self’.

As Donzelli and Hollan (2005) suggest, there is a complexity in the sociological and anthropological analysis of the emotions, given the interweaving of different representations of this object. Trying to summarise this complexity, we can therefore list at least three positions. The first explores emotions from a culturalist perspective (Spiro, 1984; Geertz, 1959), paying particular attention to aspects that encompass the construction of the person (Geertz, 1966; Wikan, 1989); the second focuses on the discursive and social character of the emotions, assessing above all the impact of power relations on them (Abu-Lughod, 1986; Abu-Lughod and Lutz, 1990; Lutz, 1988; Lutz and White 1986); the third is concerned with recovering the centrality of the body and defines the emotions as embodied (Rosaldo, 1984; Lyon, 1995).

Thus, any discussion of the emotional framework should consider both the impact that historical changes in social and structural relations have on the emotional context (Bordonaro, 2005) and the consequences that the ‘work’ of experimentation, embedding and shaping practised by individuals has on this context (Bolton, 2005; Hochschild, 1979).

Aside from an approach that can be defined as ‘discursive’ (Abu-Lughod and Lutz, 1990; Lutz 1988; Pussetti, 2005) and ‘constructionist’ (Harré, 1986), it is possible to trace an ‘interactionist’ approach (Cerulo, 2019; Sandstrom et al., 2013), according to which emotions constitute a double hermeneutic tool – necessary, on the one hand, to study the collective and individual dimension of social reality and, on the other, to trigger a process of reflective and personal awareness (Van Zomeren, 2016; Feldman and Mandache, 2019; Fields et al., 2007). That is, a circular process (Donzelli and Hollan, 2005) is created between emotions and awareness: through emotional expressions, individuals manage to stay and act in the different situational contexts of daily life, while through the control of these expressions, they can interact with other individuals and trigger new mechanisms of reflexivity to understand themselves. Therefore, from this point of view, emotions are produced and reproduced, defined and redefined, and acquire meanings depending on the interaction in which they are ‘shared’ and ‘communicated’ (Kaur, 2020).

In this sense, the essential and seminal sociological works of Arlie Russel Hochschild, who introduced the concept of *emotional labour*, must be taken into consideration (1979). Emotional labour is categorized as *cognitive* if it tries to modify one’s emotions through a change of images, ideas and thoughts associated with them; *bodily* when we intend to modify the somatic or physical symptoms connected to emotions; or *expressive*, when one tries to modify one’s own expressiveness by trying to change the resulting emotions as well. With the expression ‘emotional labour’, the American sociologist refers to the emotional contribution and management of one’s emotions necessary to carry out some waged work activities (Hochschild, 1983).

Building on the complexity of the analyses described above, our ethnographic investigation of women’s emotions and their impact on reproductive health choices also encompasses the relationship between bodies, spaces and time. In doing so, we subsume both the position that attributes a discursive and relational nature to emotions, and that which recovers the centrality of the body.

Alongside the pioneering work of Sheper-Hughes and Lock and their description of the body “as simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as firmly anchored in a particular historical moment” (1987: 7), many scholars have theorised the ambivalence of the body. Some, for example, have interpreted the relationship between bodies, spaces and times in light of the ‘spirit of resistance’, set in motion by bodies to resist the dominant role of the colonial encounter (Comaroff, 1985), or the production of spaces and times regulated by the capitalist regime, especially in the workplace (Ong, 1987). Others read this relationship from a phenomenological perspective, emphasising bodies as a tool through which to decipher the multiple directions and trajectories of agency (Emirbayer and Mische, 1998; Pandolfi, 1990) – as an interactive process between individual and society, structure and action, as well as social constraints and individual autonomy (Scherr, 2013: 232).

Closer to our object of research is Martin’s investigation, in which she deals with how “women find in the concrete experiences of their bodies a different notion of time that counters the way time is socially organized in our industrial society” (2001: 197). From the Author’s perspective, the efforts women make to resist procedures that affect their autonomy of choice are reminiscent of those made by women in the workplace. As shown in the empirical paragraphs, the emotional plane that re-orientates women’s decisions seems to affirm a stance against highly institutionalised spaces and times, putting women’s autonomy, their spaces and their times in the foreground.

The long tradition of socio-anthropological studies on emotions (Feldman and Mandache, 2019; Harris, 2015; Hochschild, 1979; Lutz and White, 1986; Pussetti, 2005; Rosaldo, 1984; Turner and Stets, 2005), however, has only used these perspectives in a limited way to read the migration dynamics that intersect society (Carling, 2008; Lindquist, 2009; Baldassar, 2010; Brooks and Simpson, 2013).

In the field of migration studies, the emotional dimension has mainly been considered to analyse the subjective drives shaping choices of departure and migration trajectories. More frequently, it has been used in contributions relating to transnational family relationships and the family – separated and/or reunited – in migration (Della Puppa, 2018; Baldassar, 2010; Bustamante and Alemán, 2007; Parreñas, 2008; Shaw and Charsley, 2006; Skrbiš, 2008). For example, Charsley’s study (2005) on the unhappiness of Pakistani husbands who came to Europe through family reunification, following wives who belong to second and third generations born and raised in the UK; or the case of various insights into the guilt felt by migrant women as a result of physical separation from their elderly parents and/or left-behind children (Baldassar, 2010; Brooks and Simpson, 2013) and the consequent strategies they implement to cope with the distance (Bryceson and Vuorela, 2002). Therefore, from an analytical point of view, emotions are a social construct, embedded in socio-cultural relationships (Harré, 1986), which can influence mobility choices and the management of migrants’ transnational relationships (Baldassar, 2010).

Research that has dealt with examining the quality of the relationship of migrant women with health services has highlighted different access difficulties (Terraneo and Tognetti Bordogna, 2018). The first is linked to the legal status of women, which can discourage the use of services in some cases. Although the Italian law proposal stating that

hospital doctors had a duty to report undocumented migrants never materialised (Basso, 2010), the idea among undocumented migrants that they would be at risk in case of health care needs is fairly widespread. For undocumented migrants (STP, *Stranieri Temporaneamente Presenti* – Foreigner Temporarily Present), the law provides a free right to access emergency care and pro bono medical centres.<sup>2</sup> Other factors may discourage access to healthcare facilities among migrant women in Italy (Marchesi, 2020), such as low cultural capital and/or language skills, solitude, a knowledge apparatus that is differently culturally oriented, bureaucratization of medical procedures, fragmentation of services, lack of information or tendency of staff to give fragmented information, and, as we demonstrate, feelings of fear and disorientation that users develop as a product of the intersection between structural and individual conditions. When it comes to reproductive health care, there are a series of problems in the relationship between women and reproductive health services, which can be ascribed to the subjective dimension in choices inherent to the reproductive sphere (Fadiman, 1997) and to the co-construction of knowledge related to body and motherhood. In this regard, Bonfanti (2012: 7) affirms that “mothers not only receive prenatal training, but, at the same time, produce some knowledge about motherhood”. This means that women can use multiple knowledge systems, often simultaneously (Fadiman, 1997; Quagliarello 2016, 2019). As proof of this, most communicative and therapeutic misunderstandings (Fadiman, 1997; Winkelman, 2009) do not arise simply for linguistic reasons, but as shown below, also from a lack of balance between the categorisations and intervention strategies implemented by services and the extreme heterogeneity of migration scenarios (Tarabusi, 2014). Reproductive health and international migrations are phenomena and experiences that range from personal to social dimensions as well as from public to private ones, in a reciprocal and complementarity perspective (Bonfanti, 2012). In this sense, (female) migrant users tend not only to reconfigure the health system of destination societies (Pasini and Pullini, 2002), but also to shape all sectors of social life in these societies.

## Research setting and methods

This contribution is the result of broader research aimed at investigating the needs of migrant women, on the issues of reproductive health provided in the socio-territorial context of the municipality of Verona (Veneto Region, north-east Italy). The research has deepened the understanding of the needs of migrant women in the phases of access to services, admission and care; and the practices and strategies adopted by reproductive health professionals. Concerning the former, the needs of women belonging to four specific categories were analysed and examined: asylum seekers, long-term residents, ‘undocumented’ migrants, and victims of trafficking.

The social backgrounds of women asylum seekers and victims of trafficking involved in the research almost overlap: women aged between 18 and 27, with little cultural and social capital, from the degraded suburbs of the metropolises of sub-Saharan African countries (Ivory Coast, Cameroon, Nigeria). They arrived in Italy three or 4 years ago, crossing the desert and the Mediterranean, having experienced forms of violence during their migration journey, especially in Libyan prisons. The long-term resident migrant

women have heterogeneous social profiles: they come from Africa (Nigeria, Somalia, Ethiopia, Ghana, Morocco and Tunisia), South America (Peru and Ecuador), Eastern Europe (Moldova, Ukraine, Romania) and the Indian subcontinent (Pakistan, Sri Lanka and Bangladesh), arrived in Italy alone, during the 1990s or 2000s, as ‘economic migrants’, or through family reunification, following their husbands, who had already been in Italy for years. They are often part of families from the low-income working class, with precarious jobs or unemployed due to crisis – albeit with a generally good education – and, therefore, in a situation of economic and often social vulnerability. ‘Undocumented’ migrant women live in even greater socio-economic distress, often unemployed or employed in the shadow economy and sometimes homeless.

After analysing the existing literature and having examined the quantitative data to ‘size’ the female migrant presence in the municipality of Verona, we conducted 8 months of participant observation and ethnographic practice in hospitals, clinics for ‘undocumented’ migrants, reception centres, and family counselling. We generated and collected 20 in-depth interviews with coordinators and operators, and 20 more with migrant women users of these services.

Before considering the narratives of migrant users and staff in reproductive health services, it is necessary to provide a brief analytical description of the regulatory framework, and the consequences this has on the health of migrant women and their ‘reproductive trajectories’. Migrant women and families without a regular residence permit, the so-called ‘STP’, are not entitled to a series of health protections. Among the denied protections, access to screening to prevent cervical cancer, recommended every 3 years for women aged between 25 and 64 and free of charge for Italian citizen, should be mentioned.

It is also worth noting that the city of Verona’s administration is led by the politically xenophobic Northern League party, which, at a national level, has exacerbated the already severe stances towards migrants, while at the local level, it has attacked the social rights and reproductive health provisions of women, approving a resolution that declares Verona as a ‘pro-life city’, which compromises – for now, ‘only’ symbolically – the right to voluntary termination of pregnancy (VTP) and supports Catholic associations and their field initiatives against VTP. This resolution contributed to the creation of a social climate which is hostile to women – especially migrants – and to services for the protection of their reproductive health.

Veneto is also the Italian Region with the second highest number of conscientious objectors among medical doctors – those who refuse to perform VTPs. Out of 66 doctors working in the obstetrics and gynaecology operating units in Verona, 54 are objectors. Finally, a further useful statistic for understanding the context of Verona is provided by the Italian National Institute of Statistics that recorded 1065 VTPs in the city, for 2016, of which 50% were requested by migrant women, from a migrant presence of 11.4% in the province and 13.9% in the municipality (Centro Studi e Ricerche Idos, 2018).

### *Fear as a product: Women's experiences*

As we affirmed at the beginning of this contribution, in our analysis fear is at the core of a dialectical relationship, which can be concretely shown through the questions: what is fear produced by? And what, in turn, does fear produce?

Regarding the first question, several factors generate the feeling of fear among migrant women. Some of these factors were identified among the women's stories. For some women, the experience of a caesarean section, an unwanted pregnancy or a post-partum depression may turn out to be fear-inducing due to their underprivileged social and material condition, described above (e.g. being undocumented, homeless and unemployed), in addition to their unfamiliarity with the Italian language and the inability to navigate fragmented health services.

A long-term resident woman said that she found herself in extreme difficulty during her pregnancy due to her social and economic conditions:

When I got pregnant, I was in a lot of trouble, I did not even have a safe place. I suffered a lot, because I did not even have a job [...] my husband went to live in another city where he works, but not with a real job, like me, something 'in the air'. Before, I slept at a friend's house. Afterwards I was afraid. I slept a little bit everywhere. I came and went to my friend because my belly was not visible, I was very thin, up to 7/8 months nobody knew I was pregnant. At 9 months, the belly was visible. When I was in my fifth month, then, I talked to the social worker... I was afraid to tell her, because I knew how difficult [social workers] are also because I had no job, then I thought it was bad. Therefore, I remained silent. Because with the difficulties I had, they could tell me: "What did you do?" I do not know, it was my first pregnancy and I thought something stupid, because without a home, without a job, without anything... But it happens anyway. (Esther, long-term resident)

The fear that emerges from Esther's story suggests an interpretation of this feeling that is not limited to an individual dimension, i.e. to her homelessness.

Rather, the story provides insights into the social dimension that produces and sets in motion the feeling of fear in this woman; a dimension represented by the critical issues that emerge in cases of assistance to pregnant women without a place to live. Both individual and social dimensions deter women from contacting support services, because they are convinced that their material conditions could prevent them from keeping their child once it is born.

Thus, faced with the circumstance of having to communicate her precarious material conditions to a social worker, Esther preferred silence – at least as long as her 'thinness' made it possible. Esther's case demonstrates how fear can be defined as an 'embodied thought' that merges individual, material and social conditions (Rosaldo, 1984). Indeed, thinness, as well as the swelling of her belly, played a decisive role in her choice to conceal or communicate her state. This choice was also influenced by the intersection of her individual material conditions and her social sphere – being homeless and unemployed – conditions that are rarely considered in diagnoses made by so-called bourgeois medicine (Singer et al., 1992).



Below we illustrate the weight of social conditioning, including that of figures who embody the institutions (Pizza, 2020), on women's choices in the field of reproductive health. Herein, it is not mere fear that dominates the women's stories and experiences, but rather fear of the judgement of others for becoming mothers despite their economic conditions. In these circumstances, it is shame that drives the women's actions, induced by the feeling that their behaviour is neither appropriate nor conforms to social norms (Sheff, 2003). Rita, a long-term resident from Nigeria, told us:

Everything is fine with me; my only problem is the job! I have only this daughter. Because there is no job. How can you make children out of work? When you work and you have money you can do it. Even my social worker told me: "You can't do this alone, without work! When you find someone good, you first marry him and then look for a job. Save all the money and bring them to the post office, because you have to buy the clothes for the girl, you have to send her to school." So many things, even hospital exams must be paid! When you make a mistake the first time, then you have to think about it and you do not have to go wrong again. I am alone. My social worker helps me a little, but after 6 months she said: "Stop! It is enough! There is another person." (Rita, long-term resident)

Although Rita's story does not directly show the feeling of fear, it reveals the expectations that revolve around the idea of motherhood (Ong, 2003). Moreover, it highlights what pressures women are subjected to and what type of conduct and behaviour society expects from them. The fear of judgement produces, among other things, a spiral of unspoken words and silence (Marabello, 2017). As Sheff (2003), citing Elias, highlighted "Neither rational motives nor practical reasons primarily determine this attitude, but rather the shame of adults themselves, which has become compulsive. It is the social prohibitions and resistances within themselves, their own superego, that makes them keep silent" (Elias, 1978; in Sheff, 2003: 181).

During an interview with a Cameroonian woman who was a guest in a reception centre in the province of Verona, we were told that:

Others are ashamed and because of that they take the medicine of their country. This is very bad, risky and dangerous... but they are ashamed... They feel ashamed to go to the hospital to have the abortion [...] and then they do it with their country's medicine, but this is very dangerous. Many guys sell these medicines... Now I have a friend who has been bleeding for 3 months because she has taken this medicine. My friend does not want to say what she has done. [...] If a person does not want a child, she can go to talk to the centre, to the hospital, which is very good for having your tummy wash also having a safe abortion. If, on the other hand, you take medicine and you don't know what it can do in your belly, after you have problems, you don't even know the reasons (Blessed, asylum seeker)

In the conversation reported above, fear (of judgement) occurs at two different levels, each expressing a situation of 'impasse', which helps define the risks these women run when they act out of fear. The first level describes the condition of women who decide not to carry on with pregnancy and who, out of fear of judgement, prefer to resort to 'do-it-

yourself' methods by taking drugs with abortive and highly harmful effects. The second level concerns the fear that Blessed's friend felt at the thought of having to communicate to doctors and health professionals that she had taken 'medicine' and that she had not seen a doctor.

In the framework of the reasons we have listed, we see how the feeling of fear is produced by processes of stigmatization which, due to prevailing categories and social norms, operate to identify individual faults and responsibilities without taking into consideration the underlying structural causes. In this sense, stigmatization produces fear among those individuals whose behaviours and lifestyles are socially sanctioned and, no less important, it generates effects that, in some cases, can lead to behaviours (e.g. inability to properly care for new-borns) that seems to warrant stigmatization, and, in other cases, puts their health at risk.

Looking carefully at these examples, what emerges is that one or more beliefs provide the basis of women's fear. In the first case, it is the belief of not being 'a good mother', since the material conditions in which Esther finds herself are not adequate for the birth and growth of a child. In the second case, it is the belief of being neither 'a good woman' – because the choice not to continue a pregnancy is, in many circumstances, considered not uplifting for a woman – nor a 'good patient', since she has not contacted a doctor for the termination of the pregnancy.

On the other hand, fear of judgement pushes women to act and find alternative solutions to their uncertain and unstable situations. Although these women very often must deal with the inadequacy of the health care system, the absence of translators or the extreme physical and logistical fragmentation of services, they still manage to navigate the system. Thus, the fear and uncertainty within which they move do not prevent them from turning to social workers or an informal support network when necessary.

### *Fear as a product: The professionals' experience*

The experiences of professionals who meet migrant women daily define Janus' half face and allow researchers to investigate and draw out the specular dimensions, sometimes never seen, of fear as a product:

This year we have had a woman from Niger with a malformation: she had pre-eclampsia and many other problems. If we could talk with these people in advance... because her husband was working, she was alone here. We have to run many clinical tests before the ultrasound. This aspect could improve her pregnancy and help us to understand her situation [...] Then, when they have delivered, they never come back and we don't have feedback. (Carlo, voluntary doctor in a health care centre for undocumented migrants)

A professional who works in a health care centre for documented and undocumented migrants underlines how the condition of administrative/legal irregularity, as well as their underprivileged material conditions, causes a feeling of fear in migrant women that undermines the regular attendance of scheduled examinations during pregnancy and produces post-partum invisibility. When their babies are born, undocumented women,

even those with an STP, fear potential penalties or expulsion from the country, and for this reason, they stop attending clinics, renouncing the possibility of monitoring their reproductive health after delivery.

The responsibility for this situation is partially ascribable to the political and social environment that has characterized Italy in recent years. In fact, the securitarian and emergency character of legislative immigration provisions (Della Puppa et al., 2020; Basso, 2010) and the rhetoric constructed to the detriment of migrants have both facilitated a widespread fear that inhibits access to health services. In this way, vulnerable subjects such as new mothers are exposed to conditions of marginalization that can endanger their own health and that of their babies. Thus, the experience of the professional working in the clinic testifies not just to an isolated case, but to a continuum of ‘invisibility’ situations at the post-partum stage, as if the birth of a baby erases the possibility of a ‘visible’ existence for the mother – and consequently the possibility of taking care of herself. Here, then, if administrative irregularity pushes migrant women to become invisible, those who have a regular residency permit and look to public health services for help and support also express feelings of fear. The experience of a social worker in a private family-planning clinic is explicit:

I had an issue with a Nigerian girl, who was a victim of trafficking... It is very harsh to work with these users, they are suspicious and she didn't want to sign the privacy form because she thought that by signing, she agreed that we could take her baby when she had delivered... she was afraid and for this reason she wanted other people to read the form before her signature. I gave it to her and scheduled another meeting, then a neighbour of this woman called me asking for an explanation. At the beginning of each meeting, I explain everything about forms, about the rules of this place... I tried to minimize the bureaucratic part... but there's distrust because I'm a social worker, there's the fear that social workers take babies away from their mums.<sup>3</sup> Luckily, here we are a private centre, here mums are relaxed, this is an informal environment... migrant women are more honest here, than in a public centre... for example, they told me: "Here it is written that I'm working, but is a fake job, it is just because I have to renew the permit of stay... but this a secret", or they say: "Don't tell to the public social worker that I'm pregnant, I don't want to risk that they take my baby away". They have clear in mind that this place is a freer place, here you don't need to ring a bell and wait for somebody... here our volunteers go out and meet women side by side. (Giovanna, social worker in a private family planning clinic)

The words of this professional show how fear can push migrant women to generate practices to protect themselves. For example, the choice to confide in a private social worker, rather than in a public one, on the one hand, allows them to find comfort and support and, on the other, to avoid alleged risks for their own family. Again, the decision to refuse a privacy form signature and the request for support from a person of trust highlight how this emotion permeates every action of their daily life, but at the same time it shows the women' agency in developing protective practices.

The interviewee underlines that women live public socio-health services as institutional spaces, which can exercise power over their bodies and their families (Fadiman, 1997).

Again, the political, social and media climate induces in migrant women the fear of being controlled by the institution – and that fear guides their daily choices, such as whether to confide in a private social worker who could encourage and support them and avoid possible risks for their families. The key used by professionals to dismantle the asymmetric relation typical of institutional contexts and build a relationship of trust with women is the specific care promoted in the private family planning clinic.

In this way, the fear of being controlled by the institution is attenuated by the informal approach, which allows for the creation of friendly bonds: when the professional meets the woman ‘side by side’, they are not only demolishing an invisible wall, but also laying the foundations of a healthy relation for that woman, her family and the entire community.

The experience of a professional working in a Cas (*Centri di accoglienza Straordinaria* – Extraordinary Reception Centres) hosting asylum seekers shows another aspect of fear embedded in migrant women’s everyday lives:

They wait for the missing period. It has never happened to me that a woman comes into my office and tells me: “Look, yesterday, I had sex without a condom... I’m afraid... what can we do now?” They don’t do that. Maybe they are afraid that we blame them, or we reproach them for it. (Giulia, professional in a Cas)

The job of professionals working in the host system is characterized by firm adhesion to the rules and norms required by the hosting system, but also by attempting to create trust relations with the women being hosted. Nevertheless, the structural asymmetry between professionals and migrant women only allows for the creation of artificial and forced bonds, despite the professionals’ need to know intimate decisions related to the sexual and reproductive lives of the women.

The asymmetrical relationship necessarily implies control and violence dynamics to the detriment of asylum seekers, who must adhere to behaviour models defined by the host organization (Pasian and Toffanin, 2018). As Pinelli (2015) pointed out, in the hosting system these women become the targets of a moral and emancipatory project whose goal is to construct and modulate their subjectivity. Professionals and social workers use pedagogical rules, practices and techniques to promote a female subjectivity conceived as emancipated and self-reliant. Any lack of adhesion to such behaviour models generates fear of being blamed or reproached and, ultimately, being expelled from the Italian reception system for refugees and asylum seekers.

Turnaturi (2012) argues that, “The fear of being judged is so strong and pervasive that you can feel ashamed just imagining what others can think about you, even if you have done nothing to be ashamed of”. Indeed, beyond judgement, women fear reproach and blame from professionals who are dealing with their primary, health, educational and social needs, and who can mediate the possibility of obtaining a residency permit.

Migrant women’s delay in requesting support from professionals, sometimes exacerbating reproductive health problems, can be the result of the underlying fear that behaviour which is not compliant with the expectations of host organizations might affect the entire migratory project.

### *Fear as a producer: Women's experiences*

While fear may prevent action being taken, it goes without saying that among the effects that we should take into consideration is the inhibition in accessing services dedicated to health. And this is one of the effects that evidence shows manifest itself frequently. However, deliberately choosing not to return to dedicated services can, in some cases, leave room for action in which personal subjectivity is foregrounded (Mattalucci, 2017). Deciding to do nothing is not necessarily synonymous with non-action (Bourdieu, 2000), as such a decision may indicate that people find it more convenient to act otherwise or wait for more favourable conditions. Unlike the previously highlighted examples, the fear motivating the choices discussed here did not endanger the lives of women or unborn children, but rather took on a tactical role (De Certeau, 1980).

A Gambian asylum seeker interviewed said that without the aid of a Sprar (*Sistema di protezione per richiedenti asilo e rifugiati* – Protection System for Refugees and Asylum Seekers) project in which she lived during the entire period of her pregnancy, she would not have been able to manage. Thanks to the support and work of the project in which she lived, Amina had the opportunity to take part in an prenatal course. However, having almost reached the end of the course, she decided to stop attending:

Once I got to Italy, luckily the birth went well. My only fear was that she [referring to one of the twins] had her head up, so I had to have a caesarean-section. And I was so scared and I didn't want to do a C-section [...] In the antenatal courses, I understood well, they explained me well, but I didn't go anymore because I was afraid of the C-section and I didn't want to hear that I have to have a C-section. (Amina, asylum seeker)

The fear of having to have a C-section made Amina decide to stop attending the course. In particular, she justified her choice by saying that she “didn't want to hear” about having to have a caesarean. Faced with the impossibility of evading an eventuality that could not be controlled, she stopped listening. Previously, we have seen how women seized by fear had decided not to speak. However, we observe how the refusal to accept a condition outside of personal control – seen as a reproductive disruption (Inhorn, 2007; Mattalucci, 2017) – in this case is processed and dealt with by choosing not to hear.

This reminds us of what Wikan (1989) called ‘managing the heart’ which draws on the techniques of ‘not caring’ and ‘forgetting’. Hollan (1992) shows how Toraja individuals direct these efforts not only towards themselves, but also towards others. In saying this, Hollan distinguishes between the work of the emotions in individualistic societies, such as the American one analysed by Hochschild (1979), in which the work of the emotions is mainly oriented towards ‘protecting’ oneself, and that carried out by the Toraja individuals. In our case, the ‘managing of the heart’ and the ‘work of the emotions’ that the migrant women who navigate the Italian health system put in place seems more like a form of agency (Donzelli and Hollan, 2005), oriented to protect themselves from bad thoughts – from what causes them worry and anxiety – and from the judgement of a society that does not understand and underestimates their desires and needs.

The experience of caesarean delivery is one of the most addressed and discussed in the literature, since it is an example of the process of controlling the female body using invasive, and sometimes unnecessary, medical procedures (Davis-Floyd, 2001). The WHO believes that the ideal rate for caesarean births should be between 10% and 15%, while the national average in Italy is above 33%. During our research, we collected testimonies from migrant women who said they had experienced a c-section, although – from their point of view – there was no reason for the procedure. In other cases, however, the intervention was recognized as necessary.

Together with age and level of education, being a foreigner is one of the reasons why the moments dedicated to information and dialogue in the doctor-patient relationship tend to be underestimated, if not neglected. The ethnography conducted by Chiara Quagliarello (2016) has shown how this belief is often the result of prejudice on the part of the health personnel, which does not always find confirmation in reality, but which corresponds with the speed and rhythms imposed by the healthcare facilities and can be detrimental to providing information. Together with the fact that, in many circumstances, foreigners have demonstrated a familiarity with the language that makes linguistic mediation unnecessary, what must also be taken into account – and Amina's case seems to bear out this interpretation – is the fundamental difference between 'not understanding' and 'not wanting to hear'.

The failure of this relationship may also result from a choice that comes directly from the individual, who imposes her will over that of medical knowledge, operators and technicians (Pizza, 2020). Especially in the moments before delivery, refusing to talk or listen to what the doctors have to say is one of the most common tactics used by these women.

As we have already pointed out, the inadequacies of the health system do not prevent women from turning their concerns into practice. For example Maria, a long-term resident, felt abandoned by the public health system and turned to a private gynaecologist. In her words, the birth experience had been a nightmare, since her birth plan was ignored by the doctors. The post-partum period was also experienced by Maria in a traumatic way. The fear she had experienced returned when she realised she was suffering from post-partum depression. The possibility of asking for support from the same health system that had supported her during the birth plunged her back into "a nightmare".

We have already described how fear can set in motion choices that, although at first seem to indicate a lack of action, can translate into a suspension, waiting for the most favourable and comfortable conditions possible for the person who makes them. The work of Pizza and Ravenda (2016) highlights the centrality of time in the analysis of the production of medical knowledge and the relationships and dynamics it produces. If, concerning c-sections, time – granted or denied – becomes a crucial factor for a good relationship between doctor and patient, Maria's case allows us to confront the question of time, from the point of view of those who react to the management of time 'from above', slowing it down or speeding it up according to the needs of the medical personnel. This reaction consists of implementing the production of another time, that is, one's own time. In these terms, even Maria's choice, provoked by the fear of having to communicate her state of health to a system she had stopped trusting, can be interpreted as a tactic.

Whereas the tactic exercised by Amina was to master her fear of the c-section, Maria's tactics, based on a lack of trust, did not seek to avoid fear, but rather to act on it. Regardless of these differences, stopping attending prenatal classes or deciding not to ask for help are choices that are part of the repertoire of tactics women put in place to cope with institutionalised practices, spaces and times.

### *Fear as a producer: The professionals' experience*

As we have seen, migrant women's words have shown how fear can produce a lack of action and this can be considered to be a tactic. Another aspect of what fear can produce is shown in the experiences of professionals: the tragic consequences of some non-actions, as in the experience of the family-planning clinic coordinator with which we opened the article.

Despite plenty of information and advice from health professionals on free access to the hospital in case of childbirth or emergency, even for undocumented migrants, the fear of going to hospital can often lead to tragic consequences for both mother and baby: for example, Jennifer's experience of delaying access to hospital after her waters broke, could result in severe neurological damage.

The lack of information and the fear produced by inconsistent administrative directions prevented two women from going to the hospital to monitor their pregnancies after their due date, causing the deaths of their babies. In these cases, the material and social background of those women, as described above, jointly with the hostile social and political climate towards migrants guided women in their choices of treatment/care or no treatment/care. The openness of professionals working in family-planning clinics to inform and steer women was not sufficient to dismantle the fear of administrative repercussions. The choice of avoiding care in hospitals, in an attempt to protect themselves and their babies – and maybe having a home birth that could guarantee invisibility – appears as a rational choice based on an individual feeling, though one shaped by an adverse social and political environment.

When migrant women choose to terminate their pregnancies, professionals highlight the fear of women being too late for VTP in a clinic and resorting to do-it-yourself abortion practices. The experience of one professional working in the anti-trafficking network details this scenario:

A huge number of VTPs do not take place in hospitals or clinics, but through the use and abuse of Cytotec, a medicine that women find through their networks and use randomly... This happens when you don't have a prompt reply from the institutions: if I have to have my healthcare card, then I have to schedule an appointment, maybe I have to wait for two weeks to meet the doctor, then I have to have tests run, beta-hCG... and so on, these women start to be anxious... I can tell her, "Look, in 10 days we can have a VTP at the hospital", but if one of her friends tells her, "Take five pills and you will solve your problem"... Unfortunately, then, the problem that we have to manage is the post-abortion (Lucia, professional in the anti-trafficking network)

In the words of the above-mentioned professional we can see how the fear of not managing to stop the pregnancy before the third month, as set in the Italian law, guides women in the choice to look for abortion pills through informal networks. The literature highlights how, for many migrant women living in marginal conditions, pregnancy is often not desired or the foetus is the result of violence (Quagliarello, 2019). These are among the reasons driving women to find quick solutions – with the risk of taking uncertain paths to achieve their goal.

The time needed for bureaucratic issues and, in particular, for dealing with clinical tests and scheduling the VTP, substitutes the time of the life-project of asylum seekers and trafficking victims, producing psychological, physical and social pain. The time needed for the surgery, the fear of not stopping pregnancies and the need to go back to sex work quickly to settle the debts incurred to reach Italy are the conditions that drive women to make choices that are dangerous for their health.

Professionals never considered the health system's incapacity in providing the VTP in a shorter time or their personal responsibility in promoting a trust relationship with migrant women as a concurrent cause of the fear felt by women. Professionals interpreted the fear experienced by women as a subjective emotion, regardless of their personal and professional involvement and the wider context of structural inequalities which mostly affect vulnerable women (undocumented migrant women, victims of trafficking, poor women, etc.).

## **A two-faced soul-eating Janus: Some final remarks**

The decision to report the experiences of women and professionals separately was made in an attempt to reproduce, even visually, the distance that very often exists between patients and health workers. Beginning with Kleinman (1988), this distance has become one of the most investigated themes in medical and applied anthropology. In Fadiman's work (1997), doctors interpret Hmong refugees' reactions as a form of noncompliance, similar to some cases described by our professionals. However, interpreting fear as a two-faced Janus serves to focus on the ambivalence of emotions, rather than to measure the distance between one model and another. It is in this 'space in-between' that practices take shape, changing from time to time. While in Fadiman's work, in retrospect the author wondered what the sound of the voices of her interlocutors – the Hmong families and the doctors – would sound like if reproduced in unison, *a posteriori* the fears of our informants appear to us as a game of mirrors: one is reflected in the other, but without necessarily coming into contact with each other.

The fears we have represented, juxtaposing the voices of migrant women with those of health workers, in fact, confirm how much the social dimension and individual profiles intersect in health-related issues impacting the dimension of emotions. The difficulties in bringing the two sides into dialogue are understandable when we read between the lines of the testimonies we have reported. Although the reports of healthcare operators reveal a high degree of awareness of the needs and fears of pregnant women, we have found that the operators and the health system as a whole rarely evaluate the impact of social aspects in health issues. Therefore, representing fear and, more generally, emotions like a two-



faced Janus allowed us to fully grasp not only the distance between the health system and the social and intimate experience of women, but, above all, to observe the transformation processes and manipulation (Pizza, 2020) of power relations, operated by both sides.

Furthermore, we have seen how ‘reproductive disruptions’ in maternity paths are not produced only in the bodies, but, more often, they are the result of institutional practices that govern the ‘admissible forms’ of procreation and parenthood (Mattalucci, 2017). Therefore, the reactions of the subjects to such fractures represent an attempt to re-compose them, applying tactics and practices similar to those we have seen put in place in our ethnography. In putting these tactics into practice, women bring out the contradictions and shortcomings of the health system and carry out a self-objectification of the body, understood as a physical-political space in which the transformation processes act (Pizza, 2020).

Abandoning the purely psychological and culturalist field, the emotional field provides further interpretations of the relationship between body, space and time. In particular, the experiences of the bodies that, through emotions and practices (Rosaldo, 1984), escape the notions of time and space, socially shaped on the basis of the industrial society (Martin, 2001; Pizza, 2020), help us to ascertain both the strategies of those who exercise hegemony and the tactics of those who suffer it. Above all, by enrolling in this ‘in-between’ space, in which the processes of transformation and manipulation of power relations take place continuously, emotions also allow us to glimpse actions and practices that can, from time to time, overturn the terms of this asymmetrical relationship.

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### Notes

1. We use the concept of ‘tactics’ as conceived by De Certeau (1980), opposed to ‘strategies’: he connects ‘strategies’ to institutions, while ‘tactics’ would be used by individuals to create of their own spaces in the environments defined by the ‘strategies’.
2. Cesaim (*Centro Salute Immigrati* – Immigrant Health Centre) provides free health care to undocumented migrants in the city of Verona.
3. The interviewee reports a widespread belief according to which social workers use their power to arbitrarily and easily take the children of poor families away. The Italian law provides that the

Family Courts receive reports from social workers about critical situations and rule on these. It should be emphasized that this extreme measure – even if rarely taken – affects migrant and Roma families more frequently than native ones (Saletti Salza, 2014).

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