How institutions think

Reproductive health services and migrant women in Italy

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'We, as Western women … have a very different approach to sexuality and motherhood.' A health and social services professional spoke these words during a focus group in Verona. They capture a pattern we saw repeatedly in our 2018 ethnographic research on migrant women's access to reproductive health services in northeastern Italy. Practitioners frequently attributed migrant women's reluctance to use services not to practical barriers (distance, work schedules, precarious legal status) but to cultural difference.

To understand how such assumptions become entrenched, we draw on Mary Douglas's (1986) analysis of how institutions think. The classification systems that states use to order life and death are social and cultural constructions that, as Maria Minicuci and Mariano Pavanello (2010: 9) observe, 'put in place ways of organizing and controlling the lives of millions of people, by redefining their identities and forms of belonging'. Yet this happens 'not without meeting resistance and having to deal with the agency of social actors'. Health and social services professionals must work within entrenched bureaucratic models, but they also critically reflect on their work, sometimes adopting measures that depart from institutional logics or conflict with them outright.

Recent studies (Giacomelli 2021; Pasian 2024) have drawn on Michael Lipsky's concept of 'street-level bureaucracy' to understand how practitioners exercise discretionary authority within organizations. As Lipsky (2010: xiv) argues, street-level bureaucrats 'invent means of processing people en masse that allow them to deal with the public in a more or less equitable, appropriate, and thoughtful way. At worst, they succumb to favouritism, stereotypes, convenience, and routinization.' Our research traces both tendencies: the essentialization of migrant women through culturalist frameworks, and the reflexive efforts of some practitioners to escape these logics (Herzfeld 1992). We contend that such reflexivity should be integrated as a fundamental practice within reproductive health services.

After situating our research within the Italian migration context and regulatory framework, we examine practitioners' culturalist narratives before turning to migrant women's own accounts of their encounters with reproductive health services.

Contextualization

Before exploring our ethnographic findings, it is necessary to provide a brief analytical account of the wider Italian migration context, as well as the regulatory framework.

The specificities of migration in Southern Europe have led Russell King and Daniela DeBono (2013) to talk about a 'Mediterranean model of migration'. Italy is included in this model, having, among others, the following characteristics: a 'non-migration policy', based on the issuing of frequent emergency measures; migrants' limited access to social provisions that support inclusion; the entry of migrants in the informal economy at the early stages of their life in the country; and the structural presence of undocumented migrants within the country.

At the time of research, Verona was governed by the populist Northern League party (Donà & Bellè 2022). The administration attacked women's social rights and reproductive health provisions, approving a resolution that declared Verona a 'pro-life city' and opposed voluntary termination of pregnancy (VTP). Local and national politicians described reproductive health services as a lever for 'ethnic replacement', creating a hostile climate for immigrant women in particular.

In Verona, 54 of the 66 doctors working in obstetrics and gynaecology were conscientious objectors who refused to perform VTPs. Statistics from the Italian National Institute of Statistics help explain the local context: in 2016, Verona recorded 1,065 VTPs, half of them requested by migrant women. This is striking given that migrants made up only 11.4 per cent of the province and 13.9 per cent of the municipality.

The research explored the needs of women and new mothers with migratory backgrounds at different stages of their interaction with health and social services: accessing services, admission, treatment and care. We also investigated practices and strategies adopted by staff, with particular focus on sexual and reproductive health. Over six months, we conducted participant observation at advice centres, outpatient clinics for undocumented migrants, reception centres for refugees and asylum seekers and local hospitals. We attended meetings, participated in activities and observed everyday interactions.

The research involved three focus groups respectively with reception system social workers, health professionals and migrant women, alongside 40 in-depth interviews – 20 with co-ordinators and service practitioners and 20 with migrant women. Participants came from diverse regions: Sub-Saharan Africa, the Horn of Africa, North Africa, South America, Eastern Europe and the Indian subcontinent.

To interrogate our data sets, we adapted Kathy Charmaz's (1990) approach, informed by grounded theory, and using the following research questions: How do health and social care professionals perceive and represent the healthcare needs and demands of women and mothers with migratory backgrounds? What are the reproductive health trajectories of mothers with migratory backgrounds, and how are these shaped by their interactions with health and social services? How do cultural beliefs and assumptions held by healthcare providers shape the care that immigrant mothers receive?

Through this approach, we sought to capture institutional perspectives and the lived experiences both of migrant women navigating these services and of practitioners working within the healthcare field.

Institutional interactions

Mary Douglas (1986) showed how institutions identify, classify and naturalize individuals. We use her framework

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Fig. 1. *A pregnant mother.*

to analyse how interactions between migrant women and health services produce essentialization, here taking the form of reified cultural identity. Rooted in a historical, social and cultural context (Kleinman 1988; Martin 2001), the medical system and social services become spaces where institutional classification and identification of individuals reveal a complex intertwining of essentialization and naturalization strategies and the tactics migrant women use to escape these categories (Decimo & Gribaldo 2017).

Scholars have shown that socio-demographic patterns are used by institutions to construct national identity and to create a distinction between native and migrant women (Gribaldo 2016; Krause 2012). The stereotyped discourses and practices observed in encounters between migrant women and healthcare professionals align with Chiara Quagliariello's (2014) observations, which characterize migrant women's reproductive choices as 'natural' and those of native women as 'rational'.

The notion of 'culture' intensifies forms of stratification in healthcare treatment and practices, primarily due to tendencies to objectify and moralize migrant women's behaviours. This reveals what Francesca Decimo and Alessandra Gribaldo (2017: 10) call a 'sort of pedagogy of integration' – one that is built upon the general belief that cultural determinants are at the root of migrant women's reproductive choices. A key risk in social and healthcare practices is the tendency to oversimplify individuals' complex realities and life trajectories (Marchetti 2019). We address this by examining how migration entails a process through which women may 'become other' (Schmoll 2022), and which influences their health and reproductive choices (Gribaldo 2016; Marchetti 2019).

While reproductive choices can be functional to the 'othering' process (Decimo & Gribaldo 2017) by creating stratifications between native and migrant women, they can also reveal how social and economic inequalities play a decisive role in shaping those choices.

Our purpose is to analyse how group or workplace thinking becomes so institutionalized that it produces a system of practices, judgements, stereotypes and formal prejudices. If, as Douglas writes, 'the triumph of institutional thinking consists in making institutions completely invisible' (1986: 151), then our task is to render them visible again.

Maternity, reproductive health and migration

During a focus group at a reception centre for asylum seekers, a health and social services professional reflected on how different habits and styles of socialization shape conceptions of sexuality and motherhood. Her words, with which we began this piece, marked the first step in a process of identification ('We, as Western women … have a very different approach to sexuality and motherhood'). She then stressed the 'diversity' of migrant women, pointing to their perceived reluctance to use all available services. While she cautiously avoided directly offending sensibilities, carefully noting that she was 'not simply butting in', her conclusion nonetheless attributed these women's resistance to cultural difference (Spada 2025).

Beyond this resistance, however, one can often discern a fear of undocumented, homeless or socio-economically vulnerable women (Sanò et al. 2022). Any behaviour deviating from institutionalized norms was interpreted as unthinkable and in need of correction.

Another pattern that emerged in the narratives of health professionals was a recurring infantilization of migrant women, portraying them as vulnerable and dominated by their male counterparts (Pitzalis 2024). Reproductive health education, particularly around sexually transmitted diseases, was often described as ineffective because women were allegedly unable to assert themselves in

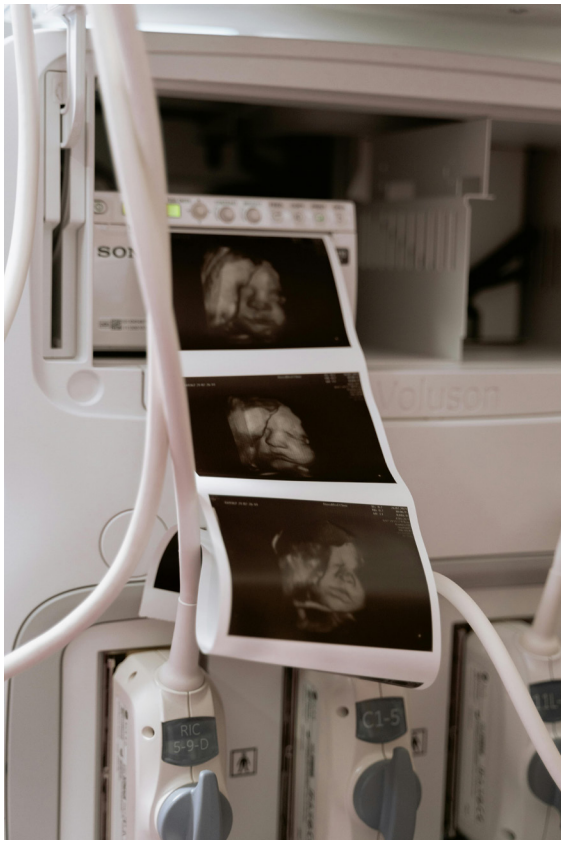

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Fig. 2. *Images printed during a three-dimensional ecography.*
Fig. 3. *Maternity ward alarm monitor panel.*
Fig. 4. *The corridor of a hospital.*

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Fig. 5. *A new mother with her baby.*

intimate settings. Consequently, the failure of biomedical institutions to protect women's sexual health was traced back to an image of femininity seen as burdened by outdated social and cultural habits, insufficiently mature or in need of emancipation.

Although some practitioners acknowledged the limitations of certain health practices within their institutions, their attempts to rethink these practices often fell back into the same culturalist frameworks. When the views of the health practitioners are compared to the stories of the migrant women, it is evident that the problem is lack of listening rather than socio-cultural resistance. These women's so-called 'distrust' or 'resistance' often reflects a broader disconnection between their actual needs and the assumptions made about them. Such assumptions have less to do with cultural difference than with their shared condition as migrant women and mothers (Fadiman 1997).

The story of Lianet, a woman from Peru, is illustrative. She recounted how her wishes during childbirth were ignored: to give birth standing or squatting, to have her husband present, to avoid induction and caesarean. Her experience was followed by postpartum depression, after which she chose not to seek further assistance from local services, preferring instead to return to her home country for treatment. Lianet's story challenges the professional narrative. Culture here is a tactic of resistance against an alienating biomedical system, not a limitation.

The experiences of our participants contested the stereotype that women withdrew from services as random acts of distrust. In many cases, they were reacting to systemic experiences of obstetrical violence and culturally alienating practices. Further insights come from practitioners' discussions about infant weaning. An obstetrician described Nigerian women as having a 'more relaxed' attitude towards motherhood, accusing them of 'forced weaning' by pushing nutritionally inadequate food onto their children. The generalization expanded when another worker spoke of 'them', meaning all African women, reinforcing stereotypes about food practices tied to poverty.

This stance reveals an underlying asymmetry: the assumption that professionals must teach migrant women the 'correct' methods of childcare (Schmoll 2022). The use of terms like 'forced' weaning not only judges migrant practices but also masks a broader failure to engage in genuine dialogue. Here again, evaluations were loaded with cultural prejudice, linking entire continents to problematic behaviours.

Listening to migrant women

Yet when migrant women themselves were asked about their experiences within the biomedical system, a different set of concerns surfaced. During a meeting with asylum-seeking women, they identified the imposition of contraceptives, blood tests and breastfeeding practices as major issues. Their testimonies pointed to a need for clearer communication, genuine listening and a culturally sensitive approach: a meeting between different systems of care rather than a top-down imposition of norms.

Some service providers recognize the relational asymmetries in their work. They want to understand and act differently, acknowledging that factors such as precarious life conditions, rather than 'cultural backwardness', often explain women's reluctance to follow medical advice. These responses indicate that we need to alter the way professionals understand their work and avoid assumptions when establishing caregiving relationships.

Within the broader context of the 'government of reproduction' (Mattalucci 2017), which operates through hierarchies of gender, race, class, culture and nationality, migrant women are often positioned as subaltern subjects. These hierarchies expose shortcomings and legitimize interference, urging women to adapt to dominant norms deemed 'better'. Yet some emerging discourses recognize migrant women's autonomy and agency within biomedical institutions. In this sense, a practitioner from a reception centre for asylum seekers affirmed:

> We have to be very careful, because who said that our way is always better? There are cases in which it is clearly better, because there are then problems that arise that are undeniable, but sometimes you just butt in and say: 'No, do this and that.' This is a violence.

It is precisely these forms of street-level bureaucrats' reflexivity and agency that can promote transformative processes enabling the repositioning of migrant mothers at the centre of practices aimed at supporting their reproductive health.

Attention should be given not only to regulatory coercion or overt health discrimination but also to the subtle institutional influences that shape women's experiences within the system.

What is needed is both a reconfiguration of service delivery and a reimagining of care itself: one that includes space and time for reflection, recognizes migrant women's subjectivities, respects their experiences and genuinely engages with their needs and desires.

Conclusion

As noted, Lianet's decision to return to Peru for treatment after her wishes during childbirth were ignored represented a sensible reaction against an oppressive system instead of defiance against her cultural background. Her story, like those of other women in our research, shows how reproductive health services in Verona often fail to listen. The problem is not that migrant women are culturally illegible. Institutional frameworks make certain needs and desires difficult to hear.

This failure stems from what Douglas (1986) calls the triumph of institutional thinking: its capacity to render itself invisible. Health and social services present themselves as neutral and universal while amplifying the visibility of the Other. Migrant women become objects of classification. Their choices are read through cultural perspectives that obscure the structural conditions shaping their lives: precarity, homelessness, fear.

Yet institutions are not monolithic. As we have seen with the case of the reception centre worker quoted above, some practitioners in our research recognized the asymmetries embedded in their work and sought to act differently. This awareness allows healthcare systems to challenge their practices that undermine migrant women's autonomy and agency in their care practices.

What is needed, finally, is both reconfigured service delivery and reimagined care: an approach that includes time for reflection, respects migrant women's experiences and treats their knowledge of their own bodies and needs as the foundation of medicine rather than an obstacle to it. ●

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