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Migration and Healthcare Accessibility

A Case Study in South Tyrol

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Preface

The present study gives attention to the highly relevant question of how health and social care organizations can give access to migrants who experience linguistic, organizational or cultural barriers to service access. Even if appropriate services are available, as in the city of Bolzano, access for the target group is not a given. Since the hospital of Bolzano, which has been the object of observation in this study, has low-threshold entry points for migrants, including those in irregular situations, to basic medical services and preventive initiatives in respect of anonymity, the above question may appear obsolete, at first sight.

However, there are barriers on both sides, on the part of patients and of service providers, which can hamper access and also interfere with treatment. This is particularly evident in the field of maternity services. The current yearbook on migration in South Tyrol (IDOS, 2024) shows a migrant share of 9.7% of which 51.7% are women. According to current data (Di Napoli, Ventura & Petrelli, 2024), migrant women on average not only have more children than locals, but they also access less services and have worse health outcomes as well as a higher occurrence of infant mortality. Therefore, in this sensitive context, services for women and especially maternity care are highly relevant. What is needed is accommodation, cultural understanding and communicative competences from service givers as well as trust from the users.

Franca Zadra in the present study shows a remarkable capability to approach the complex question of accessibility of health and social care to the migrant population in South Tyrol. She chooses a context-sensible strategy of participative and ethnological approaches in a multimethod case study, integrating all relevant stakeholders within the respective system. This required her understanding of the recent social and healthcare policy frame, which she outlines in this study, as well as an understanding of the responsibilities of different actors and sectors within the institution.

Her aim, however, was not only to come to a description of the situation but to initiate actively social innovation and institutional change through her research. This objective lead her to the combination of research, qualification and network building of the medical personnel involved by transgressing individual research approaches and creating interdisciplinary group settings. Zadra created an impressive database that included a stakeholder map, participative observation, fieldnotes, 62 semi-structured individual interviews, group interviews and iterative dialogues.

This comprehensive base gives this study an exemplary character for social work research for social change. Also, the participative debriefing of her study with the involved actors is in line with this understanding and research culture. It seems to be obvious that Zadra with her research setting favoured awareness building and reflexivity spaces among the involved actors. It fostered their cooperation and network building within the interdisciplinary health care team and supported processes of institutional innovation.

The study should be read by students and practitioners of social and healthcare services, by those who cultivate migration studies, as well as by responsible actors in social and healthcare policy.

Susanne Elsen

Introduction

This study is inspired by the belief – upheld by many national constitutions in Europe – that health is a fundamental human right, and therefore states should grant all their citizens access to healthcare services. There is a wide consensus on this idea. The debate arises around who is a citizen, therefore eligible to receive public services from a certain nation state, and what extent, type or standard of quality in healthcare services is the state in the obligation to provide. Policies on healthcare for migrants address the boundaries of such entitlement. The principle upheld by the Italian legislation states that public healthcare services should be universally available and accessible to all those present in national territory, regardless of ethnicity or legal status. Italian law is in this sense comparatively advanced in Europe, but policy restrictions in recent years have significantly reduced migrant protections, and there is a wide gap between entitlement to specific rights and effective access to the exercise of those rights. There are many reasons for improving accessibility of basic healthcare. Aside from social justice concerns, there is a legislative coherence which is demanded by fundamental rights principles in international and European law. There is an economic argument as well. The cost of restricting treatment to emergency interventions has been shown to be superior to the cost of universal access to care. There is also a medical ethos of universal access in healthcare professionals, who refuse to let themselves be reduced to a gatekeeper role.

However convenient, legal and just (or not) one might find universal access to healthcare, its achievement is easier said than done. Even in those countries which have healthcare policies based on the principle of universal access, as it is still the case of Italy, various structural and situational barriers limit the accessibility of healthcare services for different migrant groups, which is shown by the documented disparities in healthcare access in comparison to comparable local populations (Cernigliaro, 2024). This work does not attribute barriers to the shortcomings of persons left out, or in the organizations exclusively, but rather in the interaction between both. Research has shown time and again that barriers emerge in the interplay between the individual capabilities and the readiness of public spaces to include their most vulnerable users. This study aims to document the attempts of a healthcare organization to reach such readiness: its conditions of possibility, its mechanisms, the levels of agency involved, and the indicators of success or failure.

Albeit its proximity to a very charged political debate about migration, the core concern of this work is technical: How can healthcare institutions ensure accessibility for migrant patients, provided they find it necessary to try? Reasons supporting the value of investing on this problem are gathered. However, it isn't a political work centered on *why* healthcare institutions should be adapted to be able to include the needs and capabilities of migrants and other vulnerable patients, but rather a technical work on *how* this can be done. Therefore, the resulting knowledge of this work comes from the documentation of a network of medical professionals in a specific local context attempting to do so, along several years, learning and changing in response to their shared and varying outcomes. While a better documentation of barriers is needed, this study deals with answers to perceived barriers, from the perspective of practitioners, where the initiative appeared to be located. The hospital, a complex organization, was addressed as a structural context which facilitated or hampered such efforts.

This book is based on a doctoral dissertation at the Free University of Bozen-Bolzano (Zadra, 2020). The original case study has been entirely rewritten, updated, clarified and significantly reduced in length. This book also draws on articles published about partial outcomes of the original doctoral research (Zadra, 2021a, 2021b).

The first chapter frames the research problem in the transdisciplinary area of migration and health, its policy context, and main empirical evidence in current literature. The second chapter presents the methodology: the approach of social innovation, and the construction of a multimethod case study. The third presents practitioners' perspectives on barriers experienced by migrant patients. The fourth and fifth chapter describe the practices of accessibility implemented respectively in the clinic for migrants in irregular situations, and in maternity. A final chapter collects main takeaways, limitations and new questions for a future research agenda.

All shortcomings in this work are entirely my responsibility. However, its best aspects have been greatly enriched by the input of remarkable scholars, whose wisdom has profoundly shaped my theoretical and methodological approaches and whose examples have provided invaluable lessons in social engagement through research.

I am deeply grateful to the Free University of Bozen-Bolzano for supporting this research through a generous scholarship, opportunities for international research during my PhD, postdoctoral teaching and research engagements, and this publication. The University has also granted me the privilege of learning from outstanding scholars. My deepest gratitude goes to the coordinator of the program and my supervisor, the brilliant and innovative Prof. Dr. Susanne Elsen. She has introduced me to a transformative research culture, nurtured my professional growth, included me in fascinating research endeavors, and blessed me with a friendship that honors me deeply.

I have a debt of gratitude with outstanding European scholars in the social field, with whom I have discussed parts of this work. I am especially grateful to Walter Lorenz, whose reflective insights are a cornerstone of European social work. I have learned from remarkable immigration scholars such as Paolo Boccagni from the University of Trento, as well as Thomas Faist, who leads COMCAD at Bielefeld University. They have redefined migration studies from a transnational perspective, and their original insights continuously nurture this important field. I extend my gratitude to Belgian social scholars including Jan Blommaert from Tilburg University, and Rudi Roose, Ilse Derluyn, and Griet Roets from Ghent University. Their insights have been precious. My thanks also go to Eva Maria Hohnerlein and the scholars from the Max Planck Institute for Social Law and Social Policy, for the thought-provoking dialogue during my stay in München. I owe a special acknowledgment to Frank Moulaert from the University of Antwerp, whose introduction to the social innovation research approach left a profound imprint on this study. To all of them, and many others who shared moments of this journey, I offer my most heartfelt thanks.

Lastly, I must acknowledge the unwavering support of my family. I dedicate this work to my son, who brings immeasurable joy to my life every single day.

1. Exploring the Migration-Health Nexus

1.1 The Framework: Health as a Social Issue

In 1948, the World Health Organization (WHO) formulated its definition of health: “Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO, 1948). This definition recognizes the fact that health may not be reduced to its biophysical elements or even to the psychophysical dimension. It also includes the social situations, processes, and structures in which a person exists. These exert a powerful impact on health outcomes and health access. This section frames the issue of unequal access of migrants to healthcare in the broader context of the social determinants of health contributing to health inequities and postulates that the lens of intersectionality may contribute to a better understanding of the interplay between different factors of disadvantage.

1.1.1 The social determinants of health

The correlation between health outcomes and socioeconomic studies was first observed by social reformers on public health in the 19th century, such as Edwin Chadwick in England and Rudolf Virchow in Germany, linking poverty to high mortality rates. In the early 20th century, social medicine began examining how social conditions and economic disparities affected health, but it wasn’t until the mid-twentieth century that this link was systematically studied by epidemiology and medical sociology. The work of Samuel Preston (1975) focused on a cross-country quantitative analysis of the relation between life expectancy and GDP per capita, introducing a graphic known as the Preston Curve. It demonstrates that as a country’s income increases, its life expectancy also tends to rise—but with diminishing returns at higher income levels.

The curve (Figure 1) shows that for poorer countries, improvements in income are strongly correlated with improvements in life expectancy, often due to better access to healthcare, nutrition, and sanitation. In wealthier countries, which reach a certain income threshold, other factors—such as lifestyle, healthcare quality, and education—play a larger role, so further income growth has less impact. Over the decades, the Preston Curve has shifted

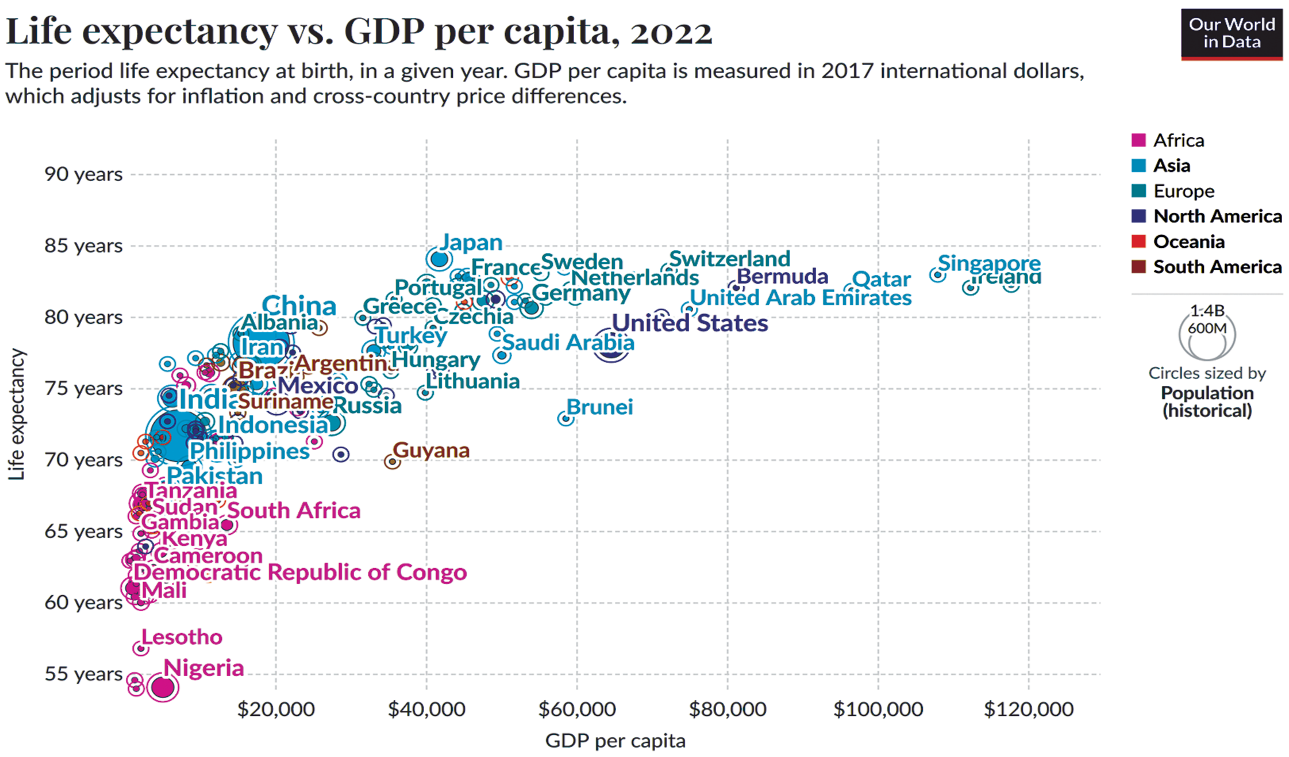

Figure 1 – The Preston Curve, 2022. Data source: UN, World Population Prospects (2024); World Bank (2023). Processed by Our World in Data ourworldindata.org/grapher/life-expectancy-un-vs-gdp-per-capita-wb. CC BY.

upward, showing a general improvement in life expectancy, usually attributed to global advancements in healthcare, technology, and education, which benefit people across income levels.

To gain a better understanding of the factors that affect health outcomes, the World Health Organization (WHO) in 2005 founded the Commission on the Social Determinants of Health (CSDH), "tasked to collect, collate, and synthesize global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity" (WHO Commission on the Social Determinants of Health [CSDH], 2008, p. vii). The CSDH has given visibility to the health equity movement among researchers in the 1990s, making the WHO "responsible for translating this theoretical interest into a global policy drive" (Ingleby, 2012, p. 332). Research on health inequality has grown exponentially, and studies regarding the health outcomes of disadvantaged populations have confirmed the correlation. For example, a study shows the contribution of inequality in the distribution of wealth to child mortality and malnutrition in India (Chalasani, 2012); in Italy, a study documents how even with a universal access system, income is a major factor related to healthcare access (Masseria & Giannoni, 2010; CENSIS, 2018; Petrelli et al., 2017).

The CSDH was chaired from its inception by Sir Michael Marmot, responsible for its report *Closing the Gap in a Generation* (CSDH, 2008), informally known as *The Marmot Report*. It analyzed worldwide empirical data to document the factors contributing to health inequalities between nations, subnational regions, and throughout the social gradient. The data illustrated not only the fact that the life expectancy of a child was highly dependent on which country he was born in but also on which socioeconomic position within that country. Within all countries, rich or poor, a socioeconomic gradient was affecting health outcomes: "Poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health" (CSDH, 2008, p. viii). The *gradient*, shown consistently between and within countries, depicted a multilayered stratification that went beyond the social imaginary of the extremely rich or extremely poor: "There is a striking social gradient in health and disease running from top to bottom of society. The social gradient has now been shown to be widespread across the world in countries at low, middle, and high income" (Marmot & Allen, 2014, p. 518).

Moreover, Marmot conceptualized the *status syndrome,* expanding the focus from income per capita to include education, employment, social status, access to healthcare, and environmental factors. He found that such factors collectively shape health outcomes and lead to health inequities within and between countries beyond what income alone can explain. While the Preston Curve is most applicable at the macro level, the analysis of the social determinants of health focuses on *how* elements such as housing, community, networks, stress levels, and working conditions affect health to identify more holistic policy recommendations.

The tendency is to associate those elements to their effect on socioeconomic status (SES), and link SES to health outcomes. However, as will be shown, other factors that cannot be expressed on a gradient may also contribute to differentiated health outcomes, and less quantifiable axes such as gender, ethnicity, religious beliefs, or legal status should not be pushed to the background.

1.1.2 Health inequities

The CSDH (2008), in the Marmot Report, defines health inequities as "avoidable systematic health differences" and relates them to "a host of socioeconomic and cultural factors, including income, ethnicity, gender, and rural/urban residency" (p. 94). Marmot and Allen (2014) argue that acting for health equity requires more than improving healthcare quality and access. The work to overcome health disparities must involve social contexts, and the *causes of the causes* of health disparities must be addressed. For this, he identifies six priority areas:

> quality of experiences in the early years, education and building personal and community resilience, good quality employment and working conditions, having sufficient income to lead a healthy life, healthy environments, and priority public health conditions, as smoking, alcohol and obesity. (Marmot & Allen, 2014, p. 518)

The review he chaired about health inequalities in the European context (WHO/Europe, 2013b) underlines that "health inequalities that are avoidable are unjust", offering different and complementary motivations:

> The review makes the moral case for action on social determinants of health -social injustice kills and causes unnecessary suffering. There is also a strong economic argument. The cost of health inequities to health services, lost productivity and lost government revenues is such that no society can afford inaction. Tackling inequities in the social determinants of health also brings other improvements in societal well-being, such as greater social cohesion, greater efforts for climate change mitigation and better education. (p. 3)

The review, then, calls for universal access to high-quality health services, to responses to socially determined harmful behavior and moreover, "the review recommendations extend further -to the causes of the causes: the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them" (WHO/Europe, 2013b, p. 1), following such calls with practical and focused recommendations that offer strategic guidance to European health systems and policymakers (see also Seeleman et al., 2015).

The mentioned social *causes of the causes* of health inequities are interrelated. A document of the Fundamental Rights Agency refers to such interrelation through the concept of *multiple discrimination,* concurring factors of disadvantage burdening vulnerable populations, mentioning ethnicity, age, sex, migration status, and ability as variables that might impact a person's capability to access healthcare services. When disadvantage elements pile up in the same persons or communities, they can face multiple or intersectional discrimination (FRAU, 2013). In the report, both concepts are used here as if they were synonyms.

However, the term multiple discrimination has faced criticism. Despite its use in European policy, the concept seems to imply that different factors are merely additive instead of reciprocally constitutive. Moreover, "to assume an unquestioned similarity of inequalities and to fail to address the structural level and to fuel the political competition between inequalities" (Verloo, 2006). In the next section, the social determinants of health will be considered not only as the accumulation but also the interaction between different factors of disadvantage. In this attempt, the intersectionality framework can prove to be a useful lens.

1.1.3 Intersectional factors of disadvantage

Since the early work of Marmot regarding the social determinants of health, it has become clear that there are many factors other than socioeconomic status that are weighing on health outcomes in disadvantaged populations. Social stratification, social closure, and social class have also been studied as determinants of mental health disparities (see also Muntaner et al., 2013), but so have race, nativity, ethnicity, and cultural influences (Brown et al., 2013). Gender has also been found to be a determinant of health. Women worldwide tend to have a higher life expectancy. However, higher morbidity among women has been documented and related to the social construction of gender roles (Phillips, 2005; Sen & Östlin, 2007; Garcia-Calvente et al., 2012).

The intersection of multiple factors of disadvantage is gaining attention in diversity and inequality studies (Crepaz et al. 2020), as they not only accumulate but interact with each other. The term *intersectionality* was coined by Kimberlé Crenshaw in the 1990s (Crenshaw, 1989, 1991) concerning the specific intersection of gender and race in women of color as generating new layers of exclusion. Intersectionality as a theoretical concept, particularly among feminist scholars, has since then generated significant attention throughout inequality studies (Dhamoon, 2011; Walby, Armstrong & Strid, 2012; Carbado et al., 2013). It renders visible the relation between different instances of collective disadvantage as they are shown to be mutually constitutive. Their interplay results in new ways of disempowerment, especially for the marginalized sectors within each category. The location of intersectionality studies in specific times and places may offer a contextualized view of exclusionary mechanisms, even if it is not conducive to global epidemiology. Yuval-Davies (2006) argues that even though “some social divisions, such as gender, stage in the life cycle, ethnicity, and class, tend to shape most people’s lives in most social locations” (p. 203), not all intersecting categories have the same effect, as “in specific historical situations and in relation to specific people there are some social divisions that are more important than others in constructing specific positionings” (p. 203).

Even if it has received some critical evaluations (e.g. Geerts & van der Tuin, 2013; Chang & McCristal Culp, 2002), or if the reception of the concept has sometimes been vague or misapplied as some scholars contend, (May, 2015; Nash, 2008; Walby, Armstrong & Strid, 2012), the intersectionality lens continues to evolve conceptually and methodologically (Cho et al., 2013). Since its inception, the theory has raised important analytical and methodological questions as to how inequalities should be documented through their multiple causes, in the face of social complexity and increasing diversity (Simien, 2007; Wilson, 2013).

Overall, the value of "intersectional thinking", the promising prospects of intersectionality as a framework for equality policy, and the need for the development of methodological tools to that effect has been affirmed (Hankivsky & Cormier, 2011, amongst others). The approach is gaining attention in migration studies (e.g. Però, 2014; Anthias, 2012). Its spread from the US to the European public sphere has been object of a study which considers the intersectionality approach "a way to move beyond the gap in literature between diversity and migration research on the one hand, and gender research on the other" (Mokre & Siim, 2012, p. 224).

Exception made for a few deserving attempts, (e.g. Cole, 2009, Bauer, 2014; Viruell-Fuentes, Miranda & Abdulrahim, 2012, amongst others), intersectionality theory has not yet been integrally and methodologically developed in health inequality research. However, there seems to be at present an awakening to the fruitfulness of the concept, as it is indeed spreading throughout the field, producing some noteworthy attempts to craft qualitative, quantitative and mixed methodologies which can account for the interplay of different facets of disadvantage in health outcomes (e.g. Gkiouleka et al., 2018; Bauer & Scheim, 2019; Gueta, 2017; Evans et al., 2018; Richman & Zucker, 2019; Ussher et al., 2017; Bastos et al., 2018).

Intersectionality theory can be particularly useful to untangle the complex problem of barriers to access to healthcare, in which multiple factors of disadvantage are not simply additional burdens but create specific and contextualized vulnerabilities, as in the conditions faced by unaccompanied minors seeking asylum, trafficked victims and undocumented migrants.

1.2 The Policy: Health as a Human Right

1.2.1 Who is a migrant?

A migrant is commonly understood as a person living in a country other than his country of origin. However, what this entails in different cases and how it is represented in the social imaginary can make it more complex to define and relative to the context in which this word is used. Kofman et al. (2000) explain "the United Nations recommends that a migrant is defined as a person who has moved to a country other than that of their usual residence and has been living in that country for more than one year" (p. 9). They observe that such definition changes significantly across different organizations, countries, and timelines, concerning a variety of factors, such as immigration history, policy, and demographics, seriously affecting processes of data collection despite the UN's efforts to foster data comparability (p. 10).

Ambrosini (2005/2011, p. 17), discusses the elements of the UN's definition of migrants, which includes: a) national border crossing, b) entering a country other than the country of birth, and c) lengthy stay, conventionally set around a year, observes that this definition does not consider internal migration, nor the migration patterns of seasonal workers, and does not come to terms with the complexities of juridical status. For instance, in many countries, the "immigrant" status seems to be hereditary, as the next generations are not granted citizenship, even if they were born in their country of residence and have never migrated. Ambrosini reflects on the fluidity of the concept in the context of its use, noticing that the concept of "immigrant" is usually ascribed a pejorative meaning by associating it with a limited residence and mobility permit and a situation of poverty, in contrast with welcomed affluent foreigners who are empowered by material resources to enjoy unrestricted freedom of movement (p. 18).

Migration studies conceptualize migration as a dynamic process. It is not merely the act of moving across borders but an ongoing process involving adaptation, negotiation of identities, and the transformation of social ties. Therefore, a "migrant" is not a static category, but a relational identity shaped by the social, economic, and cultural interaction in both the country of origin and the host country. In a rich research space, developed in more than a decade, Boccagni (2023, 2017a) explores how homemaking becomes a symbolic anchor, helping to define migrant identity amidst the challenges and opportunities of migration. Boccagni's work frames migrants as persons navigating the complexities of displacement, belonging, and homemaking, as they experience a transformation of "home" due to mobility, negotiating between past roots and current realities. Migrant identities are, thus, contextually renegotiated, and enacted throughout processes of displacement and replacement.

The agency of migrants in embedding and negotiating identities across homing processes does not operate in a void, but in specific socioeconomic, cultural and juridical contexts. The powerful determinant of juridical status weighs on the accessibility of material means of survival, such as labor or housing, and of symbolic belonging, for instance, through the ability to decode relevant linguistic and cultural cues.

Italian law distinguishes between a) migrants who are stable residents with long-term residence permits (MSR), b) asylum seekers (AS) in the process of petitioning for residence permits, and c) migrants in irregular situations (MIS), in Italian legislation called *stranieri temporaneamente presenti (STP),* which stands for "foreigners temporarily present" to refer to those who do not have a valid visa or permit to reside in the country, whatever the reason. In short, documented, seeking documents, or undocumented seems to be the first important distinction with concrete healthcare access ramifications.

The stratification of citizenship rights introduced by ever-changing immigration policies is more complex than that. Nash (2009) explains that there is a "proliferation of statuses produced out of the interplay of citizenship and human rights" and that "members of each group enjoy a different package of formal and substantive rights according to their situation as citizens or non-citizens, the way in which states administer human rights, and their access to material and moral resources within the state" (p. 1072). Moreover, she explains that processes of racialized scapegoating affect how human rights are interpreted and implemented, even where human rights law is well-established (p. 1080).

The problem of everchanging and complex definitions in migration-related categories is intrinsic to the study of migration phenomena. The complexity and diversity within as well as between groups is so wide that contemporary migration studies speak about the need to overcome the concept of the ethnic group as a unit of analysis (Glick Schiller & Caglar, 2011, 2013; Wimmer & Glick Schiller, 2002; van de Vivjer et al., 2015). Others have conceptualized the emergence of superdiversity as the complexification of migration-related diversity (see also Vertovec, 2007, 2012, 2020) underlining the need to consider not only ethnicities, as if they were homogeneous, but to intersect multiple diversity axes, as the multiplication of political and legal status, socioeconomic status, social and cultural worlds as well as religious and ethical principles, amongst others. The consequences of such complexity have been discussed by sociolinguistics such as Jan Blommaert (Blommaert, 2013; Blommaert et al., 2017) as well as anthropologists and sociologists, giving accounts of how new factors and axes of diversification come into play structuring relations and inequalities in multi-layered social fields.

Current diversification processes have been affected by many factors as the differences in legislation about who gets naturalized, multilingualism, technological advances in communication and mobility, as well as the socioeconomic disadvantage in which immigrants are overrepresented, amongst many others. Such processes of diversification are significantly affecting systems of public service delivery, such as public education, social services, or law enforcement. Phillimore has developed an important work documenting how diversity affects the healthcare sector changing the way services are configured, delivered, and used, as well as how different models of service provision in health make a difference in migrant trajectories and integration processes (Phillimore, 2011, 2012; Phillimore et al., 2016). Other experts in this field have contributed to this effort (Seeleman et al., 2015)

Specific migration flows are everchanging and hard to map, but migration is a global phenomenon. In the year 2020, marked by the global pandemic of Covid-19, international migrants in the world, defined as people living in a country other than their country of birth, were "estimated to be almost 281 million…, with nearly two thirds being labour migrants" (McAuliffe & Triandafyllidou, 2022, p. 2), constituting 3.6% of the global population. Moreover, "Europe is currently the largest destination for international migrants, with 87 million migrants (30.9% of the international migrant population)", just one million more than Asia. Considering the proportion of immigrants on total population, Europe is the third more dense area (11.6%), after

Oceania (22%) and Northern America (15.9%) (p. 24). The 2024 edition of the report refers to the same data.

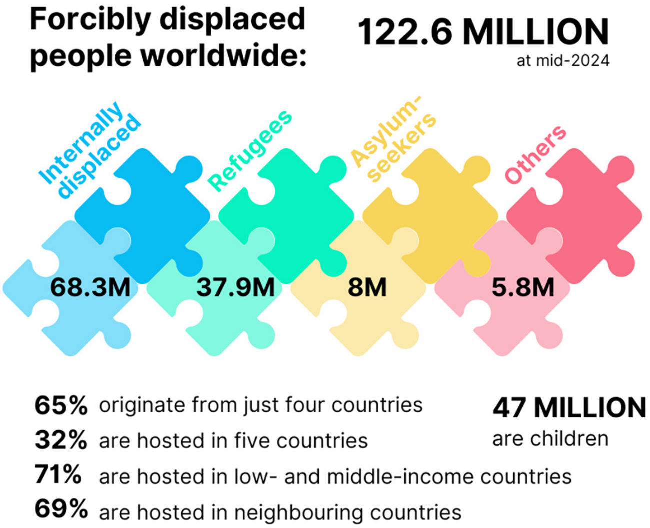

Figure 2 – Forcibly displaced people worldwide. Figure based on UNHCR's *Refugee population statistics database*, last updated 8 October 2024, https://www.unhcr.org/refugee-statistics.

With such numbers, the different policies of local societies about migrant populations are put to the test in many areas relevant to social cohesion, such as language, labor, education, housing, and more. Recent statistical data on immigration in Europe (Eurostat & European Migration Network, 2024, p. 8) shows that Italian count of third country nationals on January 1st, 2023 is 3,747,559, with a 6.4% share of the total population. Despite different perceptions, this is not a particularly high number, as twelve countries in Europe have a higher density of migrant population.

1.2.2 International policy on migration and health

It should be remembered in the first place that the problem area of migration and health is related to 15 Target Areas of the UN's Sustainable Development Goals agenda, which calls for leaving no one behind. On September 19th, 2016, the General Assembly of the United Nations adopted the New York Declaration for Refugees and Migrants, containing the commitment of all member states to protect the human rights of all migrants, regardless of status (United Nations, 2017, p. 1). The right to health has been internationally established in the Universal Declaration of Human Rights, Article 25, and in various other legally binding treaties[1], as the International Covenant on Economic, Social and Cultural Rights, Article 12, which states "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". It was later developed in other documents[2], explained by the World Health Organization in these terms:

> It includes the requirement that, within a country, health facilities, services and goods must be available in sufficient quantity, be accessible (including affordable) to everyone without discrimination, be culturally acceptable (e.g. respectful of medical ethics and sensitive to gender and culture) and be of good quality. The right to health also includes the underlying preconditions of health: an adequate supply of safe food, nutrition and housing, access to safe and drinkable water and adequate sanitation, safe and healthy working conditions, and access to health-related education and information. Moreover, the

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[1] E.g. International Convention on the Elimination of all Forms of Racial Discrimination, Article 5 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial); Convention on the Rights of the Child, Article 12 (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child); International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, Articles 28, 43 and 45 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-protection-rights-all-migrant-workers); as well as Convention on the Rights of Persons with Disabilities, Article 25 (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities).

[2] See the CESCR General Commitment n. 14 in relation to Article 12 on the right to the highest attainable standard of health of the Covenant, E/C.12/2000/4, 11 August 2000 (https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf); as well as the CERD General Recommendation on discrimination against non-citizens, 1 October 2004 (CERD/C/64/Misc.11/rev.3) (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities).

> right to health embraces a wide variety of socio-economic factors indispensable to the achievement of health. It contains freedoms, such as the right to be free from non-consensual medical treatment and to be free from forced sterilization and discrimination, as well as entitlements, such as the right to a system of health protection. Another important aspect is the participation of the population in all health-related decision-making at the community, national and international levels, including migrants. (WHO, 2010, p. 47)

The CESCR general commitment n. 14 on the right to health details the legal obligations of states:

> In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. (CESCR, General Commitment 14, Art. 34)

The World Health Organization (WHO) promotes a fundamental rights and social justice approach to health policies, especially for addressing the social determinants of health (CSDH, 2008; Stronks et al., 2016). It addresses the lack of uniformity in national and regional policies, particularly in how entitlements of migrants to healthcare services are structured between and within member states: "differences exist between countries in access requirements to health services and the level of implementation of regionally agreed strategies, recommendations and policies, particularly for migrants in an irregular situation" (WHO Regional Office for Europe [WHO/Europe] 2018, p. ix). WHO calls for cooperation in contrasting health inequalities (WHO/Europe, 2016) and creating migrant-friendly healthcare services (WHO/Europe, 2010, 2018). The impact that national policies on migration and health have on access to services and health outcomes has been proven important. In its 2013 *Review of Social Determinants of Health*, the WHO argues that inclusive policies are associated with a reduction of health risks, for example, on newborns:

> Recent systematic reviews suggest that many European migrant groups have poorer self-reported health than the majority population. One on the relationship between pregnancy outcomes among immigrant women and the host countries' integration policies showed that immigrant women had a clear disadvantage for all the outcomes considered: risks were 43% higher for low birth weight, 24% for preterm delivery, 50% for perinatal mortality and 61% for congenital malformations. These risks were clearly and significantly reduced in countries with strong integration policies. (WHO/Europe, 2013b, p. 44)

The analysis includes policy provisions that limit the level of service delivery, which interplay with other factors, limiting early access to healthcare:

> studies in the Netherlands and the United Kingdom have pointed to the increased contribution of deaths in vulnerable immigrant or ethnic groups to current overall levels of maternal mortality. Differences in maternal mortality are related to the level of service provision, gender norms and values and other social determinants that prevent some women from accessing the health services they need, resulting in delays in seeking appropriate medical care for an obstetric emergency, reaching an appropriate facility and receiving adequate care when a facility is accessed. (WHO/Europe, 2013b, p. 64)

The most exposed seem to be migrants in irregular situations. The restrictive policies of several European countries interplay particularly with socioeconomic factors in excluding those who don't have many alternatives: "Undocumented migrants face the greatest problems in accessing healthcare services and are expected to cover the full costs of their medical treatment in many European countries." (Rechel et al., 2013, p. 1235).

The European Union, which conceives protection of human rights to be an essential mission of its democratic institutions, has in place legal provisions against discrimination and racism, has taken steps to address and reduce healthcare inequalities (European Commission, 2009), and has funded projects as EUGATE and EQUI-HEALTH (European Commission, 2014) or SH-CAPAC, EUR-HUMAN and the CARE PROJECT (European Commission, 2018). Especially towards forced migrants seeking refuge, the UN Refugee Convention mentions in Article 24 "the right to health, within the issue of labor legislation and social security" (UNHCR, 2010, p. 25). However, individual states in the European Union have seen the evolution of citizenship policies towards a "nested membership" (Faist et al., 2016, p. 104) at multiple levels, and transnational pressures by the European Union, which have an impact on the articulation of social rights, by influencing national legislations in issues such as health and occupational safety, as well as labor market mobility within the EU borders, are not able to make a dent in naturalization policies (Faist et al., 2016, p. 105), from which rights disparities follow. There is a high heterogeneity between national migration policies:

> European institutions have achieved greater results in coordinating security policies or border controls than in the field of policies for migrants. Aspects such as naturalisation policies, family reunifications, voting rights, are treated in very different ways in the European Union. (Ambrosini, 2016, p. 113)

That is the case in healthcare policy as well. Uneven healthcare policies for migrants throughout Europe manifest a tension between the question of principle, in recognizing health (and essential healthcare) as a human right, and the pragmatic question on the extent of the services that governments should guarantee, considering the available resources, and to whom. The concept of advanced welfare states and the negotiated boundaries of their social protections (see also Hogsbro & Shaw, 2017) does certainly impact the arena within which the topic of migration and health is discussed. Fraser observes that in a globalized and transnational public sphere, the articulation of human rights and welfare provisions into the legislation of national and regional law entails a complex process of deliberation (see also Fraser, 2007; Fraser & Nash, 2014), in which immigrants without citizenship are not entitled to participate even though their rights are affected by the discussed measures.

The stratification of the right to health in European national and regional legislations is particularly visible in healthcare provisions for MIS. European legislation presents variable, conditional, or absent health service entitlements for this group. The Migrant Integration Policy Index (MIPEX) offers an overview of the uneven provisions throughout Europe, evaluating comparatively European migrant healthcare integration policies in the following areas: healthcare entitlements, healthcare accessibility, responsive services and policies to promote change (Solano & Huddleston, 2020).

Data collected by MIPEX on national policies includes various aspects of service provision, as discretion obstacles to claim entitlement, obligation of reporting or sanctions for serving migrants in irregular situations, the use of cultural mediators and interpreting services, information policies, amongst others. The overall appraisal of MIPEX on European healthcare policies reads:

> On one end, health systems are usually more "migrant-friendly" in countries with a strong commitment to equal rights and opportunities. Policies are at least slightly favourable in most English-speaking countries (NZ, US, AU, UK), the Nordics (NO, SE, FI) and major regions of destination in CH, IT and AT. On the other end, health systems are rarely inclusive or responsive in countries with restrictive integration policies, such as in most of Central and Southeast Europe. … Where numbers of migrants are very low (BH, RO, BG, JP, PL, KR, SK) little or nothing may be done to adapt service delivery to their needs. Austerity measures also play a major role (GR, PT, ES). Targeted migrant health policies are usually stronger and services more responsive in countries with greater wealth (GDP), more immigrants and tax-based as opposed to insurance-based health systems. (Huddleston et al., 2015)

The grave consequences of gaps in entitlement to healthcare for migrating people has been empirically documented, as is the fact that austerity measures play a significant role on restricting healthcare access. A study documenting the negative impact of economic crises on welfare provision for migrants in southern European countries shows that "the first services to face cuts or be discontinued altogether were those that specifically related to migrant health" (Kentikelenis, 2018, p. 61. See also, Kentikelenis et al., 2016). Populist political discourses present good welfare entitlements for migrants as a pull factor, to justify cutting service costs for those who do not vote and cannot talk back. The use of welfare policies as tools to restrict social protections for migrants has been described by Thomas Faist (1994) as defensive welfare chauvinism, stating "processes of ethnicization of politics are characterized by constructing and mobilizing boundaries against selected groups of immigrants and/or ethnic and racial minorities" (p. 454). Jenny Phillimore (2015) has applied the concept to healthcare policy:

> Restrictionalism, also labelled welfare chauvinism, emerged from political concern about the availability of benefits acting as an incentive and attracting migrants ... Restrictionalism is said to have culminated in poor welfare outcomes for migrants and immigrants experiencing high levels of unemployment, poor housing conditions, low levels of educational attainment and poor health outcomes as exclusion has become tinged by ethnification. (pp. 247–248)

Far from diminishing immigration flows, welfare chauvinism has had the effect of creating barriers in migrant's access to services and locating healthcare professionals in the position of having to face needs they are disempowered to address. Systems face "the increasing politicisation of migration and renewed pressures to reduce welfare provision for new migrants, and to move away from multicultural provision generally" (Grzymala-Kazlowska & Phillimore, 2017). In fact, a comprehensive policy study documents that "in 2010, emergency care was effectively inaccessible to undocumented migrants in nine of the 27 EU countries and access to health services beyond emergency care (e.g. primary and secondary care) was offered to undocumented migrants in only five EU Member States (the Netherlands, France, Italy, Portugal, and Spain)" (Rechel et al., 2013, p. 1240). In addition, many European nations charge undocumented migrants the full cost of treatments (p. 1240). Health rights are particularly important for migrant wellbeing in the place of residence, as they enable individuals to protect the physical resources, which are essential for a positive outcome in migration trajectories. Tognetti Bordogna has argued that health policies toward migrating people "contribute to structure social relations and favor their inclusion in the context of arrival" (Tognetti Bordogna, 2012, p. 111). She also points out that health is an essential form of capital migrants mobilize to accomplish life goals and locate themselves in the labor market, therefore health policies should also consider the immigrant population settling in their territories of reference. In addition to social justice arguments, it is a sound investment for local governments to keep their immigrant population healthy, self-sufficient, and productive. To this issue, accessible healthcare services make a difference.

Being health a human right, policies restricting healthcare access for its less protected inhabitants stand in contradiction with the European legal framework and constitute a slippery slope with a dangerous domino effect.

Studies on migrant health have documented the various ways in which the lack of entitlements for migrants in irregular situations affects their physical and psychological well-being. Restrictionalist policies aggravate chronic visa stress: the negative effects on the health of the undocumented. A study on migration and health in the United States (Jasso, 2013) has shown that

> health deteriorates due to the hardships of the visa process, hardships which are intensified if the migrant goes through the visa process after moving to the destination country, but then improves, as visa stress and migration stress end, migrant energy exerts a positive effect on health, and the migrant learns how to navigate the destination country's health environment, mitigating its harms and extracting its benefits. But chronic visa stress -as among the unauthorized- may prevent health improvement, even if migration stress ends and even if the migrant masters the destination country's health environment.
> (p. 378)

Universal access healthcare legislations might contrast entitlement insecurity and alleviate chronic visa stress, which promotes migrant energy to actively integrate in the host society and contribute to its economy instead of aggravating health conditions and becoming dependent on social protections. Having access to healthcare regardless of status would make a critical difference for migrants attempting to make a living in host societies, as well as alleviate healthcare costs. Solid arguments have been made in favor of implementing universal access policies, as well as special provisions for most vulnerable groups as newborn and trafficked persons. Public health experts in a report on behalf of the European Commission (EC) and the International Organization for Migration (IOM) (Ingleby & Petrova-Benedict, 2016), argue that healthcare entitlements do not constitute significant pull-factors for migration, therefore "the firm conviction of many politicians and members of the public that good entitlements to health services encourage irregular migration needs to be equally firmly challenged" (p. 38). The research states that "providing only emergency care makes no sense in terms of public health considerations and cost-efficiency. It ignores half a century of global experience concerning the importance of prevention, primary care, early intervention, good medical records and continuity of care" (pp. 18–19). Therefore, the report recommends universal access policies by appealing to international juridical frameworks, public health principles as well as economic arguments. About the latter, the mentioned report states that "governments should take into consideration the increasing amount of evidence that restricting access to primary care in fact costs more money than it saves" (p. 5).

Evidence is being gathered on the cost-effectiveness of granting universal access to healthcare rather than stratifying access or reducing it for vulnerable populations to emergency interventions. The European Union Agency for Fundamental Rights [FRA] reaches the same conclusion in the report *Cost of exclusion from healthcare. The case of migrants in an irregular situation* (FRA, 2015). Applying a model to compare the costs of granting or denying access to undocumented migrants in the case of hypertension and prenatal care, the study gathers clinical research data from Germany, Greece, and Sweden. The FRA report concludes: "the results of testing the economic model are a conservative but powerful indication that governments would save money by providing access to primary healthcare to migrants in an irregular situation in the case of hypertension and prenatal care" (p. 34). This conclusion calculates direct healthcare costs only, without estimating the costs of bureaucratic gatekeeping or the weighty costs that lay on the individual and society when critical conditions arise. The report suggests policies that protect healthcare access for the undocumented:

> Reporting of IMS [undocumented migrants] by health workers or service provider organizations to police or immigration authorities should be explicitly prohibited. This prohibition should be strictly enforced, and IMS should be given explicit reassurance that such reporting will not take place. (Ingleby & Petrova-Benedict, 2016, p. 5)

The FRA report also proposes policy directives to "protect the health-related rights of particularly vulnerable groups such as children, pregnant women and trafficked persons, regardless of whether such persons are residing regularly in the country" (p. 5). This recommendation brings to the fore the issue of specific groups of migrants facing complex barriers in accessing healthcare services, which FRA has address in its report on Inequalities regarding access and quality of healthcare (FRA, 2013).

Policy should address more explicitly the issue of barriers in access to healthcare. IOM published a comprehensive overview of international law about migration and the right to health (Pace, 2009), and in a Background Paper (Pace & Shapiro, 2009), IOM documented the following overall appraisal of the situation regarding migration and health in Europe:

> The right to health includes the right to the underlying preconditions of health as well as the right to healthcare. The right to health also contemplates health facilities, goods and services that are available, accessible, acceptable and of good quality. The current European legal framework governing the right to health for migrating people fails to address all of these facets of the right to health. While concentrating on ensuring that migrating people are de jure entitled to health care, the legal framework fails to create provisions designed to alleviate de facto barriers that inhibit the ability of migrating people to receive health care. (Pace & Shapiro, 2009, p. 13)

It cannot be said that policies have substantially changed since then. Questions of entitlement and questions of accessibility are even more distant in the Italian context, as the next sections will discuss.

1.2.3 Italian policy on migration and health

The right to health is sanctioned at the highest national level, by the Italian Constitution, which in Article 32 establishes that “the Republic protects health as a fundamental individual right and collective interest, and grants free healthcare to the indigent”, in the respect of persons and their free will. The Italian government has developed a legal framework that grants universal access to medical care to all those present in the territory. The main juridical frame for healthcare access of immigrants is Law n. 40/1998 (Legge n. 40/1998), which states in Article 32 the parity of rights and duties with regards to healthcare between Italian citizens and migrants residing legally in the country, equally required to register to the National Public Healthcare System. It differentiates immigrants from temporary visitors as tourists and students, who are to acquire insurance. In Article 33, the law establishes healthcare provisions for foreigners who are not legally residing in the country. Comma 3 establishes explicitly that the state ensures to migrants in irregular situations all “urgent or essential” services, even if continuous, for illness or injury, and including preventive medicine programs. Special attention is to be reserved to maternity services, health of minors, vaccinations, international prophylaxis as well as infectious diseases. Moreover, these services are to be granted free of charge to the individual in case of economic indigence and with a prohibition to health workers and institutions to report them to the authorities.

It has been noted that the use of such adjectives as *urgent* and *essential* leaves the burden of interpretation to individual doctors. This is a feature of legal entitlement of migrants in several countries. Ingleby & Petrova-Benedict document the barrier-generating effect of

> the widespread use of adjectives such as “emergency”, “urgent”, “essential”, “acute” (etc.) to describe the health problems for which help may be given, and the fact that administrative discretion is so frequently involved. … Health care for IMs is dominated by the concept of “emergency”, while criteria are elastic (often to the point of often being totally unpredictable).
> (Ingleby & Petrova-Benedict, 2016, p. 18)

In Italy, further clarification of these terms has been offered in a circular by the Ministry of Health (Ministero della Sanità, 2000), which makes it explicit how health workers should interpret the *urgent or essential* treatments available to migrants in irregular situations. *Urgent* treatments are defined as those whose postponement would cause danger or harm to the patient’s health. *Essential* treatments are defined as those healthcare interventions, diagnostic or therapeutic, related to pathologies not dangerous in the short term but which in the long term could determine a greater damage or risk (complications, chronic conditions, or deterioration) those whose postponement would cause danger or harm to the patient’s health. This binding document sets very wide and comprehensive margins for medical practitioners in the establishment of what constitutes urgent or essential care. Virtually all European countries offer migrants in irregular situations urgent treatments, but very few have extended coverage to this range of essential treatments. This piece of legislation alone contains the most progressive, inclusive, and innovative element of healthcare policy for migrants in Europe.

Nonetheless, in the general picture of European healthcare policies for migrants, and particularly regarding pathways for accessing services, the study finds Italian policy comparatively to be on a very good standing. In relation to access and quality of healthcare services offered to migrants in irregular situations, the report states that "in Europe, only Switzerland, Italy, Spain, Belgium, Sweden, and the Netherlands offer reasonably adequate health services to IMs" (Ingleby & Petrova-Benedict, 2016, p. 20).

Experts often see the inclusive Italian legal framework for migrant health as an example to be followed, as pioneering effective measures in European and global contexts. One of the founders of the Italian Society for Migration Medicine (Società Italiana di Medicina delle Migrazioni - SIMM), Salvatore Geraci, who for decades has researched and promoted inclusive healthcare policies towards migrants, often states that Italy has been the first nation in Europe to have an integrated, adequate, and farsighted system for healthcare provision to migrants in its law, which has protected public health and cost containment. Members of the SIMM historic leadership praises especially:

> two major areas: 1) the complete equality of rights and obligations, regarding both health and rights to health care, between Italian citizens and foreigners legally present (with stay permit), with complete health care cover from the public health system; and 2) the broad possibility of health protection and health assistance also for undocumented immigrants, especially for women and children, and in relation to infectious diseases. (Marceca et al., 2012, p. 4)

However good the policies, according to Geraci[3], actual accessibility in healthcare for migrant groups has been constructed throughout the years at great cost. Significant steps forward in legislation have followed migrant deaths caused by restrictions in healthcare policies. In those cases, tragedy caused mobilization, and the gaps in the system which costed lives were filled. Inclusive legislation was built on migrants' sacrifice. Italian legislation on migration and health is not without flaws, and it is not immune to xenophobic pressures, and "pathogenic choices" (Geraci & Bodini, 2011, p. 133). In the quoted article the authors narrate the role played by SIMM as a network of networks

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[3] Presentation at the Convention "Migration and Medicine" (Bolzano, 05.04.2019).

lobbying favorable legislation for migrant health, against proposals of restrictive norms. For instance, the legislative proposal of a "security package" in 2009, included two amendments which would remove the prohibition of reporting undocumented immigrants receiving medical care to the authorities. Despite the protests of the medical profession and civil society, one of those amendments was approved in February, and on the 17th of March, a massive mobilization by SIMM and other medical and civic networks protested in 20 Italian cities against such measure, as inacceptable, unconstitutional and against medical ethics, under the slogan "*noi non segnaliamo*" [we shall not report]. They were ultimately successful, as the prohibition of reporting undocumented status to authorities was restored in April. However, during its short life, this amendment, even if not yet applicable, produced the effect of significantly diminishing the access in low threshold clinics for undocumented migrants, due to fear of expulsion.

This and other restrictive attempts, as the recent Law n. 132/2018 (Legge n. 132/20158), which restricts humanitarian rights and protections to asylum seekers[4], show us the vulnerability of Italy's generous healthcare legislation.

1.2.4 Between entitlement and assertability of rights

Even if it has been said to provide the most advanced legal framework in Europe, its problems arise in governance, for different reasons. Firstly, Italian law, despite granting ample rights, does so more from an enabling than from a providing approach. It fails to create provisions to ensure accessible services of good quality for those who are entitled. As Tognetti Bordogna (2012) has noted

> the legislator was mainly concerned with defining entry procedures, border controls and regulation of the immigrant's labor market, while it took for granted access to health services for the immigrant, underestimating that health capital is a fundamental element to be able to play the migrant role.
> (p. 112)

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[4] In fact, this law has been signaled by the European Union Agency for Fundamental Rights as one of the "emerging key fundamental rights concerns" (FRA, 2019).

Secondly, the Ministry of Health and the Ministry of the Interior intervene on the same matter often having a different knowledge base and conflicting priorities. Thirdly, local policies can develop in different directions than national ones. Ambrosini (2013) explains how local policies, often studied on their positive impact on integration, can also be used for the exclusion of migrants from social benefits or to limit investment on their behalf. In the specific case of South Tyrol, a report monitoring the situation of migrants has documented instances in which local authorities have been called out by the Italian Council for Refugees on violations of national and European policy (Associazione per gli studi giuridici sull'immigrazione [ASGI] et al., 2017, p. 89). This ambivalence in the process of immigrant inclusion has been flagged in the study of citizenship rights in relation to migration (Boccagni & Kivisto, 2019), as the interplay of juridical status and effective access to citizenship rights stratifies their entitlement and assertability (Nash, 2009). Regarding health policy, the process of devolution of competencies (between which many aspects of healthcare provision) to the authority of Regions and Autonomous Provinces has taken place since 2001. This process of administrative and political decentralization has led to growing regional inequalities in healthcare delivery, intersecting educational and socioeconomic factors to create unequal outcomes, that have been studied as a "map of mortality" in Italy (Petrelli & Frova, 2019).

The result is that the generous legal national framework is not homogeneously applied in the country, but autonomously regulated by local authorities, creating location-specific entitlements and organizational arrangements (Perna, 2017; Tognetti Bordogna, 2012, 2016), so that "the topic "health and immigration" seems ambiguously suspended between the "exclusive" legislation of the State and the "competing" legislation of the autonomous Regions and Provinces" (Marceca et al., 2012, p. 4). Apart from conflicting instances of regulation, the lack of common knowledge base seems to be a noteworthy problem, as well as a lack of political investment. As Dauvrin et al. (2012) have pointed out, a significant lack of implementation commitment can also hamper the application of existing knowledge for the reduction of health inequalities.

The mechanisms and consequences of this uneven situation have been observed in recent studies located in the northwest of Italy, which conclude that the access of undocumented migrants to healthcare services is not generally granted, as it varies in its application from one location to another, from one healthcare organization to another, and sometimes even from one practitioner to another. Ambrosini has observed how the hardened policies towards irregular migrants have made it easier to resort to civil society organizations for primary medical care (Ambrosini, 2015). Perna (2016, 2017) has documented how the criminalization of undocumented status in political discourse and public opinion has had an impact on the interpretation and conditional application of healthcare allowances with outcomes of debated entitlement to services, circulating discourses of diversified deservingness and justification of discriminatory practices (Huschke, 2014; Willen, 2012). Moreover, at the national level, comprehensive Italian studies (Petrelli et al., 2017; Tognetti Bordogna & Rossi, 2016; Bruni et al., 2007; Hoxha, 2015) at different scales and with different instruments have documented the presence of significant barriers faced by migrants in general, but particularly undocumented migrants to access healthcare services, despite policy entitlements, both in hospitalized settings and outpatient services (e.g. de Waure et al., 2015; Silvestrini, 2013; Tognetti Bordogna, 2012). For instance, recent studies in Italy (Cernigliaro, 2024) and systematic reviews of international studies (Pérez-Sánchez et al., 2024; Rosato et al., 2023) document women's barriers to accessing sexual and reproductive health.

Attempts to contrast the regional differences have been made by proposing a revision of essential standards of care[5], through an agreement between the central state and the regions, which set standards and specific norms regarding healthcare services throughout the national territory (Conferenza Stato-Regioni [CSR], 2012). It includes vital principles expressed in norms (e.g. there are no "second class" minors), translated into specific indicators, (e.g. all immigrant minors have the same right as locals to choose a pediatrician). Making sure that all minors are registered in the healthcare service is an essential milestone that hasn't yet been achieved. Twelve years later, some regional authorities have not yet ratified the Agreement.

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[5] In Italy known as LEA: *livelli essenziali di assistenza*.

1.3 The Evidence: Health in Migration Trajectories

1.3.1 Migration & health: A transnational and transdisciplinary field

Studying migration and health without considering the transnational implications is not doing justice to the field. Migrant networks, unlike healthcare systems, are borderless. Despite healthcare services being normed, organized and delivered at national[6] and regional levels, which makes for a sedentary bias in healthcare data collection, documentation of international heath practices is increasing. Transnational flows of medical resources and care practices are mobilized and combined by people on the move, to address their health needs throughout the life course. Healthcare services are not a pull factor for migration. However, on occasion, they are contributing factors for temporary cross-border mobility, aimed at satisfying healthcare needs or obtaining high-quality healthcare treatment (Bochaton, 2014). Whittaker, Manderson and Cartwright (2010) describe a growing medical travel industry with implications for the health systems of both sending and receiving countries and the handling of health resources as a commodity rather than a right and a global public good. The push for transnational healthcare services has the potential to strongly affect accessibility levels by contributing to enhancing (or contrasting) inequalities. Between a profit-driven international healthcare market rapidly growing for fee-paying patients regardless of citizenship status and the circuit of medical professionals providing emergency care and interventions in resource-poor settings, the globalization of healthcare seems on the rise. In this increasingly transnational space of healthcare resources, migrants combine strategies to seek responses to their health needs, depending on their positions, capabilities, and networks. The article "If I get ill, it's onto the plane, and off to Poland" documents the transnational use of healthcare services by Polish migrants in London (Osipovič, 2013), documenting the "ubiquitous transnational health care-seeking practices" that Polish migrants enact, in a combination of strategies such as "avoiding contact with all health-

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[6] Obviously, this does not intend to question nation-level research on migration and health, not only with regards to statistical information, but qualitative interpretation as well. As a showcase of the value of such studies, see Portes & Fernández-Kelly, 2009. However, for complexities in data collection regarding migration and health in Italy, see Terraneo & Tognetti Bordogna (2018).

care services, self-medication, utilizing Polish private doctors in London, and accessing public health services in Poland and London" (p. 98). Within "majority-minority" cities, a (partially declared) market of worldwide traditional remedies and health resources functions is developing in parallel to the official system of public healthcare.

The issue of migration and health not only transcends national boundaries, but it transcends disciplinary boundaries as well. The problem area of migration and health is gaining priority and evolving in the various arenas of political discourse, policy implementation, medical professions, and academic debates. Within academia, several disciplines have approached the intersection between migration and health. It has been a significant topic for epidemiological studies and public health scholarship; migration studies approach it as an aspect of the migration and incorporation process; medical sociology has established correlations between health processes and outcomes with ethnicity, length of stay, and socio-economic status of migrant groups; social law and political studies treat it as a human rights concern which combines the effects of migration policy and health policy; organizational anthropology observes the interplay of different cultural frames in relations occurring within healthcare settings. All those facets constitute this problem area, but they have not yet been significantly connected, as this would require shaping an epistemological common ground across disciplinary boundaries. Perna (2016, pp. 382–383) has rightly observed that disciplinary approaches are inadequate to study a naturally boundless phenomenon as migration, and only a multiple and interdisciplinary approach can account for the complexity of the increasingly relevant migration-health nexus.

Going a step further, the field could be widened beyond the academic world: transdisciplinary research has the capability to include those directly involved in the issue, as patients or practitioners, in the process of knowledge production. New modes of transdisciplinary knowledge (Nowotny et al., 2003; Moulaert et al., 2017; Nowotny, 2003) can contribute to this complex field, enabling actors to create more connected, contextualized, and impactful knowledge and practice.

Policies related to migration and health are grounded in different definitions of migrants, generating blind spots in data collection, and generating unequal visibility: "definitional issues often have a specific impact on women migrants. Data collection focuses on the head of the household, which is implicitly assumed to be male. Female-headed households are often neglected" (p. 13). Epidemiological studies of migration find themselves dealing with a heterogeneous, transnational, and mobile target population. The growing complexity of ethnic categorization during data collection in surveys, and the impact of the political discourse in their construction has been increasingly noted (Prewitt, 2012; Aspinall, 2012, 1997, 2003). In this context, acquiring reliable and comparable information is a great challenge. In epidemiological studies, different definitions have been used, combining factors as nation of birth, nation of citizenship, declared mother tongue, ethnic group categorization, nationality of parents, time of residence, forced or chosen migration, refugee status, among others.

Rendering comparable data with such heterogeneous variables is a challenge, and more so when regarding undocumented migrants, mostly unreported in healthcare systems.

Mobility-related barriers may affect additional groups, such as naturalized citizens, tourists, persons not fluent in local languages, or cross-border seasonal workers. Health practitioners themselves construct definitions and taxonomies of migrants in their experience, and they deploy such categories in the context of healthcare access processes. Some differences are normalized and become invisible, while others are accentuated, and assigned meanings that may hamper service delivery.

1.3.2 Migration and health outcomes

Epidemiologists concur in stating that migrant populations are much healthier than their equals in host societies upon arrival, which has been called the *healthy migrant effect*. However, studies show that their health deteriorates in correspondence to their length of stay in the country of arrival (see also Petrelli et al., 2017; Lassetter & Callister, 2009). These empirical findings have constituted a counter-narrative to the prevailing social imaginary regarding migration. Questions arise on why migrants are healthier, coming from disadvantaged countries, or why their health deteriorates once they reach a country seen as a safe harbor. Epidemiology has explored these issues through the available data, offering the concepts and hypothesis that are graphically gathered in the following Figure 3.

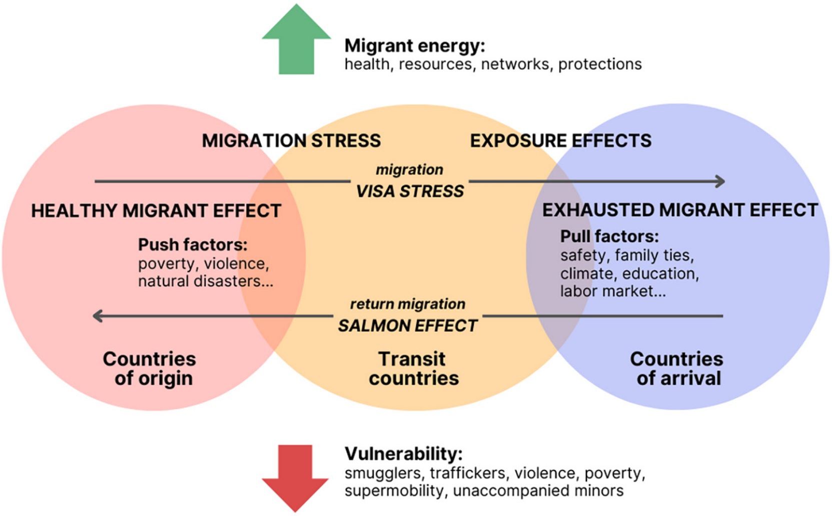

Figure 3 – Key epidemiological concepts on the impact of migration processes on health outcomes

The healthy migrant effect is explained by the process of selection at the point of origin. Depending on a variety of factors, often, the young, resourceful, and healthy members of a family attempt migration. However, this advantage does not last because of the *exhausted migrant effect*. It has been documented that the longer migrants stay in host countries, the more their health tends to deteriorate, especially when positioned in lower social strata and experiencing *exposure effects*. For instance, poor conditions of labor and housing, and barriers to accessing public services or social protections. It can also be influenced by the *salmon bias effect*, by which immigrants tend to return to the country of origin when aging or ill, to benefit from the support of enlarged family and social networks. This may be true for certain groups, but as a phenomenon, it has been disconfirmed by a Danish study (Norredam et al., 2015). These concepts are consistently used throughout the literature. A recent overview offered by Melissa Siegel (2020) explains effectively the progressive loss of the healthy immigrant advantage from the first to the second generation of immigrants:

> On many measures, first-generation migrants are often healthier than natives in the country of destination, but this effect seems to diminish as migrants

> increase their duration of stay in the destination country. However, and this advantage is usually not present in the second generation who were born and usually grow up in the country of destination. Migrants who stay in the host country for extended periods of time are subject to several environmental/socio-economic and behavioural aspects that may impact their health outcomes. Environmental and socio-economics aspects include poverty, housing conditions, and access to care. Behavioural factors include changes to diet and increased use of tobacco, alcohol, and drugs, as well as less physical activity. (Siegel 2020, p. 223)

Jasso offers an overview, stating that "two questions dominate research on migration and health: the health selection question, which seeks to learn the direction of selection on health across different migration streams; and the health change question, which seeks to learn whether health improves or deteriorates in the destination country" (Jasso, 2013, p. 366). About health change, three sources of health effects are identified in the study: visa stress, related to difficulties experienced before migration, influencing its motives and trajectories; migration stress, related to difficulties experienced during migration and the settling period, and exposure effects of the environment, as work and living conditions in the country of arrival (Jasso, 2013, p. 368).

It appears that taking into account the relative positive health selection of migrants in the land of origin and the mostly negative effects of the temporary migration process on health, the lasting difference is made by whether exposure effects and visa stress are perpetuated in the land of arrival, creating chronic stress conditions (including especially particularly vulnerable populations, as migrants in irregular situations, unaccompanied minors and trafficked victims); or if, on the contrary, in the destination country exposure effects are contained, visa stress comes to an end, and migrant energy is not exhausted while learning to navigate local systems, and the person attains a healthy work and living environment (see also Jasso, 2013, p. 378).

Jasso does refer to the difficulty of navigating local systems, but this factor, albeit difficult to measure with epidemiological instruments, deserves greater attention. A study of health outcomes of migrants includes barriers in access to healthcare between causal factors of immigrant's deterioration of health status over time: "In the literature, there have been five main explanations for deterioration: the experience in resettlement; patterns of assimilation; the change in perceptions and diagnosis; regression to the mean; and barriers in access to health care services" (Pita Barros & Medalho Pereira, 2009, p. 6).

The contribution of epidemiological studies to the understanding of relations between migration and health outcomes is undeniable, but somewhat ambiguous. On one hand, the epidemiological observation of migrant trajectories overall, is quantitatively significant, and offers measurable variables to observe. Epidemiological studies on comparative health by ethnicity are a more delicate matter, since such studies have been used in the past to reinforce theories of race superiority. Tracing patterns of health and illness on the health needs and outcomes of migrant and local cohorts through comparative methods can be used to bring to light broad inequalities and justify equity interventions. However, they have on occasion been used uncritically to depict immigrants as public health liabilities, to racialize diseases or to pathologize minorities (Ahmad & Bradby, 2007; Nazroo, 2003).

Table 1 – Glossary based on epidemiological studies, especially by Jasso (2013) and Siegel (2020).

Healthy migrant effect	Migrants are on average much younger and healthier than locals. Reasons for that are selection factors at the origin of the migration process.
Exhausted migrant effect	Migrant health tends to significantly decline with time in the host country. Reasons for that are exposure effects as the health-related environment, as work and living conditions or barriers in accessing services.
Visa stress	Difficulties experienced especially before migration, influencing its motives and trajectories, mainly related to legal aspects.
Migration stress	Difficulties experienced during migration and the settling period.
Exposure effects	Difficulties due to poor conditions of labor and housing, barriers accessing public services and social protections, while having lost familiar health resources
Migrant energy	It is the personal investment in the success of the migration, linked to the original choice to migrate. If strong, leads to a sooner embrace of the destination country and extraction of its health benefits.
Salmon effect	Migrants tend to return to the country of origin when ageing or ill, to benefit from the support of their family and social networks. It varies on ethnic groups and is more frequent in workless or older migrants.

The connection between epidemiology and medical sociology has been useful in problematizing the constructs used in demographic studies to form ethnic and cultural categories (Brown et al., 2013). Medical sociology calls for a more reflexive, contextualized, and intersectional account of ethnicity aspects in epidemiology, as the ways to gather ethnicity data in healthcare research are being debated. Nevertheless, giving up group identities wouldn't help in locating patterns of disadvantage. A systematic review of 29 systematic reviews finds that "perinatal outcomes were predominantly worse among migrant women, particularly mental health, maternal mortality, preterm birth and congenital anomalies" (Heslehurst et al. 2018, p. 1). In the specific case of asylum seeker or refugee status, data suggests worse outcomes compared to other (migrant and local) women, "particularly relating to complex obstetric issues (e.g. SAMM, uterine rupture, eclampsia), mental health, offspring mortality, sexual assault and unwanted pregnancy, FGM, infectious disease and anaemia" (p. 21). Medical sociology has greatly contributed to understanding the interrelation between exposure effects and health vulnerability, as well as the intersectional impact of different areas of disadvantage on health outcomes (e.g. in mental health, McLeod, 2013; Muntaner et al., 2013). It has also documented some culture-bound syndromes included in DSM-V, offering evidence to take cultural diversity seriously in epidemiological analysis, especially in mental health (Brown et al., 2013).

In the Italian context, despite the generous juridical framework and the universal access healthcare system, the decentralization of competences in the health sector to regions and provinces has created uneven standards of care, which interact with geographic and lifestyle factors. The *Italian Atlas of mortality inequalities by education level* (Petrelli & Frova, 2019) on one hand confirms at the national level the "health gap" documented worldwide by Michael Marmot (2015), where a higher educational status results in a higher life expectancy, but also a significant variation in mortality by region:

> There are strong differences in general mortality among the various geographical areas of the Country. Compared to the national average for women, there are areas where deaths are below -15% and others where they reach 30%, regardless of the different distribution by age and education level. Among men, the differences vary between -13% and +26%. (Petrelli & Frova, 2019, p. 29)

A widespread perception of inequality in health outcomes, as well as accessibility of healthcare and user satisfaction, have been documented: "54% of Italians consider that in Italy people don't have equal opportunities of diagnosis and treatment" (CENSIS, 2018, p. 223), with most salient differences reported being regional – with satisfaction in the Northeast reaching 79,4% against the 40,6% in the South and Islands – and socioeconomic, as the less satisfied are reported to be the less wealthy and less educated, and one in four Italians report using social connections to obtain or accelerate access to medical visits, diagnostic tests or treatments, in higher numbers between the most educated in the Southern region (CENSIS, 2018, pp. 223–226). The progressive growth of inequalities in healthcare services delivery and its impact on the erosion of social cohesion has been described by the CENSIS report in these terms:

> differences have always existed … however a qualitatively new phase has started in which it stands out that the health service, which in the past, in addition to guaranteeing decisive care for citizens, also generated security and helped to reduce social disparities by redistributing health risk and the associated costs throughout the community, is now unable to perform these fundamental social functions. (p. 226)

Public services play an important role in diminishing social disparities, including the disparities towards persons on the move. As expected, because of the healthy migrant effect, lower mortality rates have been found among migrants, with the exception of deaths for some particular causes: tuberculosis, congenital malformations, and homicide (Petrelli et al, 2019, pp. 11–12).

Available evidence about the health of migrants documents that health conditions of migrants, which used to be on average better than locals upon arrival, tend to deteriorate for long-time residents, being exposed to "chronic health problems, but also correlated to socioeconomic inequalities in health" (Petrelli et al., 2017, p. 4). It is essential to understand what causes erode the health of migrants, and particularly what keeps them from an equal access to healthcare services.

1.3.3 Migration as a social determinant of health

David Ingleby has highlighted the analytical loss caused by a fixation on socioeconomic status (SES) in the study of social determinants of health: "A coherent view on the complex genesis of social inequalities is sacrificed to the goal of highlighting the correlation between health and a single variable, SES" (Ingleby, 2012, p. 332). He notes how the implicit association of social determinants of health with SES throughout European documents and research projects, with little or no mention of ethnicity or migrant status, concluding that "As well as social marginalization, these groups are thus subjected to scientific marginalization, in a new, streamlined research agenda that is already undermining work on migration and ethnicity in the EU" (p. 332).

Ingleby has made significant contributions to methodological critique in health and ethnicity studies. One of such contributions, drawing from previous work (Kaufan, Cooper & McGee, 1997), is a problematization of the methodological procedure of controlling for SES in studies about ethnicity and health, assuming its priority, and discarding other contributing factors as "residual confounding" elements. However, ethnicity and migration status are often not independent variables, but might contribute to a lower SES. The causal relation, therefore, may also be represented like this:

This consideration is not isolated, as other studies are making a similar point in the literature:

> Many health discrepancies between migrants and non-migrants disappear after controlling for socioeconomic status, though poor socioeconomic status might itself be a result of migrant status and ethnic origin, because of processes of social exclusion. Although much of the published work about upstream determinants of health has focused on socioeconomic factors, largely ignoring the role of migration, there is beginning to be some recognition that *migration itself can be a social determinant of health*. (Rechel et al., 2013, p. 1237)

The need to incorporate the perspective of the social determinants of health into research on migrant health has been argued in several different and complementary ways. A conceptual framework to integrate social epidemiology into immigrant health research (Acevedo-Garcia et al., 2012) proposed a cross-national perspective, which incorporated available knowledge about migration flows into public health studies in sending and receiving countries, overcoming a de-contextualized approach, which construed the topic of migration and health as a special interest, inconsequential to public health within borders. The study observed that cultural explanations of health patterns in communities of immigrants were often given as preventive health behaviors or assimilation to the receiving society, while the social determinants of health approach was less frequently used, and it should be encouraged, as it would render visible the social and structural explanations of health outcomes without placing exclusive agency on the community itself. Migration-related disadvantage is not only social and material but on the other hand, it is not only cultural as well. Bradby and Brand (2016, p. 6) observe tension in the literature regarding health inequalities of migrants between explanations related to cultural differences and those related to SES or material inequality. As Bhopal (2012) points out, "by combining perspectives we create a more powerful 'equity lens'" (p. 171).

The World Health Organization in the European Region presents evidence on the multiple factors of disadvantage accumulating in migrating people, and affecting their opportunities to maintain their health: lower socioeconomic status and social exclusion of migrants, juridical status, barriers in access to healthcare services, lack of information among both service providers and service users, experiences of discrimination and less favorable integration policies (WHO/Europe, 2018, p. 57). Experts focused on the field of migration and health have been documenting how the mentioned factors can intersect with each other. For instance, David Ingleby explains how migration may contribute to lowering socioeconomic status:

> Being a migrant or a member of an ethnic minority leads to ill-health by lowering one's socioeconomic status. There are many ways in which this could happen: discrimination may lower one's chances of getting a good job, education

> or housing; legislation may deny one's group many rights and privileges (for example, if one is an undocumented migrant); one may experience linguistic and cultural barriers; and one's social capital may be reduced if one moves to a new country in which one's own social "currency" is worthless. (Ingleby, 2012, p. 337)

Studies among undocumented migrants especially report their heightened exposure to poverty and, therefore, poverty-related illness. A study in Orange County, California, shows that migrants in irregular situations seek less often healthcare treatment, as they are less often covered by health insurance, stigmatized as welfare drains, and more likely than others "to experience a number of economically related stressors, such as hunger, homelessness, and a lack of transportation. … Compromises between health needs and other survival needs are common among undocumented immigrants" (Chavez, 2012, p. 892). Heidi Castañeda et al. (2015) point out that studies about social determinants of health have largely left out the issue of migration, which is both socially determined and constitutes in itself a social determinant of health. As can be seen, the nexus between immigration and health is attracting increasing research, but not all research projects incorporate in the research design the awareness of the social determinants of health.

It is important to consider the intersectionality between material and symbolic factors of disadvantage. Several identified risk factors are associated with migrant trajectories, which would be reductive to consider only material or only symbolic. Considering the availability of material resources, it can be seen how they are culturally embodied and mobilized according to a certain habitus[7]. In the case of migration, the absence of habitual material resources might introduce exposure to avoidable risk factors, which could be otherwise easily prevented. For example, the absence of familiar foods and self-care products, the lack of access to spaces and resources for familiar routines of physical activity or the lack of knowledge about appropriate clothing for the local climate and geography. Both dimensions are entangled in all

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[7] Habitus is conceived by Bourdieu as "a subjective but not individual system of internalized structures, schemes of perception, conception, action common to all members of the same group or class. … It is because this world has produced me, because it has produced the categories of thought that I apply to it, that appears to me as self-evident" (Bourdieu & Wacquant, 1992/2008, p. 127).

factors of disadvantage, and mutually reinforce one another. One could think about exposure to work-related injuries; social marginalization and racism; loss of protective familiar and social connections; limited, unknown or debated entitlements to access healthcare services, amongst others. Some risk factors are composite and causative of other conditions of disadvantage. For instance, a reduced linguistic competence in the receiving society's languages in turn impedes the mobilization of migrating people's cultural capital, hampers the resulting health literacy and constitutes significant barriers in knowledge about and access to health care services.

Mara Tognetti Bordogna is a leading expert on the sociology of health and illness, and her work is particularly notable in regards to the sociology of migration and health in Italy (Tognetti Bordogna, 2007, 2008, 2012, 2017; Tognetti Bordogna & Rossi, 2016; Ingrosso, 2015). It has brought attention to the specific significance that health inequalities acquire in the context of immigration. Being mostly located in disadvantaged social strata, migrants are exposed to enhanced risk factors and unhealthy habits, suffer health-threatening work and housing conditions, can count on scarce economic and social capital, and have fewer resources to prevent or remedy the consequences of illness (loss of work, impoverishment, etc.). However, socioeconomic factors intersect with the new inequalities generated by migration processes, like a lower health literacy brought by linguistic disadvantage or experiences of racism and discrimination (Tognetti Bordogna, 2016, pp. 29–34).

Migration and health are interdependent. On the one hand, migration trajectories influence health, changing circumstances of exposure and restricting the availability of familiar and accessible health resources, at least during displacement and in the early settlement period. In turn, health conditions affect important goals of migrant trajectories, such as safety from harm, family protection, education, and work opportunities, as well as social connections, use of services, and processes of incorporation in the host society.

Tognetti Bordogna (2012) has referred to health as an essential form of capital for migrants. Moreover, she points out that contact with healthcare contexts are experiences of interaction with local institutions which can become a training space (often at significant costs) to learn about local practices, rules and procedures, build citizenship trajectories from the bottom up, and sometimes even stimulate organizational change. Moreover, in the name of protecting their health, whatever their understanding of it, individuals are often ready to renegotiate their behaviors, habits, and principles, or submit to procedural novelty and disciplining actions (see also Tognetti Bordogna, 2016, p. 13). The concept of "cittadinanza sanitaria", or "health citizenship" (p. 13) refers to this complex and interactive work of inclusion which often takes place in the healthcare setting.

The issue of inequalities linked to migration and ethnicity has received the attention of the European region of the WHO, in the document *How Health Systems Can Address Health Inequities Linked to Migration and Ethnicity* (WHO/Europe, 2010). Processes of discrimination, racialization, or ethnicization of minority individuals that have a different nationality, religion, skin tone, or just a foreign-sounding name affect physical and mental health (Santone, 2010).

1.3.4 Migration and health access

The Marmot Report addresses universal health care, affirming that "healthcare systems are a vital determinant of health. Yet, with the exception of rich industrialized countries, they are frequently chronically underresourced, and they are pervasively inequitable" (CSDH, 2008, p. 94). This overall evaluation is based on concrete evidence: "over half a million women die each year during pregnancy or delivery or shortly thereafter, virtually all in low- and middle-income countries. Lack of access to and utilization of adequate maternity care is a key factor in this appalling statistic" (p. 94). The evidence extends to high-income countries as well, as inequitable use of services is documented throughout the social gradient in developed countries such as the United States, where

> minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer than whites. Patients in lower socioeconomic strata are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications (Agency for Health Care Research and Quality, 2003). (CSDH, 2008, p. 94)

Barriers to access services are context-dependent and therefore hard to map or measure. However, comparatively lower use of services is a variable that can be measured, even if it does not clarify the precise reasons behind this lower use. Despite the significance that health as a right and as a resource has in an immigrant's trajectory, comparative studies have documented a lower use of healthcare services by immigrants, except in emergency and maternity services. A systematic review of comparative studies of healthcare service use, mostly based in European countries, found throughout the literature that "migrant populations appear to have a lower use of health services than native populations, with a similar use of primary care services. This result appears to be independent from differences in need of access" (Sarría-Santamera et al., 2016, p. 25). The report also indicates gaps in available data, as the need for greater documentation on service use variations by country of origin, and the significant lack of studies that include undocumented migrants. One small but worthy exception is a study in Orange County, California, which indicates that the use of healthcare services is especially low among the undocumented (Chavez, 2012), who often face cumulated barriers stemming from health exposure, inaccessible information, juridical status, stigmatization, and poverty.

Studies (Norredam et al., 2010; Terraneo, 2016) have contributed to further detail the picture, documenting migrants being significantly lower users of preventive healthcare services and screenings, particularly related to women's health issues (Marlow et al. 2014). In breast cancer screenings in Sweden and Denmark, foreign women were "twice as likely to be non-attenders compared with Swedish-born women after control for socio-demographic factors and live births" (Norredam et al., 2010, p. 560). For cervical screening, studies in the UK, the Netherlands and Spain agreed on a lower attendance of migrant women with respect to non-migrants (p. 560). The use of general medicine and specialist care was ambiguous, as migrants rated "more contacts per patient to general practitioner but less use of consultation by telephone and same or higher level of use of specialist care as compared to non-migrants" (p. 555). Family doctors, or general practitioners, in many European countries, act as gatekeepers and pathways towards more specialized medical care, and the repeated interactions might generate a trust relation or at least a predictability which might contrast perceived barriers. On the other hand, linguistic barriers seem to have a significant impact on the frequency of consultations and the preference for personal contact over telephone consultation, as shown by a study in the UK reported that Chinese women who spoke English were more likely to visit the GP than those who did not (p.555). The similar rate of specialist consultation, according to Terraneo (2016), could be the result of the interplay between lower access of migrants to specialized services, with the higher need, related to the higher natality rate or higher exposure to work-related risk among migrants (p. 72).

Emergency services appeared to be slightly more used by migrants of some countries of origin, according to a Danish study (Norredam et al., 2004 indicates Somalia, Turkey, and ex-Yugoslavia as higher users, while other nationalities were found equal or lower). The study found that "higher utilization rates among some immigrant groups may be explained by disparities in health or lack of knowledge about the Danish healthcare system as well as barriers to seeking primary care including language, fear of discrimination, and low satisfaction with primary care" (p. 53). A subsequent study delved deeper into why that is, by inquiring about motives to ER access. Results show that "more among immigrant patients than among patients of Danish origin had considered contacting a primary caregiver before visiting the ER, and more immigrants reported going to the ER because they could not contact a general practitioner or could not explain their problem on the telephone" (Norredam et al., 2007). It can be seen that when barriers prevent access from one end, health needs overflow a different access point to the healthcare system.

Italian data confirms the conclusion that migrants have a lower utilization rate of health services than locals despite a universal approach to entitlements. More than a decade ago, Tognetti Bordogna (2012) offered a descriptive analysis of specificities in migrant's access to healthcare services: Patients of migrant origin go more often to the Emergency Services, and often with irregular causes, which might imply correlation with voids in other supporting services, in turn frequented much less than the local population: specialized treatment, hospitalization and visits to the general practitioner. Immigrants show a prevention deficit, especially among male patients. Immigrant women subject to screenings and prevention controls about 20% less frequently than Italian women. Most frequent causes of hospitalization among immigrant women are those connected with pregnancy and among immigrant men those connected with accidental trauma. Access to hospitalization seems hence conditioned by urgency. Empirical data shows also that juridical status, linguistic competence and time of residence in Italian territory are positively related to access to healthcare. Factors associated negatively with access are costs of services, opening hours and bureaucratic complexity.

Two comprehensive reports on the health of migrants before and after the pandemic, Petrelli et al. (2017) and Cernigliaro (2024), analyzing comprehensive quantitative data, reach similar conclusions, documenting that -especially excluding emergency and maternity- migrants have lower overall use of healthcare services. In the first report, was reported that:

> Although in Italy access to social and health services is guaranteed to the immigrant population by the presence of a universalistic National Health Service and an overall favorable legislation, there still remain strong imbalances and inequalities across the country in guaranteeing essential levels of care to this population. The persistence of bureaucratic and informal barriers to the use of services is often evoked to explain these inequities: for example, Istat data reveal that 12 out of every 100 foreigners over the age of 14 have difficulties in carrying out the necessary paperwork to access medical services. In addition, significant difficulties are documented on the communicative-relational level: among foreigners over the age of 14, 14 percent say they have difficulty explaining the symptoms of their illness to their doctor. (Petrelli & Di Napoli, 2019, p. 11)

A cross-sectional study analyzing the use of healthcare services by foreign and local populations, concludes that

> foreigners have a lower probability than Italians to make a medical examination, both for visits motivated by any health problems (OR: 0.80; 95%CI 0.73-0.87), and in case of medical examination carried out for preventive purposes (OR: 0.72; 95%CI 0.64-0.82). … The lower use of medical visits highlights inequities in access to services. In order to reduce health inequalities, barriers that affect equitable access to health care should be removed, taking into account the heterogeneity of these sub-groups. (Petrelli et al., 2017, p. 41)

The study documents a lower use of services by migrants both regarding health problems and prevention, and results are consistent with those in other European countries (Rosano et al., 2017; Rosato et al., 2023). The study on cervical and breast cancer screenings among women, show an even larger difference in use between both groups. The study shows overall a significant growth of screening participation of immigrants between 2005 and 2013, mostly related to accessibility of screenings in northern regions. It also identifies associated factors with use of screening opportunities in SES and "integration markers". In fact, the study observes that lower SES women in the South have a lower rate of participation as higher SES women in the north. It also shows influencing factors as educational level, length of stay, economic resources and familiarity with the preventive services:

> Among immigrants (No. 2,601), Pap test uptake was higher in women who: had a preventive examination in the previous month (OR: 2.13); have an Italian partner (OR: 1.72); have been staying in Italy for more than 13 years; are graduated (OR: 1.87); perceive their economic resources as adequate or optimal (OR: 1.39); come from the Americas (68% more if compared to Africans). As regards mammography uptake in immigrants (No. 636), associated factors are: having had a preventive examination in the previous month (OR: 3.35); having high educational level (OR: 2.51); perceiving economic resources as adequate or optimal (OR: 1.75). (p. 18)

There is concrete evidence of a lower use of healthcare services in migrant population with respect to locals, especially with regards to preventive medicine (Rosano et al., 2017), albeit it varies significantly by location, by type of service and by country of origin. Petrelli et al. (2019) have found that

> lower access to primary care in the absence of complaints or symptoms has also been observed among immigrants, particularly among the most disadvantaged socioeconomic classes, although a higher degree of integration seems to favor access to medical examinations. (p. 11)

A more recent epidemiological study documents health outcomes and health access of migrants during the Covid-19 pandemic (Cernigliaro, 2024), documenting that the

> illness did not hit casually, but accentuated conditions of poverty, consolidating known patterns. Mortality was much higher among the elderly, the poorest

> groups and ethnic minorities, and more generally, among more fragile individuals. (p. 18)

Moreover, it affected especially migrants because of specific disadvantaged situations:

> The pandemic acted on health inequalities directly because it affected the most disadvantaged social strata of the population most severely, in terms of infection and outcomes. These certainly included immigrants, who were often engaged in occupations where exposure to the virus was high, even during lockdown periods, such as retail work, in public transportation, in jobs that could not benefit from agile work. They also live more frequently in overcrowded housing conditions and in urban areas, which are more affected by the pandemic. Poorer and less educated population subgroups, characterized by higher prevalences of chronic diseases and risk factors such as obesity, had more severe outcomes of the infection, in terms of hospitalizations and mortality. The greatly reduced access to health care for nonemergency interventions, caused by the pan- demic emergency, also proved inequitable. (p. 27)

The study highlights how maternity is a critical health area for immigrants, not only because of the higher fertility rates but for the worse health outcomes in that area. Specifically, heathcare service access among migrant mothers is lower, as confirmed by several indicators:

> Foreign women more frequently than Italian women receive fewer than 5 visits (16.6% vs. 9.3%), make their first visit after 12 weeks gestational age (11.8% vs. 3.4%) and have fewer than 2 ultrasounds (4.3% vs. 1.1%). 10,11 Lower care during pregnancy is also reflected in the health outcomes of infants born to foreigners, who account for about a quarter of those born in Italy, among whom, compared to children of Italians, significantly higher rates of stillbirth (+55%), birth weight less than 1,500 grams (+22%) and Apgar at 5 minutes less than 8 (+24%) are observed. (Cernigliaro, 2024, p. 26)

A higher level of integration, however, is demonstrated to make a difference, for instance, in a significant raise in female cancer screenings among migrant women cohabiting or married to an Italian partner (Cernigliaro, 2024,

p. 26). Incorporating a gendered perspective into the study of migration and health can be crucial to the development of equitable policies and intervention strategies.

Access disparities are documented in other areas as well, as the failed or tardy healthcare admission determines acutization and hospitalization in the case of conditions that could have been treated with lower levels of assistance. A heightened recourse to emergency services shows barriers in accessing primary care, also because of an incompatibility with lengthy work schedules (p. 27).

More studies are necessary to identify the causes of this lower use of services and inquire about accessibility as well as other influencing factors. However, two ranges of factors in the literature seems to have an impact on better health outcomes and access for migrants: Firstly, for migrants to acquire and enact navigational knowledge on available healthcare services, and secondly, accessible service provision. The next section shortly reviews approaches to these two dimensions which can make a substantial difference.

1.4 The Goal: Accessible Healthcare

1.4.1 Conceptualizations of migrant agency

Having reviewed migration as a social determinant of health, it is important, however, not to victimize migrants. Migrants are not always and not only subjects of disadvantage but also agents of migration projects and trajectories, and have, as everyone else, an active role in protecting (or not) their health and the health of others. They do so in the measure enabled by their capabilities, social conditions, and life choices. Although studies using an individual approach to health-seeking behaviors often fail to recognize the social determinants of health, the information gathered on individual and collective behaviors toward health protection remains a valid and useful issue. It does not contradict the presence of structures of disadvantage and might help document the issue from a perspective of agency. In this sense, while often the criticisms made towards unilateral studies constructing behavior as choice alone have a point (see also Castañeda et al., 2015), the either-or perspective proposing a choice between structure and agency seems reductive.

A fitting example is the comparative literature about migrants' use of healthcare. Agency, culture, and structure could all be factored in when considering a higher birth rate among migrants or a greater exposure to work-related injuries in migrant populations.

Elaborating on the concept of migrants' agency, seeing them as other than victims, Tognetti Bordogna (2012) portrays the immigrant not only as a consumer, rather also as a provider of welfare services, referring to the immigrant origins of a growing section of professionals within and without healthcare institutions, such as nurses, cultural mediators, elderly assistants or physiotherapists.

Educational contributing factors to health-seeking behaviors and their role in health inequalities have been studied by Petrelli & Frova (2019), showing that education and region of residence are the two main factors contributing to inequalities in mortality in Italy. But the question is, how does this factor impact health?

On the one hand, the concept of *health literacy* has been identified as an equity challenge and a key determinant of health, as literacy, measured by reading skills, is a stronger predictor of an individual's health status than income, employment status, education level and racial or ethnic group (WHO/Europe, 2013a, p. 7). This is a social issue, as it does not refer only to individual skills but to the systems and contexts that determine the relevance and circulation of health knowledge. These pose challenges to migrants and other disadvantaged groups to obtain the necessary knowledge to fully participate in health prevention and navigate healthcare systems. The WHO report suggests related measures: specific health literacy strategies for migrants, environmental interventions for user-friendly hospitals, health provider training to improve communication, use of cultural mediators and interpreters, as well as networking and intersectoral interventions (WHO/Europe, 2013a, p. 20).

Other more comprehensive approaches are drawing from Bourdieu's notion of cultural capital, to better understand the dynamics of health capital (e.g. Larsen et al., 2013). The concept of cultural health capital (Shim, 2010) has been proposed to conceptualize

> the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships. (p. 1)

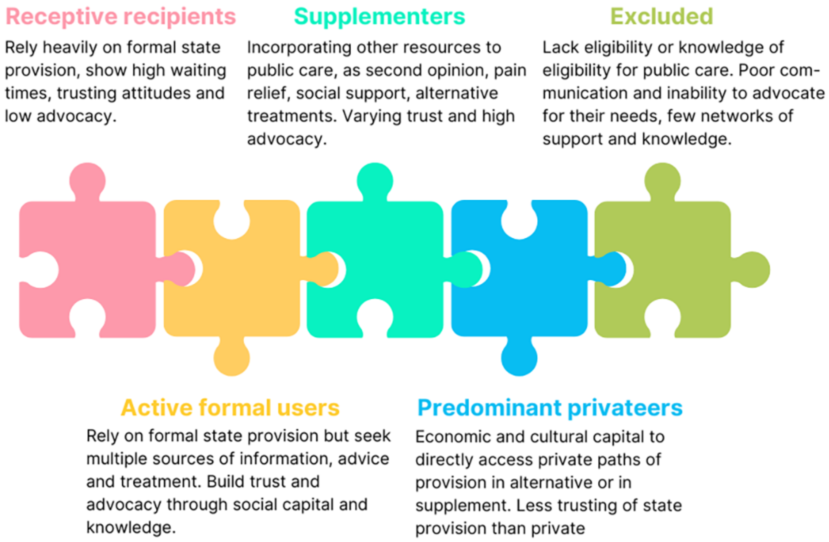
The concept brings into the analysis how patients and practitioners reciprocally shape and redefine the interactions in the asymmetrical and normatized practices of clinical relations by mobilizing a wide variety of internalized resources in their habitus as cultural capital, amounting to greater or lesser success. Moreover, *cultural health capital* (Shim, 2010) is seen as contextual and situated, thus contributing to challenging illusions of objectivity and transparency in medical relations. The term has been used in empirical studies (Dubbin et al., 2013; Chang et al., 2016), and disseminated by empirical and policy studies (Phillimore, 2015, 2016, 2019; Pemberton & Isakjee, 2017) and it has spread into studies of patient-clinician relations in the co-creation of trust in the presence of cultural diversity (Simonds et al., 2014). It has been especially relevant in ethnographic studies offering contextualized analyses on the co-creation of knowledge in health care access and advocacy. Gengler refers to the term as a frame to compare illness management strategies (Gengler, 2014). Fanning Madden (2015) connects the concept to critical race theory perspectives to address health inequalities in marginalized communities, which contributes a valuable empirical scope (even if it does not seem to provide the theoretical broadening it announces). Gage-Bouchard (2017) explores the impact that cultural knowledge has on differential styles of health-related advocacy and its contribution to explaining inequalities in healthcare experience. Another recent ethnographic study refers to it to contest the "individualistic and rationalistic bias of conventional approaches to health literacy" and positioning the concept as a social practice, as it is "situational, multidimensional –comprised of different sources and forms of knowledge- and co-produced in social relations" (Samerski, 2019, p. 1).

Phillimore and other scholars at the Institute for Research into Superdiversity have forwarded the concept of *healthcare bricolage* (Phillimore et al., 2015, 2016, 2018, 2021; Pemberton & Isakjee, 2017) to explain the health-seeking processes and behaviors of people living in superdiverse areas (Vertovec,

2007) or majority-minority areas, often underserved, combining available resources to achieve more with less. They explain that bricolage

> is not radical; non-teleological; partly purposeful; partly unintentional; it entails small adjustments. … Finally, bricolage offers a possibility to connect resources from across the world and to highlight agency in health-seeking, whether this is mobilized in times of crisis or as an imaginative way of improving quality of life. (Phillimore et al., 2016, p. 15)

A typology of bricolage elements in health-seeking behaviors indicates different strategies (Pemberton & Isakjee 2017, p. 21), as highlighted in Figure 4. As can be seen, the level of initiative in bricolage depends strongly on the individual access to cultural, social and economic capital. However, the practice of healthcare bricolage in the context of transnational resources and a limited access to public health systems may help explain the ways migrants address needs that are not covered (sometimes not even perceived) by public healthcare systems.



Receptive recipients
Rely heavily on formal state provision, show high waiting times, trusting attitudes and low advocacy.

Supplementers
Incorporating other resources to public care, as second opinion, pain relief, social support, alternative treatments. Varying trust and high advocacy.

Excluded
Lack eligibility or knowledge of eligibility for public care. Poor communication and inability to advocate for their needs, few networks of support and knowledge.

Active formal users
Rely on formal state provision but seek multiple sources of information, advice and treatment. Build trust and advocacy through social capital and knowledge.

Predominant privateers
Economic and cultural capital to directly access private paths of provision in alternative or in supplement. Less trusting of state provision than private

Figure 4 – Profiles of healthcare bricolage. Summarized from Pemberton & Isakjee (2017).

Bricolage "may offer an alternative discourse on the health seeking behaviours of people from minority or vulnerable groups to that of passive victim" (Phillimore et al., 2016, p. 17). Not only users but also providers of healthcare are described as bricoleurs, in their effort to adapt services to their increasingly diverse and mobile public (Phillimore et al., 2021, 2018).

The areas of lower use of healthcare services in comparable entitlements, positions and needs show us that entitlement is not enough and that accessible services are stratified. Even in the presence of responsive services, barriers affecting specific groups should be understood and addressed, before brushing off low utilization of services as individual choice. For instance, a study analyzes evidence of social networks interfering with individual agency in seeking mental health services between Pakistani women, who are found to be "at a considerable disadvantage in gaining access to and using statutory mental health services, compared with white women; this, in part, is due to negative attitudes to mental health problems evident in social support networks" (Kapadia et al., 2017, p. 1304).

Specifically, social exclusion affects migrants' experience of services, as they are often "perceived as undeserving because they do not belong or have not contributed sufficiently" (Phillimore et al., 2018, p. 4). Lack of clarity about juridical and administrative entitlement to services, racist sentiments publicly displayed in the media as well as discourses of practitioners enraged at "expectations" and "demands" of immigrant patients as if healthcare services were concessions and not rights, might give rise to a sense of isolation and social exclusion. Especially for undocumented migrants and asylum seekers, experiences of discrimination can become internalized and hamper health-seeking behaviors: "Whereas 'deservingness' is socially produced, politically determined, and institutionally implemented, the vulnerability that results from being rendered undeserving becomes embodied" (Quesada, 2012, p. 895).

The approach that focuses on individual agency in mobilizing resources for one's health must be counterbalanced with the consideration of contextual and structural factors, which might restrict the spaces available for individual choice. Considering the social determinants of health might prevent blaming the victim, by considering individual responsibility in the context of its structural conditioning factors of privilege and disadvantage. It is especially visible in the case of undocumented migrants, who experience cumulative factors of disadvantage.

1.4.2 Towards accessible healthcare organizations

In reviewing the latest empirical evidence around migration and health in Italy, one of the crucial observations in the data analysis is that in the areas "where the healthcare system manages to offer an active and effective assistance towards all the resident population, Italian and foreign, inequalities between those groups are reduced" (Petrelli et al., 2019). Moreover,

> In general, there is also heterogeneity among foreigners in health in Italy, as regions with more efficient social and health care provision for their residents also ensure more adequate responses to the health demand of foreign nationals, as in the case of women's cancer screenings. (Cernigliaro 2024, p. 26)

Responsive and inclusive healthcare systems, according to the evidence, do increase the demand and use of services by foreign nationals and promote greater accessibility, which ultimately contributes to better health outcomes. The case study engages with the question: *how* can accessible and responsive services be shaped, to facilitate their use by disadvantaged groups experiencing barriers, and migrants in particular? There is little literature on this, and even though valuable recommendations have been made by WHO, they refer to the policy level rather than the organizational level.

Multilevel organizational research shows the reciprocal influence between different levels, and between policy and practice:

> the effects produced by the dynamics of a multilevel and complex system, in order to comprehend its influence on policy outcomes. In fact, here it can emerge not only what occurs in micro-relations, choices and events, but also which effects result from macro- trends ... It also concentrates the attention on the implementation as a crucial moment in the understanding of the conditions which determine outcomes very different from those declared at the level of policy. (Saruis, 2013, p. 546)

In this sense, understanding street-level practitioners as they interpret and recreate policies instead of only implementing them mechanically has been a core contribution of Lipsky's approach to *street-level bureaucracies* (Lipsky, 2010), which sheds light on the interplay of factors that contribute to shaping inclusion and exclusion logics in public service practice.

From this point of view, the key role of practitioners in inclusive service delivery is evident, as they often have a discretional space to decide which information on available treatments and healthcare pathways to pass along to patients, they interpret eligibility criteria for healthcare services and might facilitate or hinder access to quality services. Despite the blind spots determined by their cultural and professional paradigms and by their position in the healthcare system and society, medical professionals occupy a strategic viewpoint concerning migrant barriers to health.

Practitioners documenting efforts for accessible healthcare to migrant patients in Italy's Friuli region, for instance, adopt the approach of "initiative medicine", which is based on a shift from reactive to proactive medicine, attempting to meet the patient before pathologies arise or become acute (Blasutig et al., 2021). This approach based on prevention implies a) centering on the person and their social context, b) continuity of care based on patient activation and empowerment, c) the enhancement of community resources, and d) the connected intervention of multiprofessional care teams (p. 142).

Approaching healthcare organizations as complex systems (Tsoukas, 2009, 2017; Tsoukas & Mylonopoulos, 2004), and studying the processes by which they create knowledge, innovation, and adaptation to the increasingly diverse population they serve, has a significant impact on methodology selection. Different theoretical frameworks can support such an inquiry. For instance, Bourdieu's methodological situationalism (Bourdieu & Wacquant, 1992/2008, p. 15). Bourdieu's theory of fields of practice (Bourdieu considering the interplay between different actors in this specific social field and the structuring elements of context. With Bourdieu's social theory in the background, this research considers the field as a bundle of relations, where different spaces of play interact with each other. Therefore, it would not make sense to evaluate practice innovations as isolated components, assuming they were planned and executed top-down in a timely fashion, because the process of healthcare delivery has proved to be much more chaotic and complex than that.

Literature about healthcare service delivery seems to point toward the need for robust qualitative research within organizations instead of only considering evidence-based research. Of course, there is nothing wrong with evidence-based research measuring results and validating outcomes, especially in the healthcare field, but around accessibility, a call for a different approach is emerging. David Kernick (2006) referred ironically to how “the evidence-based medical tail wags the health service research dog” calling for wider use of complexity theory in this field. Also, Oxford professor Trisha Greenhalgh has been signaling the need to overcome the limitations of evidence-based research in complex healthcare environments, and valuing mixed methods approaches, which include narrative and ethnographic data about innovation and change in healthcare organizations (Greenhalgh & Paoputsi, 2018; Greenhalgh & Swinglehurst, 2011; Greenhalgh et al., 2005). Evidence-based knowledge in healthcare is certainly valuable, provided it is applied in those fields where it might be more useful, and not taken as the only valid scientific paradigm. In the specific case of healthcare reshaping services to respond to the changing needs of its diverse public, an approach that takes into account the complexity of organizations becomes necessary. To study them, it appears more appropriate to create open models that include data from a wider variety of sources and to operate what Tsoukas calls conjunctive theorizing:

> Complex theorizing is conjunctive: it seeks to make connections between elements of human experience through making those analytical distinctions that will enable the joining up of concepts normally used in a compartmentalized manner. (Tsoukas, 2017, p. 132)

In her work about organizational change in healthcare, through the lens of complexity science, Greenhalgh and her colleagues treat organizations as complex adaptive systems composed of multiple interconnected elements, such as staff, patients, technologies, or policies, that interact in unpredictable ways. She recognizes that healthcare environments are dynamic, interdependent, and constantly evolving, making change processes nonlinear and influenced by numerous interacting factors. Large-scale interventions might have limited or unintended effects, but small changes can lead to significant impacts due to the interconnected nature of the system (Greenhalgh & Papoutsi 2018, Greenhalgh et al., 2017). This realistic view of how change can be brought about at the organizational level in healthcare has brought Greenhalgh to identify avenues of change that may make more of a difference than a normative, top-down approach to organizational change. Effective change management often requires distributed leadership, where decision-making is not centralized, but shared across different levels and teams, thus fostering adaptability and resilience toward new challenges. It is necessary to contextualize measures in change processes, because solutions that are effective in one context may not work in a different one. This distributed leadership and context-sensitivity is also fostered by relations of trust, collaboration, and communication across professions and departments, as well as in patient-practitioner relations. Communication must also be iterative and reflexive, circulating on feedback loops that enable organizations to collectively assess outcomes, adjust strategies, and learn from successes and failures, in real time (Greenhalgh & Papoutsi 2018, Greenhalgh et al., 2017).

The literature reviewed in this section about the wider problem area of migration and health shows the need to address the causes of the causes of poor health outcomes in disadvantaged populations. That is, to conceive and research the nexus between migration and health by considering migration as a social determinant of health. The policy framework described attempts to show that if European governments are to be coherent with their founding principles, they need to invest not only in declaring on paper migrant populations' right to health but also in creating concrete provisions for the accessibility of healthcare services to all vulnerable and impoverished populations, including migrants. This quick survey of the available knowledge clarifies that it is urgent, possible, and worthwhile to contrast health inequalities and protect the health of all. What needs to be focused on is *How?* The next chapter will contextualize the case study within the main hospital in South Tyrol (Italy) and explain the epistemological framework and the methodology used in this study.

2. Positioning the Case Study: Context and Methodology

The research question that guided this study was *how to shape healthcare services that are more accessible to migrant patients?* There have been many studies centered on institutional racism, or practices of discrimination. A choice at the base of this study has been to document what works. By understanding how accessibility is constructed and improved, it is easier to identify and repair failures.

This research question needed a holistic approach that was feasible for one sole researcher during the time frame of a PhD program. In this section, the territorial and organizational context of the hospital is presented, as well as the reasons behind the focus on healthcare practitioners, the choice of social innovation research as an epistemological grounding, the case study methodology that was constructed around this case, and how it translated into research phases and actions.

2.1 Contextualizing San Maurizio Hospital in South Tyrol

South Tyrol, also known as the Autonomous Province of Bozen/Bolzano, is one of the two autonomous provinces which constitute the region of Trentino-Alto Adige, in the Northeastern corner of Italy, at the Austrian border. Only about a century ago, at the end of the World War I, it was adjoined to Italy, being previously part of the Austro-Hungarian County of Tyrol. The province has three recognized linguistic groups: German, Italian, and Ladin, which coexist maintaining separate governance institutions and even distinct school systems. The province enjoys ample autonomy, granted by the Second Statute of Autonomy for Trentino-Alto Adige/Südtirol (1972) which devolves wide administrative and legislative competencies to the provincial level. By law, in the years in which this research was conducted (2017–2020) all public service professionals in South Tyrol, including medical staff in public healthcare organizations, had to be certified as fluent in both German and Italian to access public sector employment, and worker quotas were reserved for members of each linguistic group, in proportion to its consistency within the local population. While this policy orientation still stands, since then, some long-awaited flexibility has been introduced.

According to Atz et al. (2017), despite being on average much younger and more educated than locals, immigrant residents in South Tyrol have access to much inferior incomes than local populations. The percentage of the local population with null or negative assets oscillate between 7 and 15%, while among migrant families, such proportion is over 50% (33% with no assets and 20% with negative assets). A study (Pokriefke, 2017, p. 309) demonstrates that the lower income levels and the lower assets indicate a situation of economic precariousness of migrants in South Tyrol. Approximately 50% of migrant families manage to live only with difficulty or with great difficult on their family income. This study only includes families of working migrants who are regular residents, and the situation would presumably be worse for asylum seekers or MIS, who are not allowed to work. Considering the economic vulnerability that limits the possibility of migrants' access to private healthcare, rendering public healthcare services accessible, to which all persons are entitled in Italy by law, becomes even more urgent.

Healthcare services in South Tyrol are organized in four geographical districts (Bolzano, Merano, Bressanone and Brunico), which used to function separately but were merged about ten years ago, constituting a unified system of healthcare service provision in the province, called Azienda Sanitaria dell'Alto Adige (ASAA). Covering the provincial area of 7,400 square kilometers, the healthcare system has seven interconnected hospitals, apart from clinics and decentralized services. These hospitals are ranked in three categories, with San Maurizio Hospital being the main and larger hospital, located in the province capital, followed by three hospitals in major cities: Merano, Bressanone and Brunico, and three basic hospitals in the towns of Vipiteno, Silandro and San Candido.

Figure 5 – The seven hospitals in the Autonomous Province of South Tyrol

San Maurizio is the main hospital of the Province, located in its capital, Bolzano. The population it serves is large, as the sole city of Bolzano hosts 20% of the population of the province. In fact, ASTAT, the regional statistical agency, reports Bolzano's population in 2022, to amount to 106,410, roughly 1/5 of the provincial total of 534,147 persons (ASTAT, 2024). Foreign residents in this province are 52,647 amounting to 9.9% of the provincial population, but concentrated in Bolzano, for a density of 14.5% of the city's population, which is about 50% higher than the provincial average density, as explained. The city of Bolzano has an ageing population which determines a negative natural growth of -1.4, compensated by the high migratory growth of 5.4%. It is useful to point out that in the years in which the study was conducted, South Tyrol was the only Italian province to have a positive natural growth. Nowadays, after the Covid pandemic, the province has a negative natural growth (-0.4%) and a lower migratory growth (0,31%), which shows a shrinking advantage with respect to national numbers.

Table 2 – Comparison between demographic trends at provincial and national levels (ISTAT, 2022)

	2019			2022		
	Natural growth	Migratory growth	Overall growth	Natural growth	Migratory growth	Overall growth
Italy	-0,36%	0,13%	-0,23%	-0,52%	0,39%	-0,13%
South Tyrol	0,17%	0,48%	0,65%	-0,06%	0,31%	0,25%

Bolzano appears to be the province with the lowest average mortality rate, especially between highly educated women (see also Petrelli & Fova, 2019). Contributing factors might be that it is the wealthiest province of Italy and one of the wealthiest in Europe, being its main productive sectors tourism, agriculture and renewable energy, and that more than half of the population lives in rural areas (ASTAT, 2019). On a less positive note, it has a very low count of family doctors per population: in 2022, according to ISTAT, the national statistical agency, the province had 5.4 family doctors per 10,000 citizens, lower than the national average of 6.7.

Annual reports of San Maurizio Hospital show that despite the negative natural growth of the city of Bolzano overall, births in the hospital increase every year, as per hospital reports, from 1,544 born in 2003 to 1,750 born in 2016. Practitioners' accounts estimate that minimum one in every four newborns has at least one non-Italian parent. The significant contribution of immigrants to population growth has been documented at the national level as well. Of all the births in 2017 in Italy (458,151), 78% of them (358,940) had both Italian parents, leaving a 22% of births with at least one non-Italian parent and 14% of the total (67,933) with both non-Italian parents. Given that the foreign population in Italy amounts on average to 8.5% of the population, (5,144,440 foreign residents on a total of 60,483,973 total residents in 2018), their contribution to increased birthing rates is significantly higher than their proportional presence in the territory.

The considerable presence of persons with a foreign background and the increasing awareness of medical staff regarding the diversification of their patients has determined in the last few years a considerable expansion and connection of preexisting initiatives, generating processes aimed at a better inclusion of patients of foreign origin. These processes have started in two areas of the hospital, which will be documented more closely in chapters 4 and 5, and then expanded their effects to the rest of the organization.

The first area is a clinic for undocumented migrants and asylum seekers. The Clinic serves migrants who do not have a fiscal code, which is the most basic identification form that allows to enroll in the public healthcare service. Through a temporary code, called STP (for *stranieri temporaneamente presenti*, meaning foreigners temporarily present in the territory), which grants their anonymity during healthcare service delivery, while allowing the reimbursement of their treatment by the State. In fact, as will be seen, the law forbids healthcare practitioners to report undocumented migrants to authorities. The doctors rotating in this Clinic have developed an increased capability of understanding barriers in access to services that translate in accessibility practices for other marginalized categories.

The second area of focus is the Maternity ward, and the Neonatal Intensive Care Unit (NIC), because the high natality rates among non-Italian citizens have determined a density of immigrant mothers in maternity services at San Maurizio Hospital. The heightened experience of cultural and linguistic diversity in the Maternity and Neonatology areas of the hospital has favored the adaptation of practices, the implementation of mediation services, as well as diversity training initiatives, which have extended to the entire hospital and beyond.

2.2 Epistemological Grounding: A Social Innovation Approach

The improvement of access pathways and conditions in healthcare, with regards to marginalized groups, or any group which experiences barriers or difficulties, is a problem of healthcare service delivery. As mentioned in a previous section, significant voices in this field are calling for new approaches to the study of innovation in service delivery, which can consider the complexity of healthcare organizations (see also Greenhalgh & Paoputsi, 2018; Greenhalgh & Swinglehurst, 2011; Greenhalgh et al., 2005).

Healthcare accessibility literature regarding excluded groups appear to tackle the issue in bits and pieces. Quantitative research represents very specific aspects, illnesses, treatments or populations, comparing use of healthcare by different groups, offer and demand of services, impact and cost of specific measures, among others. Policy debates deploy such data to argue in favor of proposed lines of action, in a generic and un-contextualized manner. Ethnographic explorations in this field were immersed in specificity and offered rich data about a specific space of experience, and the sensemaking processes contained in one contained environment, offering critical insight on it, but seldom offering technical conclusions on what does work well and why.

This work was influenced by Bourdieu's sociological and epistemological work. Starting out in philosophy, he arrived to sociology (Bourdieu, 2008), contributing to build a less dogmatic and more reflexive disciplinary field: "sociology must be a total science. It must construct total social facts (Mauss) that preserve the fundamental unity of human practice across the mutilating scissures of disciplines, empirical domains, and techniques of observation and analysis" (Bourdieu & Wacquant, 1992/2008, pp. 26–27). While he practiced a methodological polytheism, which implied an "absolute rejection of the sectarian rejection of this or that method of research" (p. 29), it didn't mean "anything goes" or epistemological anarchy. It meant that

> the array of methods used must fit the problem at hand and must constantly be reflected upon *in actu*, in the very movement whereby they are deployed to resolve particular questions. ... One cannot disassociate the construction of the object from the instruments of construction of the object and their critique. (p. 30)

In his view, methodologies were instruments applied in different contexts to construct the scientific object of knowledge. The discipline which provided them was less relevant than the reflexive and situated coherence and transparence of the object construction, which validated the scientific effort. This approach is compatible with transdisciplinary research. Kirby et al. (2006) explained that

> transdisciplinary research involves researchers working jointly using a shared conceptual framework drawing together disciplinary-specific theories. Transdisciplinarity is the integration and transformation of fields of knowledge from multiple perspectives in order to define, address, and resolve complex real-world problems. (p. 36)

The importance of a complex system approach, is that it allows to consider accessibility practices in their systemic context, accessing a variety of data sources. This study was inspired by the approach of social innovation research, specifically, in the work of Frank Moulaert and the group of scholars with whom he has worked over the years. It is a methodological approach which overcomes traditional divisions between qualitative and quantitative data, between material and symbolic aspects, between bottom-up and top-down processes. This approached has focused on "fostering inclusion and wellbeing through improving social relations and empowerment processes" (Moulaert et al., 2013, p. 16). It refers to the improvement of social relations at various scales, by enacting processes that mobilize and combine the resources and skills which social actors use to shape the social space. Frank Moulaert and Diana MacCallum explain that this change effort is grounded in transforming relations: "Social Innovation is at its core the interpersonal construction -and grounding in concrete action- of ethics ... system change does not ultimately work without work on interpersonal relations" (2019, p. 115). Social Innovation approaches create a space to contrast asymmetries and social relations, bringing to the fore the basic question: *"innovate for what?"* and fostering answers that tend to enhance social justice and inclusion of previously excluded groups.

> SI [social innovation] is considered as path dependent and contextual. It refers to the changes and agendas, agency and institutions that lead to a better inclusion of excluded groups, and individuals into various fields of societies at various spatial scales. SI is very strongly a matter of process innovation of changes and the dynamics of social relations including power relations. Therefore, SI is about social inclusion and about countering and overcoming conservative forces that are eager to strengthen or preserve social exclusion situations. SI, therefore, explicitly refers to an ethical position of social justice. (Moulaert et al., 2013, p. 17)

This research approach tends to generate real-world impact, by fostering new forms of interaction among actors of the field such as knowledge circulation and collaborative practices. It tends to create reflexivity about redistribution mechanisms, helps actors gain awareness of their collective voice during iterative feedback processes, and generate knowledge which aims to be endorsed in the social context from which it emerged.

In a report published by the European Commission (Moulaert et al., 2017), social innovation scholars explain some core features of this approach, which were particularly useful for this research model: *Transdisciplinary and problem-centered* instead of discipline-centered knowledge production, allows to create an epistemological framework that allows for *joint problematization*, and can integrate knowledge from various interested disciplines and societal actors. The common understanding of a problem generates new connections between actors that tend to develop in separate milieus, generating innovative solutions: "SI methodology is intrinsically reflexive and transdisciplinary", it "identifies the connections among the diverse problems of human development" (Jessop et al., 2014, p. 112). Problem-centered connections and networks do not need to be permanent or formalized. They just need to have enough time and substance to create a shared knowledge base and engage in practice. Social innovation research facilitates the participation of less represented groups, or groups that experience the problem at hand in their lives or in their professions, to foster a more detailed understanding. It considering stakeholders outside academic circles not just as sources or users of knowledge but as co-creators and co-interpreters of knowledge, as research partners. Stakeholders often participate in such networks bearing different professional backgrounds, knowledge patterns and priorities, so conflicts can arise. As Frank Moulaert explained during a workshop he offered in the doctoral program, actors gather on these dialogue spaces to build a common view on the problem at hand, but they will not agree on everything. Someone can leave the table for a while. However, finding reasons to come back to the table and keep the dialogue moving forward is what networks are about. And the process itself is often transformative. Social justice cannot be built from closed groups, formed by members with identical positions, and it is not only about finding alternative ways of satisfying the needs of people, but also about building solidarity, and fostering mechanisms for democratic functioning, to support the sustainability and lasting impact of those efforts. *Integrated area development* is a concept that embeds development efforts in localities by connecting local actors in different positions, without aiming at generating growth peaks, but aiming instead at satisfying essential needs of a larger number of persons and groups. Operating from localities, integrated area development enables actors to consider the context, features, history, structures, and institutional dynamics of the territories involved.

Multi-scalar analysis for bottom-linked governance, entails not only observing how for one level to function other levels pose conditions or create possibilities, but also considering how one group of sources can open the way for another group of sources with a different position towards the problem. It is the interplay of the various viewpoints which renders the rich analysis available. It brings the researcher to consider pieces of data not to relate cumulative but as entry points for new aspects of the problem at hand.

> Different analytical entry points can be combined to facilitate a better understanding of the potential complementarity between social innovation as a series of bottom-up strategic initiatives with local roots and as a coherent set of top-down but “enlightened” institutional reorganizations that could enable and promote bottom-up initiatives at different spatial levels. (Jessop et al., 2014, p. 111)

The bottom knows the problem at heart but does not have the position and the resources to build solutions. The top has the power but does not have the knowledge or the organizational setting and specialized resources to successfully implement innovations into complex systems: interscalar collaboration is needed, to overcome bottom-up or top-down approaches into multilevel, bottom-linked governance.

In the area of migration studies, Nina Glick Schiller has promoted for many years a transnational, multi-scalar and networked approach to migration studies, which questions the surpassed methodological nationalism from which many classic migration theories used to stem. In a recent publication she explains the relevance of multi-scalarity in policy discussions about migration:

> Multi-scalar networks link individuals to institutions of differential power … The often globe-spanning political, economic and cultural actions of all these players are part of the specificity of local life. Migration is not a separate story but is part of the larger processes that includes all people, migrants and non-migrants, living in a locality and connected to each other and to multiple places and institutions through diverse networks of differential power. There is no macro-, meso-, and micro-level and no push and pull. Therefore, there is no dichotomy between the local and the global or between structural and agentive analysis. Once multi-scalar processes are understood, scholars, policymakers and all the rest of us can shift our focus from differentiating natives from strangers to creating a politics that speaks to the interconnections among differentially empowered actors. (2020, p. 34)

Social innovation research has also been introducing a multi-scalar approach on policy discussions for a long time, centering precisely on transforming relations and connections between differently empowered actors to create social change. The same rationale should be brought to health policy discussions aimed at shaping accessible health services, which should take stock of a multi-scalar approach, by considering the variety of actors in the field, including practitioners on the front lines, as well as excluded and disempowered groups.

In this doctoral research, the creation of a large multi-scalar network was not available. However, connecting with existing networks of healthcare practitioners implementing changes in more accessible service delivery to migrant patients was[8]. It is not argued that this research generated a process of social innovation, but it certainly documented one that was already happening, and offered a small contribution to it, by facilitating instances of organizational learning and joint problematization.

Social innovation is a favorable terrain for the incorporation of Bourdieu's sociological work on field dynamics. Moulaert's reflections on structural realism (see also Moulaert & Van Dyck, 2013), link with the epistemological work of Bourdieu (e. g., 2004). This work facilitated a deeper understanding of the healthcare organization being studied, within its context, as a dynamic and contended field going through a transformation. Bourdieu is, in fact, not alien to transformative research:

> to denounce hierarchy does not get us anywhere. What must be changed are the conditions that make this hierarchy exist, both in reality and in minds. We must work to universalize in reality the conditions of access to what the present offers us that is most universal, instead of talking about it. (Bourdieu & Wacquant, 1992/2008, pp. 84–85)

Moulaert's observation that "case studies should be analysed using a methodological framework that recognizes the intrinsic interaction between agency, structure, institutions and discourse (ASID)" (Moulaert et al., 2013, p. 445) was an important epistemological principle for the construction of this case study. The methodological flexibility of both the overarching approach of social innovation and the concrete case study design, allowed to incorporate ethnographic methods.

Ethnography emphasizes discovery, using open-ended methods to better understand a complex problem without assuming it to be clear-cut, while documenting its dimensions and exploring its potential causes and solutions (see aslo Schensul & LeCompte, 2010, pp. 32–39). Schensul & LeCompte argue

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[8] Throughout the study, a connection with the SIMM (Società Italiana di Medicina delle Migrazioni), the Italian Society of Migration Medicine inspired much learning, particularly the meetings of the local GRIS, or Gruppo Immigrazione e Salute (local chapters of the SIMM dealing with migration-related issues in healthcare delivery). See https://www.simmweb.it/

for the benefits of using applied ethnography to solve organizational problems in adapting services to the emerging and changing needs of users (as does Bruni, 2003). They also argue in favor of the combination of ethnographic and action research traditions in a blended approach, as they might involve stakeholders in the interpretation of data, generating a more accurate and context-relevant analysis, as well as enhancing the impact of emerging data in the field and in the actors themselves, thus favoring more durable change (Schensul, Schensul & LeCompte, 2016). Ethnography is particularly useful in exploratory research on diversity (Blommaert, 2013, 2018a), as it helps conceptualize the microhegemonies in mechanisms of inclusion and exclusion, which entail moralized behavioral scripts that the renown sociolinguist Jan Blommaert has described in terms of *chronotopes.* (Blommaert, 2018b). Moreover, ethnography favors a concreteness which goes beyond discourse, to include the documentation of physical and material environments and objects, as well as consider their impact on field dynamics. This has been very useful in medical sociology research, for example, regarding the technical nature of patient processing practices. Davina Allen reflects on the impact of technological objects and processes in the medical context (See Allen, 2014; Bruni, 2005). As Bruno Latour (1999, 1993) reminds us, the concept of agency must not be limited to humans, rather multiple actants need to be considered, as many of our actions are technically mediated by objects which are more than mere instruments, as they enable us to enhance the scope of our possibilities:

> The attribution to one actor of the role of prime mover in no way weakens the necessity of a composition of forces to explain the action. ... Action is simply not a property of humans but of an association of actants and this is the second meaning of technical mediation. Provisional "actorial" roles may be attributed to actants only because actants are in the process of exchanging competences, offering one another new possibilities, new goals, new functions. (Latour, 1999, p. 182)

The study design and particularly data collection, was attentive to the agentic effect of spaces and objects in the configuration of hospital praxis, throughout fieldwork and during data analysis. It has proved useful especially when finding out the effects that confinement in packed reception centers played on the psychological wellbeing of young asylum seekers, the effect of a camera lens pointed to the signs of torture engraved in a refugee's skin, the complexities of negotiating privacy, sounds and smells in the four-bed and blocked windows rooms of the maternity ward, or attending a meeting of neonatal intensive care nurses, mostly occupied with discussions on incubator models, their handling protocols and technical features. In these and other instances the embodied nature of relations and knowledge came to light, especially in a hospital, where patient bodies so often are dispossessed of their agentic initiative, being rendered themselves a field for someone or something else's action.

Another intentional effort in the research approach was the practice of reflexivity about the researcher's position in in the field. Without renouncing the aim to contribute to the transformative process under study, Bourdieu's understanding of reflexivity (Bourdieu, 2004) brought to examination the evolving process of knowledge of the field and its complexities, as well as the shifting position and relations of the researcher within the field. As Bourdieu explains, reflexivity does not regard only the individual position, but the disciplinary biases and categories:

> Reflexivity calls less for intellectual introspection than for the permanent sociological analysis and control of sociological practice... It entails the systematic exploration of the 'unthought categories of thought' which delimits the thinkable and predetermines the thought... What has to be constantly scrutinized and neutralized in the very act of construction of the object is the collective scientific unconscious embedded in theories, problems and categories of scholarly judgement. (Bourdieu & Wacquant, 1992/2008, p. 40)

Coming from migration studies, the observation of service delivery reveals a different picture than it does from the medical perspective. The involvement of practitioners as research partners, that was encouraged by the social innovation paradigm, brought into question disciplinary and scholarly biases, as well as the advantages of an "outsider" position of a research process not governed by the field's hierarchies and power structures.

> We must be aware of our subjectivity and be capable of identifying its impact while continuously interrogating it. Research methodologies and methods have been developed by people who see the world in particular ways, and every time a research tool is used, the researcher must be aware that it contains the perspectives of those who created it. Being responsive to these potential assumptions or tacit theories in ourselves and others is the essence of reflexivity. Reflexivity requires that we embrace our subjectivity and actively identify its impact on the research process. (Kirby, Greaves & Reid, 2006, pp. 19–20).

The examination of the implemented processes of collaborative knowledge construction, and the asymmetric power relations it encountered in the hierarchical field of healthcare were permanently interrogated, through the tool of the research journal that was kept during the entire research process. It was a space to describe and elaborate upon prejudices, expectations and reactions to the data, as well as to discussed major data points with the extremely talented and available supervisor of this work, as with key research partners. It allowed to distinguish when biographical and positional factors of the researcher were producing a deeper understanding of the emerging data, and when they generated blind spots instead.

2.3 Focus on Practitioners as Research Partners

This study focused on the role of practitioners. The fact that they were the driving force behind the creation and implementation of accessibility measures was common knowledge within the hospital. This focus was not exclusive, as it included other types of actors. Moreover, practitioners' agency was framed in the context of the system they acted within, and the networks they created inside and beyond that system. The study also documented their contrasts with adverse internal and external structures, their collaborations with different sectors, agencies and organizations, NGOs and governmental branches, as well as their meaningful connections with national and international networks related to this issue.

Why focus on practitioners? Firstly, because innovation in service provision requires innovation in providers, and in the way in which they relate to others, individually and collectively. But they are key in connecting the top with the bottom, to renegotiate more inclusive language and meanings, services and resources, agendas and regulations, in the unpredictable and complex context of healthcare services. The social innovation perspective can open new analytical and practical possibilities in the study and management of the issue of how to reengineer a healthcare system, redistributing its resources and tasks, allowing change in its processes and relations in a way that would result in the inclusion of previously excluded groups. This work argues that the approach of social innovation can be fruitfully used to look at the problem of how to improve service delivery to ensure a better access of marginalized groups to healthcare.

Secondly, this choice responded to the needs of the research question, and the limitations of the research field. The research question regarded how to generate more inclusive healthcare service delivery. In San Maurizio Hospital, practitioners were organizing, learning, innovating, and collaborating around more accessible services for immigrant patients. Thus, the intent was to engage mainly doctors and nurses from wards that were improving accessibility for migrants and incorporating for greater context other actors both internal (such as hospital social services or the office of public relations) and external (such as relevant NGOs, or intercultural mediators). It would have been greatly helpful to have access to patients themselves, but for hospital regulations and privacy reasons that was not doable within the framework agreement for this research.

Moreover, this approach to practitioner involvement is coherent with the social innovation approach and promotes socially robust knowledge (Nowotny, 2003). The notion of socially robust knowledge has greatly influenced the process of knowledge construction alongside practitioners:

> Scientists become one actor, next to others, that add ingredients to questions about complex political issues. Next to classic scientific quality-criteria of validity and reliability, the social robustness of knowledge production becomes essential in the scientific validation process. … Social robustness as a matter of fact involves the recognition of 'local knowledge' or 'lay knowledge' as valid knowledge as well as the approval of validity and truth of knowledge beyond university communities … Validation of knowledge is continuously negotiated with concerned parties. These can be practitioners, citizens, people

> in socially fragile conditions, technical experts, scientists from different disciplines. (Moulaert & Van Dyck 2013, p. 471)

How were practitioners involved? They were conceived as research partners, all of them participating in data collection and having the opportunity to offer feedback to research outcomes. Their position in the research was carefully protected. When discussing methodological choices during a supervision meeting, Susanne Elsen posed the question: "how would these research methods shape your relation to your participants?". That question had a lasting effect on field relations, on methodological choices, on data collection and analysis. Moreover, a complex system approach was applied to the observation of collaborative interactions among services and organizations, in the creation of new services or in the improvement of the accessibility of existing ones. Interview content analysis was not just cumulatively handled, but close observation was given on the positions occupied by each participant in the field, and to how such position might influence their perspective.

In particular, three practitioners were recognized within the hospital as being instrumental in generating change, and leading accessibility initiatives. These *key practitioners* were interested in a dialogue that could offer a shared space to document and reflect upon their efforts, resulting in more effective practices and improving dissemination. They were involved from the start in research design and data collection strategies, being instrumental in enabling field access. For instance, they offered information and guidance in the process of acquiring hospital administration's approval for this doctoral research. They helped shape forms of access to the field that would not interfere with service delivery. For instance, by joining medical and nursing staff spaces, trainings and meetings, for participant observation, as well as dedicated feedback moments where the study's emerging analysis was iteratively discussed with practitioners, including their input in data analysis.

The medical activists encountered in the field do not experience conflict but continuity between their medical profession and the advocacy they engage in to promote their patient's health. Moreover, engaging in social sciences research and advocating for the disadvantaged are not seen in this study as conflicting but complementary roles. Research questions and premises were transparently presented to practitioners, creating a curious and non-judgemental interview environment. Apparently, honesty begets honesty, as the variety of their answers shows the field's diversity, ranging from reports of inclusive practices in advocacy for migrant rights, to unapologetic accounts of exclusionary or discriminatory practices, and the motivations and convictions which arose them. All of it was taken as precious data.

2.4 Case Study Methodology

Inspired as it was by a social innovation approach in its epistemology, this work was technically constructed as case study research. Yin's definition of case study research is twofold, including the scope and features of it:

> A case study is an empirical method that investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident. … A case study copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result benefits from the prior development of theoretical propositions to guide design, data collection and analysis, and as another result, relies on multiple sources of evidence, with data needing to converge in a triangulating fashion. In essence, the twofold definition – covering the scope and features of a case study – shows how case study research comprises an all-encompassing mode of inquiry, with its own logic of design, data collection techniques, and specific approaches to data analysis. (Yin 2018, pp. 15–16)

During the literature review, it was apparent that the health of migrants was an increasingly researched topic, but there was a shortage of organization-wide studies on accessible healthcare delivery for migrant patients (especially considering a complex-systems approach). The study started with many questions and few organization-wide studies on healthcare accessibility for migrants: *many more variables of interest than data points.*

As Stake explains, the research questions in a case study are often selected, defined and refined gradually, in a process he calls progressive focusing, that starts from 10 or 20 research questions that become two or three (Stake, 1995). In this case, the study progressively focused on the following research questions:

1. Which changes have been implemented in service delivery to facilitate accessibility of healthcare services for migrant patients?
2. Which actors are shaping and implementing those changes? To which difficulties are they responding, based on which knowledge?
3. How might structural conditions at various levels, in society and in the organization, facilitate or obstruct the process of service adaptation? What more (or better) could be done?

In case study methodology, sources of evidence are necessarily diversified. Yin (2018, p. 114) distinguishes between 6 types of empirical evidence. The choice of sources must be congruent with the research problem and its context. This case study, during data collection, made use of a variety of data sources, in the categories mentioned by Yin:

1. Documentation: The research was given access to documents produced by the hospital administration, such as relevant hospital reports containing annual statistical data regarding delivered services. Specific wards and offices also shared data and documentation relevant to service delivery protocols, charting practices, intercultural mediation, and information for patients. Documents provided by other organizations were accessed too, such as linguistic and cultural intermediation agencies, NGOs, social services and the National Migration and Health Network.
2. Archival Records: Mainly, the data used regarded migration and health, from official statistical agencies both at the national and provincial level, aggregated according to different variables, for comparative purposes.
3. Interviews: 62 semi-structured in-depth interviews were conducted with a variety of actors within and beyond the hospital.
4. Direct Observations: observations were recorded in real-time during the case study, on a research journal, throughout the research process.
5. Participant-Observation: it was allowed to the researcher to be actively involved in a variety of situations being studied while observing them, such as training programs, ward meetings, nursing groups, and more, with such experiences and observations being described on the research journal.
6. Physical Artifacts: objects, tools, instruments, or other physical evidence, was not collected, but those being deployed in hospital spaces, were doc-

umented, in some cases with pictures, when particularly relevant to the study. For example, ritual materials regarding different religious beliefs kept available for services in the Neonatology Ward, for instances of infant deaths.

Various sources of data must be related to each other in consistent forms of triangulation, in a way that takes advantage of the explanatory potential and situated approach that case study methodology allows. Patton (2015) describes four types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation.

The effort of this case study was to collect empirical evidence that could help answer the research questions on accessibility efforts regarding migrant patients in the province's main hospital. In responding to those questions, the various sources of data were triangulated in various forms. Emerging data was continuously triangulated, by comparing the views of different interview partners, and the different sources of evidence, and it was iteratively discussed with key actors, who played the role of research partners, allowing for investigator triangulation, which on doctoral research is a rare opportunity. According to Madden, participatory research approaches offer richer triangulation opportunities:

> in participatory ethnography, triangulation enhances the researcher's ability to interpret findings through collaboration and cross-verification with participants, who serve as co-researchers in the process. This multi-perspective approach enriches the depth and authenticity of insights, allowing researchers to align more closely with participants' lived experiences. (Madden, 2010)

Triangulation of theories was a permanent practice facilitated by an eclectic theoretical curiosity, which implied not only theoretical acquisition by literature review, but also theoretical creation and refinement by pattern matching, explanation building, logic model testing and perspective shifting. These were permanent features, not only stages of this research, which reinforced its construct validity and internal validity (Yin, 2018).

Methodological triangulation was enriched using an ethnographic approach to data collection. This is not anthropological research, but the excellent ethnographic training offered by the PhD program, and Strauss' adage "everything is data" definitely had an impact.

The space for data and methodological triangulation, which facilitated association and comparison of data outcomes of different methodologies, was the case database. It was a collection of different types of documents concerning the research study: fieldnotes after participant observation, interview transcripts, research journal entries, hospital reports, and more. NVivo software was used for codification, but also for comparison, connection, search and navigation of topics across different types of data emerging from different research methods.

2.5 Research Stages and Actions

This section describes with more detail the research process by which this chapter was constructed. Four main research stages can be distinguished, with correlated actions. However, they were not sequential, but often overlapping. For instance, data had to be collected on the issue and the context during research design, to evaluate research strategies' feasibility. Moreover, intense phases of data collection were also intense phases of impact and dissemination within the organization, not by disseminating research *outcomes*, but by disseminating research *questions*. In fact, questions asked during interviews produced a space of dialogue among practitioners, some of which seeked contact after interviews to add new reflections, report peer discussions, or to ask an opinion on emerging questions they were posing about their accessibility practices. Therefore, with the disclaimer of conceiving stages as aspects and not sequential moments, Table 3 summarizes main stages and actions.

Table 3 – Research stages, timings, and actions

Stages	Actions
Exploratory stage Research design 2017	• Getting access to the field. • Locating key areas and partners. • Acquiring orientational information and setting goals. • Crafting an initial research design. • Getting approval from both the University and the hospital administration. • Starting a research journal.
Descriptive stage Data collection 2017–2019	• Starting systematic data collection and inscription: 60+ individual interviews. • Delivery of group presentations on the project. • Participant observation in hospital areas, meetings and training sessions. • Gaining access to Hospital reports and service-specific documents. • Anonymization of sources and data protection protocols.
Explanatory Stage Data analysis 2018–2019	• Transcribing interviews and coding (Nvivo 12). • Doing thematic, network and discourse analysis of data. • Having feedback sessions and follow up interviews. • Discussing emerging data with key partners and academic community.
Impact stage Dissemination 2018–2021	• Academic outputs: dissertation, articles, presentations. • Field outputs: hospital recommendations, networking.

2.5.1 Exploratory stage: Research design

The exploratory stage of the research entailed some desk research: a scoping literature review, data gathering on migration and health in South Tyrol, as well as hospital services, and a study of potential methodologies. It also entailed ethnographic exploration of the field, such as participant observation in the public areas of the hospital, activation of existing contacts in the healthcare system and creation of new ones, fact-finding, and mapping areas in which accessibility efforts were being reported, that is, the maternity ward (including gynecology, obstetrics and neonatology) and the clinic for undocumented migrants. Establishing contact with the three key actors in accessibility efforts (red rhombus in the graphic) and securing their participation was strategic. They greatly facilitated gaining hospital administration's written authorization for the research, recruiting more than three quarters of staffers working in the target wards for interviews, and co-interpreting results.

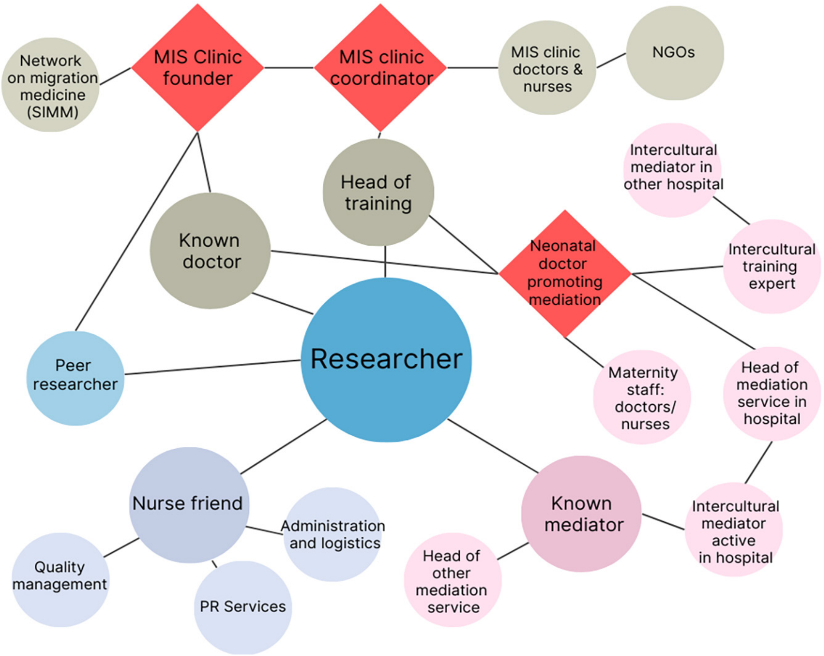


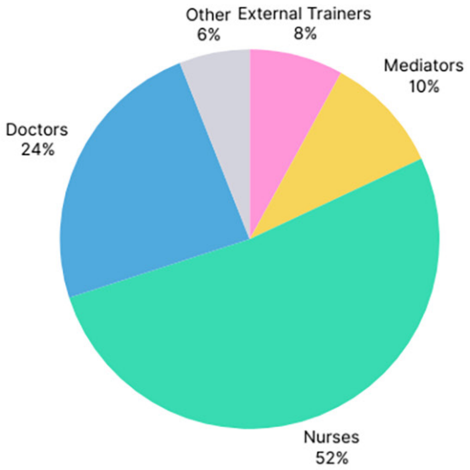
Figure 6 – Map of snowball participant recruitment: Red are key actors in accessibility efforts, in pink maternity services, in brown MIS-related services, in lilac administrative staff.

2.5.2 Descriptive stage: Data collection

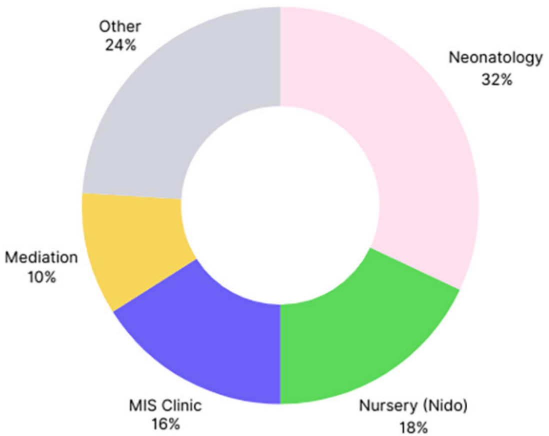
Copious notes were taken, regarding direct observation and participant observation in fieldnotes. All research processes and early analytical insights were reflected upon on a research journal. Documentation materials were shared by practitioners, but the core of the data was gathered through 62 interviews, 50 of which to hospital practitioners. Details on interview partners in Figure 7.

When it comes to interview techniques, the influence of ethnographic literature (Spradley, 1979/2016; Campbell & Lassiter, 2015) is noticeable, as well as other forms of qualitative interviewing, such as the focused interview (Merton, 1987), the discursive interview (Cardano, 2011). Particularly useful was the problematization of fieldwork and the contextualization of verbal accounts of practice in workplace research by Aaron Cicourel (2003) in the med-

INTERVIEWEES BY PROFESSION



INTERVIEWEES BY SPECIALTY



TYPES OF DOCUMENTS

- Hospital reports
- Ward-related documents
- Mediation-related documents
- MIS-related documents

TYPES OF FIELDNOTES

- Observation in hospital areas
- Staff meetings/ Feedback sessions notes
- Snowball interview notes
- NGO and mediation notes

NUMBER OF INTERVIEWEES

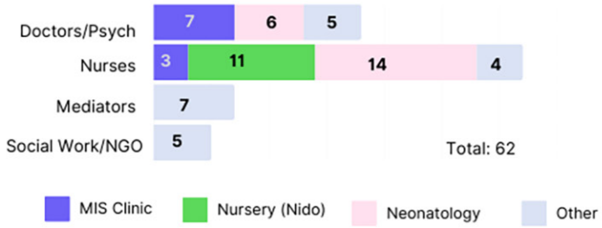


Figure 7 – Data sources in detail. Number of interview partners by area of work and by professional profile.

ical setting (Cicourel, 1981, 1985, 1987). Cicourel's readings were not only useful to prepare for data collection, which brought to increase the attention to settings, physical expressions and surrounding circumstances to locate the collected data in its context of production.

The interviews were semi-structured and discursive. The questions were not a formalized script to be applied rigidly, but rather the starting point and eliciting device for the narrations of medical professionals about their everyday practices regarding migrant patients. Most participants had received a presentation or at least a handout of the project description and the three main questions of the research, to make them aware of the interview scope. Interviews were started by explaining privacy commitments, asking permission to record and acquiring a signed informed consent form.

Each interaction was different, as new questions were posed in response to practitioner's accounts, to confirm understanding or elicit further information on mentioned topics. In some cases, questions about their professional trajectories or personal connection to the topic of migration, were added, if they referred to it. To facilitate concreteness in the data, the *concrete example question* was added: "Is there a case that has remained in your memory as especially significant?".

During interviews, a receptive mode is the usual stance of the researcher, however, sometimes emerging data was shared to obtain feedback, especially in later interviews or with expert informants. For example, when interviewing a ward chief, reporting suggestions gave an opportunity to estimate responsiveness and flag potential obstacles. This tactic was referred to by research partners as "cross-pollination". It consisted in catching an emerging piece of data (for example quantifiable data, or more often a specific proposal, presented by one interviewee), and bouncing it back on subsequent interviews, for enquiry, verification or contrast. It often had to do with proposals to improve the service. These would be introduced without taking a personal stance on it, to allow practitioners to respond in any direction. In some cases, proposals were supported by new considerations, in other cases they were objected to, or potential implementation problems were pointed out. It helped the study gather more points of view, and it helped practitioners bring further their joint problematization and solution-seeking process.

The *the system question*, that is: "what could the system do better or differently to support inclusive practices?" sometimes encountered hesitation. Especially among younger nurses, maybe for a fear that their words could have been taken as a criticism of management. In those cases, the question was rephrased, locating it in a hypothetical scenario, to invite their imagination and diminish their feeling of exposure: "Imagine you could ask for anything, and the hospital had unlimited resources to help you make your services more inclusive. What would you ask for?". That was usually effective, and they started indicating directions for further change.

Handling interviews in the workspaces of practitioners was informative. It allowed to observe first-hand the role played by spaces and objects and the embodied significance they acquired when occupied or deployed by actors in specific ways during the work of boundary construction or meaning making. For instance, seeing nurses fill in records of the amount of milk mothers produced, led to the discovery that there was a "milk production" objective to be achieved by nurses, through teaching and encouraging mothers to breastfeed. They regularly reported maternal milk production levels on staff meetings, and this brought to context some of the criticism of nurses towards immigrant mothers who were not interested in breastfeeding. Interpretations constructed and deployed through objects and practices are not neutral, rather charged with normative boundaries and meanings about what childbearing ought to be for a woman. Maternity nurses seemed motivated to manage expectations of new mothers, criticizing pre-partum courses that seemed to idealize and romanticize early motherhood. When new mothers appear relieved, thinking that the worse pain has passed after childbirth, they are quickly reminded through posters, breast pumps and diaper genies that it is only beginning of years of sleepless nights and self-sacrifice. It showed how important objects and spaces can be in the process of knowledge construction, and how embodied practices and material realities in the field should be closely observed.

As data piled up, dates and times of interviews were reported in a table, with names and codes of interview partners, which was password protected and located in an offline memory drive, together with the recordings and complete transcripts of interviews. An anonymized copy of the list, and of the transcripts were included in the case study database, to protect participants' identities. Not only were participants' names removed from transcripts, but also other persons' names that were mentioned in interviews. Someone who works in the hospital could identify them even if referred to with a codename, therefore no transcription of any interview has been ever brought or shared in the hospital field or with any other person but the research supervisor. Concepts or opinions emerging in the interviews were referred to other interviewees, for feedback, but without indication of sources. The process of transcription was helpful to flag relevant content unnoticed during interviews, as well as to observe the evolution of an understanding of the context and the problem, which brought more specific and targeted questions.

2.5.3 Explanatory stage: Data analysis

The renowned migration scholar Paolo Boccagni in Trento University, after hearing about the research design and fieldwork preparation, observed that if I was expecting to find a collective voice, I should prepare to find a cacophony instead. It was very useful advice. It took some time to make sense of the wide variety of the data collected, and the different meanings, motives and forces enacted in participants' discourse. Data analysis was layered and progressive, and it started during data collection. This offered the opportunity to verify initial outcomes by refining questions in subsequent interviews or discuss them directly with key participants, who were consulted for data verification and interpretation.

The coding process of all interviews was handled through Nvivo 12. Main coding entries derived from the three questions guiding the research, but most of the subcodes structure was developed during and after fieldwork.

To go through such a large amount of information, three types of processing were necessary: thematic analysis, network analysis and discourse analysis. They were not applied systematically to all gathered materials, but rather different methods were used for different chunks of data, relating to the various aspects of the material, as hereby explained.

Thematic analysis (Braun & Clarke, 2006) was applied using Nvivo, to make sense of the massive amount of data gathered in the case study database. It was helpful to give a general overview of the complex process observed, and helped connect and compare data from different sources, as well as generating a detailed codification structure. During the coding process, two aspects acquired unexpected relevance, so it was necessary to look at them more closely with appropriately targeted methods.

A basic form of *network analysis*[9] was used to map the connected interplay between actors creating change. It clarified the fact that no single actor could have done it separately, nor were they acting as a unified collective force. The changes in the hospital context had originated by different, albeit connected, networks, constituted by interacting actors who were occupying different positions in the system and had to find compromises over very different knowledge, interests and priorities. More often than not, the effective move creating the conditions for change had been the powerful forces taking a step back and giving space to medium level figures taking initiative and developing their influence. They were, after all, closer to the issue and could ultimately handle the problem by identifying what, where and how to implement change.

The *narrative analysis* (Bamberg, 2012) was useful to understand with greater depth the process of knowledge construction. Practitioners' reports were not principled positions in favor or against changes implemented for the accessibility of migrants. The discussion was focused on technical aspects of implementation, on the advantages or disadvantages of specific interventions, in research allocation and delivery priorities. Enaction of changes by comparable individuals were very different. And the motives behind action (or inaction) were even more different. As Williams (2004) points out:

> Narratives are small windows opening into the gritty realities of social structure and social change from a particular position and point of view. In this sense, they provide not only truth about personal experience but also material through which we can understand more fully the dynamics of a time and a place. (p. 279)

The database contained rich quotes charged with meaning which needed to be unpacked and analyzed more closely to make sense of the meanings being negotiated between actors in the field. Some aspects clarified by a nar-

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[9] It has been kept simple to avoid the pitfalls of network analysis in healthcare flagged by Blanchet & James (2012).

rative analysis of practitioners' reports were: different views on migrant typologies and needs, different indicators of effective care or ethical relations with patients, different objections to implemented practices, which connected ward-level issues to larger organization-wide issues.

2.5.4 Transformative stage: Impact and dissemination

The academic impact of research included publications (Zadra, 2021a, 2021b), as well as numerous presentations in national and international fora. In fact, aside from multiple scholarly congresses, the research was presented at the Department of Social Work and Social Pedagogy of Gent University, at the Center of Migration, Citizenship and Development (COMCAD) of Bielefeld University, at the course of Gender and Diversity Studies in the Technical University of Munich, at the Max Planck Institute for Social Law and Social Policy in Munich. Scholars in those settings gave excellent contributions to the research process, with their questions and observations.

The transformative element of the research did not only include the final stage, in which outputs were created and results were disseminated, but the overall impact that the research had within and outside the field. The following table summarizes some of the impacts the research had within the hospital, according to key practitioners and other participants:

Table 4 – Forms of research impact in the field

Critical awareness	Practitioners report an enhanced reflexivity in engagement and decision making in processes and relations regarding migrant patients, as well as increased attention to less engaged participants, expanding the scope of the dialogue.
Connectivity	Connections were created through the research process between different areas in the field, circulating relevant information within and between wards, and with the administration, bringing new feedback loops and information pathways into the system.
Dissemination	Feedback meetings and output reporting among practitioners, opportunities to create interdisciplinary attention to the issues, and foster collective engagement.
Networks	The research supported network connections with the Italian Society of Migration Medicine (SIMM), and supported practitioners in the creation of a local chapter of the network.

2.6 Ethical Principles and Practices

The table below documents some of the ethical principles respected throughout the research, explaining how they have informed the research practices and processes. Several readings (see also Van den Hoonaard, 2002; Madden, 2022; Vervliet et al., 2015; Black, 2017; Hughman et al., 2011) were instrumental in shaping the ethical framework, as well as discussions with the supervisor, professors and peers.

Table 5 – Ethical principles in research

Principles	Practices
Practitioners as research partners	• Making participation voluntary, with no pressure from superiors. • Giving practitioners a choice of timing and location for the interview. • Expanding or contracting interviews, posing secondary questions according to practitioner's preferences. • Acquiring accounts as a valid, albeit partial, perspective, triangulating it with other sources without second-guessing. • Ask all interview partners for permission before recording. • Acquiring key partners' feedback on publications before submission.
Recursive dialogue	• Presenting the project in individual or group settings while asking for comments, supplements, rebuttals or reflections. • Meeting repeatedly with key informants for organizational updates, feedback sessions on emerging data, or network discussions. • Following up on information around interviewee interests and concerns and creating feedback loops.
Transparency	• An informed consent form, consistent with hospital format was signed by interview partners. • A summary of the research project, objectives and approach was available to participants, with copies left accessible. • Researchers don't have to say everything they know, but shouldn't ever lie or mislead.
Do no harm	• Ensuring anonymous data storage. • Ensuring confidentiality for participants in all fieldwork and outputs. • Minimizing potential negative effects of the researcher's presence in the field, as avoiding interference with practitioners' work. • Letting practitioners self-organize interview turns. • Sensitive occupation of spaces, especially when patient contact couldn't be avoided. • Don't waste anybody's time. • Give back by brokering useful knowledge and supporting positive change efforts with constructive feedback.
Respect of sensitive data	• If approval for patient contact was not granted, never approach patients, even outside the hospital, to avoid collection of unauthorized sensitive data. • When bringing up emerging content for comments to participants in the field, avoid identifying the source of the information.

Handling adversarial positions	• Maintain "ethnographic curiosity" when confronted with adversarial positions, making a conscious effort to avoid judgement in favor of observation, to collect richer data. • Ask for clarifications, motivations or examples through questions as "If I understand correctly, you are saying that...". When the position has been made clear, say "I understand your position" and move on. • Do not offer any form of instrumental approval or fake empathy, nor express rejection or judgement. • Be mindful of emotional reactions to the content one is exposed to and take it as data as well (Behar, 1996).

3. Reported Barriers to Healthcare Service Access

As shown above, barriers in accessing healthcare have been statistically demonstrated, even if they are still difficult to be specified or explained. This section addresses health practitioners' reports on the barriers experienced by persons with a migration background to access healthcare services. As it was not allowed to interact with patients, it predominantly represents the insights of hospital workers, including doctors, nurses, intercultural mediators, social workers, and other employees involved in patient interaction and service delivery. It is not expected that their accounts will capture the extent, depth, and variety of migrant patients' experience of barriers. However, practitioners' representation of migrants and of the barriers they encounter in healthcare do help understand the reasons and strategies behind the processes of innovation that are being described in this research. The value of data about reported barriers from practitioners lies in the information they contain about potential weak points in organizational processes, which could be resolved, as well as strengths and resources, which could be systematically mobilized throughout the organization. Moreover, the variety of such accounts helps explain the uneven nature of service provision and the significant role played by discretionality in shaping inclusive or exclusionary practices.

3.1 Barriers as Failed Interactions

The language commonly used to speak about barriers implies *attributes them to a group of persons* seen as fragile, unskilled, or with any other defect that renders them unable to use a specific space or service. However, doesn't it say something about *how the service is constructed*, that it is inaccessible to some groups of its users? This study argues that barriers do not pertain to those who remain excluded, considering them instead as *failed interactions* in the relation between structures (spaces, organizations, services, products, etc.) and their intended users (Bruni et al., 2007; Bruni, 2003). Furthermore, barriers to access often do not entail a complete and permanent exclusion of a group of persons from services: they might present in many different forms. For instance, they may create temporary obstacles, such as obstructing communication, thus creating risks, interfering with trusting relations, or eliciting conflict instead of reciprocal respect. They might entail extra costs or efforts for some to activate services, rendering them effectively unavailable or damaging the quality and effectiveness of services. *The experience of barriers is a contextualized and relational event*. If it is not properly addressed, it can become a structural element, with a significant negative impact on service performance.

In the area of healthcare, it is important to keep in mind that relations are structured interactively by the various actors involved, not only patients and practitioners but also the complex system of structural and symbolic elements in which interactions are embedded. The specific organization of timings and spaces, the structure of diagnostic protocols, the availability of choice in languages of interaction, the unspoken evaluation criteria, and many other factors may greatly influence interactions.

Moreover, both medics and patients bring their backgrounds to the encounter, made of internalized norms and beliefs, limitations and possibilities, prejudices, resources, and stories. Migrant patients have a share of causality in barriers, as many – especially new arrivals – may have limited mastery of local languages, not be connected to information channels, not be aware of where, how, and at what cost services are delivered, may act from a different cultural view of proper doctor-patient relations, and may not be socialized in the local organizational pathways and routines. Clinicians bring to the interaction their training and habits, beliefs and prejudices, communicative practices, and previous experiences. The healthcare system in which the interaction takes place determines the available spaces and resources, the norms and time constraints, the pathways, forms, and languages in which the information flows, the system of rewards and punishments, the strategies for the mass-processing of patients, the training opportunities and the organizational culture (Lipski, 2010). There are services based on a “sedentary bias”, which operate under the assumption of implicit knowledge about how things should work and offer no guidelines for newcomers[10]. When there is no transparent information on the cost of procedures, or when a family doctor is unavailable, it is hard for a family with limited resources to seek preventive or early treatments.

Barriers to access entail costs for the patients, in terms of health, quality of life, productivity, time, and money, but also costs for public healthcare organizations, which have to invest more resources to cope with the

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[10] This is part of what Edward T. Hall (1976) has described as a “high-context culture”.

heightened acutisation and chronicisation of preventable illnesses, with the spread of communicable diseases, with repeated ineffective visitations as well as diagnostic and therapeutic errors due to linguistic barriers alone (Lavizzo-Mourey, 2007; Saha & Fernandez, 2007; Meeuwesen, 2012). Barriers to access cause patient and staff dissatisfaction and a significant drop in the quality of services and may jeopardize informed consent as well as patient safety (van Rosse et al., 2016; Gadon et al., 2007). The fact that healthcare organizations have their share of causality in barriers to access also means that they have a space of agency to contribute to their solution by shaping more inclusive services. And they should be motivated to do it because as they are part of the problem, they also have a share in the costs and consequences, as documented by the literature.

3.2 Understanding Barriers

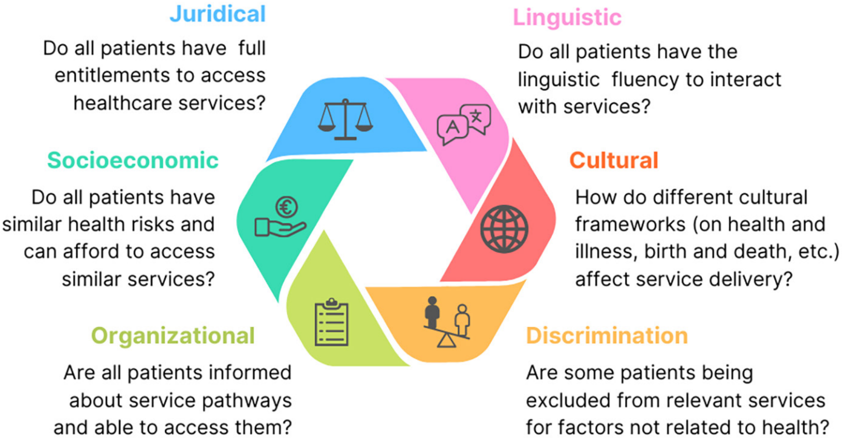
Access to health does not depend only on access to healthcare services. It includes healthy conditions of work and housing, among others. Throughout this work, only barriers in accessing healthcare services will be considered. There are various areas in which barriers can arise, obstructing access to services. Most of them are not exclusive to patients with migration background, and some persons of foreign origin might not experience them or some of them. However, exploring different factors that generate obstacles might help explain the statistics that document a reduced use of healthcare services by migrant populations and data that shows that when organizations deliver more accessible healthcare services, the gap becomes smaller (Di Napoli et al, 2017).

A recent systematic review focused on migrant women's access to sexual and reproductive health services contributes to a taxonomy of barriers, and concludes that there is a need of strategies at the institutional level:

> The most common barrier to SRH services identified in the reviewed articles was lack of information (57 %), followed by language issues (43 %), cultural differences (39 %), economic status (25 %), administrative barriers (25 %) and discrimination (14 %). These barriers led to under-utilisation of maternity services and contraceptive methods. Strategies used by migrant women to overcome these barriers were primarily based on seeking help within their own

> community or family settings. Conclusion: Strategies at institutional level to improve the access of migrant women to SRH services need to reduce existing barriers, promote health literacy, and train health workers to be culturally sensitive and responsive to the needs of migrant women. (Pérez-Sánchez et al., 2024, p. 1)

However, the literature about barriers tends not to make fixed classifications, and rightly so, because barriers are often intertwined and refer to more than one category (see also Straßmayr et al., 2012). Therefore, the list of areas offered in Figure 8, is only a roadmap, to better organize the material collected on this subject.



Juridical
Do all patients have full entitlements to access healthcare services?

Linguistic
Do all patients have the linguistic fluency to interact with services?

Socioeconomic
Do all patients have similar health risks and can afford to access similar services?

Cultural
How do different cultural frameworks (on health and illness, birth and death, etc.) affect service delivery?

Organizational
Are all patients informed about service pathways and able to access them?

Discrimination
Are some patients being excluded from relevant services for factors not related to health?

Figure 8 – Areas in which migrants might experience barriers in accessing services.

This section shortly describes juridicial, socioeconomic, organizational, and discriminatory barriers, while the following section will analyse linguistic and cultural barriers, based on the literature and on empirical data.

3.2.1 Juridical barriers

Challenges to access healthcare services by migrants in irregular situations may emerge both directly and indirectly tied to juridical status, as “intangible obstacles”, such as stigmatization, structural violence and fear may get in the way, even in the case of entitlements being granted (Larchanche 2012; Marrow, 2012). Sometimes practitioners' perceptions of deservingness, regarding persons with precarious immigration status get in the way (Vanthuyne et al., 2013). In Italy there seem to be less barriers regarding entitlements, healthcare services are granted to foreign citizens by law, even those in irregular situations, with a wide range of coverage. Italian policies for migrants' access to healthcare has been explained early in this work, showing that since 1998 the Law 40, Article 32–33 (Legge n. 40/1998), grants legally residing immigrants equal healthcare rights than Italian citizens, and entitles undocumented migrants to receive all "urgent and essential" healthcare services, where essential includes those healthcare interventions, diagnostic or therapeutic, related to pathologies not dangerous on the short term, but which in the long term could determine a greater damage or risk, complications, chronic conditions, or deterioration (Ministero della Sanità, 2000). Almost every healthcare service can be included in such a wide definition.

Moreover, in 2017 the Ministry of Health published its guidelines for the organization of health interventions in favor of refugees and asylum seekers (Ministero della Salute, 2017). These stated that, for these populations, services are free from cost in the same cases as Italian residents: for certain pathologies, under 6 and over 65 years of age, for pregnancy, and demonstrated indigence. Moreover, services are free from cost within the first 60 days from the emission of the residence permit. Under Italian law, healthcare practitioners are prohibited from reporting undocumented patients to the authorities.

However, even if Italian law grants generous entitlements to migrants, these often stay on paper, because of governance problems such as the inconsistency between national and regional provisions and regulations, the absence of control mechanisms, budgetary limitations, amongst others. Moreover, in Italy it is common that practitioners are uninformed of legal entitlements of undocumented migrants and exercise administrative or medical discretion to restrict their access, which is allowed to happen often because of the lack of control mechanisms (see also Perna, 2018).

Since the research was carried out, several attempts at reducing such entitlements have been made. The infamous Law n. 132/2018 (Legge n. 132/2018) also known as Salvini Decree, abolished residence permits for humanitarian reasons, increasing the number of persons bureaucratically driven to irregular situations as their legitimately acquired permit was not renewable as it ran its course. This excluded them and their families from previously granted protections and established ambiguous burdens of proof of "vulnerability" to acquire the residence permit for the treatment of medical conditions. Since then, in the name of security, immigration laws have increasingly eroded investments in basic protections for migrant populations and invested in expulsion mechanisms instead.

The diversification of types of residence permits and profiles of foreigners with different reasons to be present in the territory does not help render rights in general and healthcare access in particular any easier. Ambrosini (2012) speaks of the situation of migrants in irregular situations in terms of an "invisible welfare". The SIMM (Società Italiana di Medicina delle Migrazioni, 2022) in a recent mapping identified 17 different categories, with a different stratification of healthcare access rights. For instance, the healthcare limbo of immigrants in vulnerable situations coming from European countries that have not access to the basic European health insurance (called *Tessera Europea Assicurazione Malattia, TEAM).* The difficulty in pinpointing the right avenue from numerous and mutually exclusive bureaucratic pathways, is further complicated by differentiation of regional norms and organizational settings. This generates more challenges to persons that live in high mobility situations, such as migrants with disadvantaged labor arrangements. Moreover, the lack of clarity and knowledge about reciprocally exclusive pathways leaves healthcare organizations (or at least their street-level practitioners) hesitating to deliver services, as choosing an erroneous pathway would leave the hospital without proper reimbursements.

As in many other social issues in Italy, it is less a problem of legal principles than it is a problem of failing governance.

3.2.2 Organizational barriers

The way healthcare service delivery systems are structured may get in the way of accessibility for patients, and particularly immigrant patients (Geraci & Hamad, 2011; Blom et al., 2016; Dauvrin, 2013; Dobusch, 2017; Kierans et al., 2013). Some examples provided by practitioners regarded difficulties of immigrant populations when the opening times of services are inaccessible due to longer and more rigid working hours. Or when information on preventive initiatives is spread through channels which do not reach migrant families. Or yet, when interpretation services are not available out of office hours in situations of emergency.

Moreover, bureaucratic pathways may complicate access by making cost-free services carry heavy demonstrative conditions, as was also documented in other contexts (Miedema, Hamilton & Easley, 2008). In Italy, bureaucratic complications may get in the way of cost-free services which the indigent (immigrant or not) are entitled to. Namely, the long months that take to acquire the E99 indigence certification, during which healthcare services must be paid.

Another organizational challenge to accessibility is the lack of consistency in the knowledge, interpretation and application of legislation on the part of practitioners. The tendency, in some practitioners, to use discretionality to limit services to immigrants, was related by an interviewed doctor to the fear that good welfare and healthcare service would mobilize more migrants towards South Tyrol: "They think that if they are not cured migration will be limited, and that is just not true" (SCD01). The WHO observes that denying basic rights does not prevent migration, it only increases vulnerabilities:

> Withholding access to social protection, denying them the "right to the highest attainable health", is seen as an important element of "internal migration control", on the assumption that the fewer rights irregular migrants are given, the fewer will come. Detention is another internal control measure increasingly used, but measures such as these do not seem to have much effect on the numbers of irregular migrants. Their main effect is to increase the vulnerability of irregular migrants to marginalization, destitution, illness and exploitation. (WHO/Europe, 2013b, p. 107)

Migrant patients might not be familiar with the role distribution and related behavioral expectations between the participants in a medical encounter. The different types of practitioners they interact with, and the "handing out" the patient between them, e.g. from general practitioner to hospitalization, from doctor to nurse, from X-ray technician to specialist. Having to interact with multiple people about the same problem without having clarity about their different roles may create difficulty in adequately conforming to behavioral expectations they don't know about. Many nurses praise the compliance of immigrants who willingly submit to procedures as told and provide information only when asked. When they do not, some angrily judge them because they make their job more difficult by requiring time, explanations or persuasion. The fact is that the pathways through system are not always transparent, and migrants, as many other patients, may need navigational assistance.

Reporting disservice is also not practiced among migrant patients, as the Office of Public Relations in the hospital attested. Every patient is formally entitled to present complaints, but the Office, which received hundreds of complaints a year from local patients, reported they hardly received any from immigrant patients. They also explained that even if they pass along those reports to the Quality Office, only frequently recurring or particularly grave complaints about a service are consistently investigated and followed up by the administration. According to intercultural mediators, the process seems to be unknown or unreachable for migrants, which do not know or trust the system, thinking their complaints will be dismissed. If for any reason a local healthcare system decides it does not have the resources to grant a specific treatment, or thresholds are too high for the homeless to access, or a nurse is just not informed about the rights of a migrant in an irregular situation, there is no effective and accessible mechanism to seek remedy.

The high and sometimes hidden costs on healthcare systems of organizational forms of exclusion (Brodkin & Majmundar, 2010), both intentional and unintentional, should be better documented.

3.2.3 Socioeconomic barriers

The impact of socioeconomic factors on health and life expectancy has been widely researched at the global level, particularly since Michael Marmot headed the WHO Commission on Social Determinants of Health, publishing the report *Closing the gap in a generation* (CSDH, 2008). In Italy, a study addressing socioeconomic status (SES) particularly considering the variable of education level (Petrelli & Frova, 2019), showed its impact in life expectancy:

> Males with low education level in all regions show a 3-year gap in life expectancy at age 30 compared to those with high education level. In the disadvantaged Southern regions, both the less and more educated lost an additional year in life expectancy. (Petrelli & Frova, 2019, p. 36)

The economic marginalization of migrants in South Tyrol has been widely documented (see also Atz, Haller & Pallaver, 2017), and the social determinants of health brought by precarious work and living conditions also affect their access to services, which in sight of more pressing priorities is deferred until serious conditions arise. Socioeconomic factors have been shown to negatively impact on seeking preventive services and more so for marginalized immigrants with little connection to the local society and with limited access to information about healthcare services (see also Francovich, Di Napoli, Rossi et al. 2017, p. 24). Even considering that in Italy services are granted free of cost for indigent patients, local or migrant, and healthcare services are subsidized for all, not all are able to document their situation. The limitation of access to dormitories for homeless undocumented migrants and the limitations and conditions introduced to access reception centers, prevent many families from being reached by medical services at all.

The office of Social Services within the hospital represents recurrent cases among migrant populations, in which health and labor conditions are entangled to determine precarity and lack of security:

> the concrete, daily experience of the migrant who worked without insurance, who ended up in the hospital because he broke something, or an accident had happened; the domestic caregiver who out of the blue found herself homeless and jobless because she was sick, undergoing oncological treatment. (OHS07)

Neonatal doctors showed concern on releasing premature or recovering newborns in precarious living conditions. For instance, when parents are homeless, live in precarious housing, or in reception centers, with minimal resources. Specifically, they worried about hygienic conditions, adequate transportation to the housing facility, affordability of vitamins and medications:

> the problem is afterwards, when they are not in the hospital, I don't think there is a problem with access to the health care system, like that, but if they don't know it, they don't know how it's done, and then afterwards their conditions are precarious or hygienically inadequate, it's not like you can think about it in the hospital, right? We discharge children... it's not like we send adults home... So, some knowledge of what are the conditions in which the child is

> discharged, sometimes they are necessary, that's it. For example, if they have a roof over their head. Also maybe how they go home, where do they stay, that's all. Because there are those who come for them in conditions...Then you have to...I mean anyway...vitamins, those things that even healthy children have to take, you have to be able to acquire them, and so there has to be a whole organization, which is not the hospital, that has to take care of these things. (TD03)

As can be seen, some doctors consider such issues beyond the competence of the hospital, and hope that social services and agencies can ensure appropriate living conditions to infants born within the migrant reception system. They also realize that often that is not the case (Giannetto et al., 2019), and they experience frustration, sadness and worry, seeing that welfare systems are not always capable of ensuring safe conditions for disadvantaged newborns:

> In the case of a pathological newborn, we have a protected discharge, we need to collect information on where the newborn ends up: in which family context, if there is a family network that may support. In the situation of migrants, particularly those undocumented, you suspect that this family will end up in the train station, or in one of those hotels, or in a very crowded environments, where you doubt there are sufficient health and hygene conditions to enable an equal treatment of this newborn. It burdens us. You have the intuition that there are very painful experiences in the background, and you don't really know. Many women that are alone in handling the baby, and you ask yourself: how will it go? Will there be a support structure to ensure the safety of this mother with this baby? … We have heard often from mothers that they are having children as a result of sexual violence. They are depressed at discharge. They have some reference figures, but these situations are too many, and social services are overwhelmed, and we see that clearly. … The impression we have is that this mechanism takes a while to activate, and those who need support are much more than those who receive it. It is a support that goes beyond food and a bed, it would take a more holistic support. It is a political issue, it is complex to solve, but we feel upset because health is not equal for everyone. (TD05)

Reception systems should provide not only the bare minimum for survival (food and a bed) but spaces of healing from violent experiences lived during the migration trajectories. Socioeconomic conditions and inequalities, in this narrative, are a responsibility of a failing welfare system, that has eroded investments in migrant reception motivated by political calculations but end up harming innocent newborns and their victimized mothers.

3.2.4 Barriers generated by discrimination

Barriers may be created by discriminatory practices, when a patient experiences low quality or refusal of services in connection with their gender, or being associated to a community or class, or for their religious or cultural beliefs, or if extra conditions are required for them to access services for such reasons (see also Miteniece, Pavlova, Rechel et al. 2017; Nelson & Wilson 2018). Moreover, experiences of discrimination may interact with other factors of disadvantage, generating higher risks for mental health, as a recent study regarding ethnic minorities in Europe documents (van der Wal et al. ,2024).

Given the almost unrestricted entitlement to accessing healthcare services that our law grants, and the provision of free services for all those who are indigent, including migrants in irregular situations, it means that when they are not delivered services coherent with the entitlements and provisions of law, because the foreign origin of patients, it constitutes a discriminatory practice, whether caused by ignorance, or by intentional or unintentional bias. Among the interviews, some included harshly racist narratives, representing migrant persons as dirty, smelly, rule-breakers, who expect it all, which I don't see much purpose in reporting, other than when they determine discriminatory practices, as in this narrative:

> if the mother has been here for many years, and doesn't speak the language, I don't call the mediator … I give preference to our mothers, that are in need. I won't speak with someone that refuses to learn my language, to speak with me. (NN07)

It is a responsibility of the healthcare system to prevent such discriminatory practices and failed service delivery by properly informing practitioners about the legal rights of migrants, by implementing control mechanisms and sanctioning discrimination, as well as by facilitating an inclusive culture through training programs.

3.3 Linguistic and Cultural Barriers

The obvious meaning of linguistic barriers is the total or partial absence of a common language that generates obstacles in verbal, nonverbal and written communications between services and their users, hampering service delivery. Linguistic and cultural barriers are rightly seen as a complex entanglement (Dohan & Levintova, 2007). They seem to be perceived as separate yet connected difficulties, in the narratives of practitioners:

> Well, in fact linguistic difficulties sometimes... that is, it often happens that the parents come ... that is, they are only recently in Italy and therefore both parents do not understand, understand just a bit, and speak even less of the Italian language, and therefore the difficulty we have is to transmit what we want to say, both about the condition of the child and about what the mother will have to do when she gets home. So, regarding breast stimulation, how to manage yourself, how frequently, and also how the organization of the ward itself works. Then, there are also cultural problems. In the sense, maybe we have ..., surely, we have different habits in the approach with the child and maybe they expect something else. (TN08)

When basic interpretation is granted, still divergent meanings and contexts are attributed, according to the different frames of reference. Sometimes such meanings are relevant for medical care, as for instance at the moment of birth and death, in psychiatric treatment, or for informed consent in consequential and ethically challenging decision-making scenarios. In such instances, an interpreter is not sufficient to handle medical communication: trained linguistic and cultural mediators are an indispensable asset.

This section reports the accounts and experiences of healthcare practitioners in San Maurizio Hospital regarding linguistic and cultural barriers. It discusses the reasons that bring practitioners to see communication as the first and more consequential barrier in healthcare service delivery, and contextualize the issue by analyzing communicative processes, particularly in the maternity ward.

Consequences of limited communication in service delivery: "*It is a wall between us and them*"

In the literature, linguistic barriers have been shown to concur significantly in limiting the access to healthcare services of patients of foreign origin (Lebrun, 2012) or more generally, patients not fluent in the local language (Ou, Chen & Hillman, 2010). They cause ineffective interactions between doctor and patient (Deumert, 2010), they create risks for the safety of the patients (van Rosse et al., 2016), they are associated to errors in diagnostic and therapeutic decisions, to a poor understanding of medication instructions and side effects, to a diminished compliance with therapies, and less satisfaction with care (Lavizzo-Mourey 2007, p. 279). They may originate ineffective visitations, misdiagnosis, mistreatments and interfere with informed consent (Schyve, 2007; Seale et al., 2013). Patients facing language barriers are likely to consume more healthcare and to have more frequent adverse events (Bischoff & Denhaerynck, 2010). Linguistic barriers also contribute to the postponement of healthcare seeking behaviors, causing the escalation of healthcare problems, and a poor access to screenings and other preventive and health education initiatives.

After referring to the serious consequences of linguistic barriers documented in literature, the next section discusses practitioners' perceptions on the impact of limited communication with the patient in medical relations and in the quality of services rendered.

Superficial exchange of information

Barriers which reduce the scope of communication between clinicians and their patients have the effect of rendering the exchange superficial. Which is risky, being that clinicians don't have on record the medical history of foreign patients. A doctor noticed that asking enough questions and being thorough in compiling a medical history can make a difference:

> It is also to retrieve information, because they do not report... often they do not report, in my opinion, all the various diseases they have in their families. ... They probably don't have the habit or the thought that they can be important things, but then you always have to pay a little more attention, and in the end things come out. Maybe they find it a little harder to understand which are the

> things that interest us, to tell us, you see, but it goes well enough anyway. And the language, because for the other things is not that there are particular difficulties with them. So just a little more questions for the clinical history, to get the complete information. Yes, you have to be a little more careful, you know, with them, but not only them, huh? In general with everyone. Because it's not that all patients immediately think of the thing to say that is fundamental for us, right? (TD03)

As the doctor observes, local patients as well might not have on top of their heads all the relevant information. However, in the case of foreigners, a lack of contextualized knowledge of medical protocols, as well as a much more difficult access to medical records can be introduce additional challenges.

Misunderstandings

Reduced fluency in local language might bring to misunderstandings, which in the medical context can have negative consequences, and affect the quality of practitioners' work:

> The language is a barrier. We certainly grasp in a limited way, not much of what they want to express. And so there is certainly already a difficulty there, if perhaps a person understands badly, or if we want to express ourselves and explain to parents, and they already do not understand the language. Then already there is a difficulty and a barrier, where it is difficult, then, if I understand something wrong or different ... I mean… wrong... different. Then afterwards it is difficult for me to act in that way. That's for sure. (TN12)

Inefficient time allocation

Sometimes the lack of a common language leads to miscommunications which are frustrating for both practitioners and patients, and also lead to a greater time investment, in a context in which time is considered a precious and scarce resource, because of staff shortage. A nurse explained that non fluent immigrant patients take twice the time to have half of the quality in the work. Another expressed frustration for the repeated tries it took to explain simple things, as the double-weighing technique (that is, weighing the baby before and after breastfeeding, in order to determine the amount of milk consumed):

> It's a wall between us and them. Because really even the most trivial things, it becomes almost impossible to communicate, I don't know... many times we are lost, and we lose entire afternoons, to communicate that they have to do the double weighing ... They must come to us to weigh the baby before attaching it to the breast and afterwards, it becomes difficult. So, often you waste a lot of time running after them to find out if they have already breast-fed, if they have not breast-fed... that is, the linguistic difficulty is really significant. (NN04)

Reciprocal mistrust

Trust and mistrust are relationally built in communicative processes. It is harder to build trust and confidence when clinician and patient do not share a language, and the amount of information they manage to share is reduced to keywords or essential topics. It is also hard to create familiarity and trust across languages which have different communicative patterns. Sometimes the lack of knowledge of a communicative context makes people have a different perception of which are the appropriate styles of communication to patients, how to address women respectfully, how direct to be in communication, and appropriate length and style of turn-taking. A doctor shares some observations in this regard:

> So even if the father speaks perfectly, and understands me perfectly, I can't be sure that it arrives to his wife, because maybe he hasn't thought about it. These things happen, and then sometimes, from a cultural point of view, I can imagine. I don't know much about this, but I can imagine that certain things which we are used to say more directly, in other cultures are not to be said directly. As I was saying earlier, when one gives a diagnosis, the tendency of the translator is usually to estimate, or in some culture already the automatic assumption is that the doctor does not tell him the truth, right? [laughs]. (TD04)

The impact of linguistic barriers on the quality of healthcare services can be devastating. They threaten patient safety, they jeopardize informed consent, they account for barriers in access as well as ineffective visitations. They compromise public health and break therapeutic alliances, diminishing patient and practitioner satisfaction, and they end up generating higher costs to the healthcare systems than the investment it takes to contrast them. They are also linked to cultural barriers, as the translation of what has been said is often insufficient for reciprocal understanding, in the absence of a shared worldview, including meanings, values and customs.

3.3.1 Reduced linguistic skills *on both sides*

Linguistic barriers are mentioned by many as the first and more serious obstacle to the performance of healthcare services. Practitioners observe it may significantly cripple the ability to perform basic medical actions like taking a medical history, understanding reported symptoms or giving pharmacological instructions. A nurse said that not having a common language with their patients “is a wall between us and them”. It is also perceived as a serious limitation of human contact between care providers and patient families, especially felt in Neonatal Intensive Care: “On many occasions, if you go beyond the language barrier, you manage to get in touch more directly, humanly, which is very important to us in this environment” (TN06). Regarded by many as the most limiting barrier, it is also perceived as a solvable issue: “Linguistic difficulty is a big problem, but it is also the problem about which something can be done” (TCD01).

Language proficiency of staff members is influenced by local law, which requires all provincial employees to be certified as bilingual in German and Italian language, up to a level proportional to the educational level required by their job position. Many nurses have some English knowledge, but most are not fluent. Staffers with migration background are significantly more skilled at languages, as they master not only Italian and German, but often English and other languages, as Polish, Russian, Arab or French.

The unnecessary complication of bureaucratic language in written communication might in some cases function as *de facto* exclusionary practices, as a doctor points out:

> I got this letter once, from orthoptics, for a sight screening. I couldn’t even understand what I had to do with my son or where to take him. And I am a doctor. Go figure how clear it could be for a Pakistani family! Not all of them, but if they have a lower linguistic and cultural level, they struggle. (SCD01)

In practitioner's experience, linguistic resources of migrants vary, especially by length of residence (newcomers are less fluent in local languages than long-term residents) and gender (women from some countries of origin as Pakistan, Bangladesh and Nigerian are generally perceived as less fluent in local languages than men, while women coming from European countries as Albania are perceived as equally fluent as their male partners). Patients of foreign origin, when they are long-time residents in South Tyrol, are often fluent in one of the main official local languages (Italian or German). Some are facilitated by being European citizens whose mother tongue share roots with the Italian or German language. Others come from chain migration trajectories which have well established communities in the region, as Moroccan or Albanian immigrants, which are seen as being generally fluent in local languages. Some practitioners represent long-term resident women which are not fluent in Italian as difficult patients, underlining the difference that a common language makes in the quality of care:

> Between two Albanian mothers, one who knows Italian and the other who doesn't… We struggle greatly with the one who doesn't speak the language, while with the fluent one we have no problem. Therefore, the core of the problem lies there, in my opinion. (NN05)

Sometimes linguistic barriers are subtle, as the person has learned enough of the local language to be effective in basic interactions, but they are not ready for medical interactions: "-Madame, you have a polyp... -No. I have a cat!" (TD02). As can be seen, in this unintentionally humorous exchange, specialized medical language needs to be explained. However, at times language difficulties arise even at a level of vocabulary which is considered as common knowledge by doctors, such as the names of internal organs. Assessing the level of understanding of the patient can prove to be both crucial and difficult. A neonatal doctor recalled meeting an immigrant man on several occasions to discuss the failing liver of his newborn baby and the treatment options available. Judging by the parent's affirming feedback, and his general Italian proficiency, the communication appeared to go well. However, during the fourth meeting, the father asked: "Excuse me, doctor, but… what is this 'liver'?" (TD02). The practitioner then showed an illustration of internal organs on a book and clarified the issue. As can be seen, taking steps to assess comprehension and make sure key messages have arrived, is a productive measure with all patients, but especially important with patients with which practitioners don't share a mother tongue. To face this challenge, some practitioners use the "teach back" technique: having a patient repeat their understanding of the key messages, such as diagnosis, medication dosage, next steps, appointments, etc.

Patients experience linguistic barriers not only in receptive skills, but in productive skills as well. Patients who are not fluent in local languages have trouble expressing themselves: giving precise and complete information to their doctors, asking for the information they need, making their expectations explicit, or communicating difficulties they encounter:

> They can't communicate with us. Because they obviously are in need and are not able to express themselves in their own language with us. And they have a hard time communicating to us what their needs are, their difficulties, what they expect, and so on. (NN05)

Sometimes additional difficulties related to productive skills are caused by regional accents, even when practitioners and foreign patients find some common language. A nurse reported that some African patients "begin by saying –I speak English-. But in truth, for us their English is completely incomprehensible" (TN13). A linguistic mediator said that migrant patients also considered incomprehensible the practitioners' English. Either caused by patients' or nurses' insufficient fluency, the barrier remains. Interactive skills are most important in a clinical exchange, as there is a flux of information that becomes restricted, and both patient and clinician remain obscure to the other, creating gaps in understanding, generating reciprocal insecurity which in turn may generate avoidance of contact, and get in the way of trusting relations.

3.3.2 Times and mediums of healthcare communication

Time plays a significant role in medical encounters, usually characterized by their expediency. However, there are different degrees of expediency. Triage nurses in emergency services are trained to go straight to the point, whereas general practitioners, who have repeated contact with their patients, as they are charged with their general wellbeing, might invest more time making small talk, gathering non-urgent information on their general wellbeing and lifestyle, or establishing rapport.

The predictability or unpredictability of emerging health conditions and related services, as well as the acute or chronic nature of certain conditions also determine a difference in the expected pace of the encounter. Moreover, oftentimes chronic conditions frequently determine recurrent medical care in the same ward or with the same practitioners, which greatly facilitates pathways of access, as well as a reciprocal familiarity with persons and procedures, a document trail, and expectation management. On the other hand, sudden deteriorations, acute conditions or injuries might require an immediate exchange, in which language barriers are a greater problem as there might be not enough time to arrange for a mediator. The value of services such as immediate long-distance interpreting is precisely to respond to this kind of situations.

Turn taking in spoken interaction is also charged with meaning, and patterns of dominance in turn-taking often reflect relational asymmetries, which not always serve the purpose of facilitating trust and efficiency in medical encounters. A Somali colleague, commenting on my work, observed: "Your doctors are not used to listen. I wonder how they manage to do their job". Some doctors are more inclined than others to give the patients time to express their concerns. The experience of being heard, a doctor observed, has a great impact on patient satisfaction, but even more so when the patient is not fluent in the local language.

A bilateral flow of feedback may become necessary to ensure quality of care. In the context of neonatal medicine, patients and medical staff need to keep in motion a reciprocal feedback process on the status of the baby, because the situation can change at any moment, and the health of newborns is at stake:

> A child can change color; there can be a high temperature… How can this be conveyed to me if she does not speak? These are very important things. Besides, we can't wait for the mediator to arrive two days later or the day after, if the problem is right there, can we? (NN02)

In individual medical encounters, the time allowance for each patient might have a different weight on performance measurements, and influence communication speed expectations on practitioners. Patients not fluent in local languages would not be able to understand or predict these expectations or respond to them with the optimal amount of detailed called for in a certain situation. In those occasions, an increased reliance on written documents is often considered practical.

The written word is a different communicative space with time dynamics of its own. Official records, on paper or digital formats, by which the core information is collected and transmitted, from healthcare to the patient and between practitioners, can be both a challenge and a resource. Medical histories, test results, and other written documents carry essential information in a shorthand that often needs to be interpreted and explained by medical professionals, for patients to fully grasp their health implications. Moreover, some patients and doctors may heavily rely on written documents, avoiding direct patient communication, which is not conducive to contextualized and targeted patient care on the part of the doctor, or with cooperation and compliance on the part of the patient. However, in the case of lingusitic barriers, documents may prevent misrepresentation of essential information. The production processes of health records, particularly electronic health records, as well as their impact on trajectories of patients of various ethnicities, is gaining attention in medical sociology (Rozier, Patel & Cross, 2022; Kruse, Stein, Thomas & Kaur, 2018; Limburg et al. 2024). Documents such as test results or medical histories acquire a transactional significance for both practitioners and patients who rely on written data for fact-oriented communication which provides a starting point for more targeted and context-rich information to be verbally elicited.

Written documents might also prove helpful to disseminate health education or provide standardized information on health issues, services and procedures reaching large numbers of potential users. Non-urgent and relatively standardized communications can also be prepared in advance and delivered through instructional videos for massive consultation. Their convenience for immigrant patient care might lay on the fact that they can be translated to other languages and be readily available to facilitate health literacy or acquire informed consent for a procedure. The limits of their usefulness are determined by the expiration date of the content (it is difficult to standardize information that keeps changing) and the adequateness of a written or visual account of the specific content.

A written medical history recounting personal health trajectories might prove essential also on a longitudinal perspective. Especially in the case of super-mobility, in which migrants' transnational trajectories make it difficult for doctors to access archives or medical histories directly, health records might acquire a life-saving significance, provided they are rendered linguistically accessible. Moreover, in front of a skeptical practitioner, documents can be deployed to further a detailed understanding account of health conditions. To this effect, having a linguistic option for English in health communications could be greatly helpful for people on the move. For instance, the Greenpass to document Covid-19 vaccination status was available in South Tyrol in Italian, German or English. In contexts of embedded linguistic diversity, such as South Tyrol, the option between Italian and German in communications already exists, and extending it to English seems feasible, and useful, beyond emergency settings.

Moreover, in the hierarchic context of healthcare, a document-led bureaucracy tends to doubt a migrant's word until it is backed with official documents. This organizational culture does not only pertain to the medical field. It extends to all branches of public service bureaucracies, as law-enforcement, education and the justice system. The latter asks medical practitioners to produce documents certificating signs of torture or estimating the age of unaccompanied minors. The educational system asks neuropsychiatrists and pediatricians to document learning disabilities. Bureaucracies create standardized documents for other bureaucracies, in order to reduce a verbal account to a recognizable and classifiable case and open (or not) a certain services pathway. As stated by Sarah Ahmed, it is important to "reflect on the significance of vocabulary not by seeing words as repositories of meaning, but as enabling different kinds of actions within institutions" (Ahmed, 2007, p. 237). This is especially true of such formalized documents, enacted by practitioners who have the power to decide over the legitimacy of the claims of patients, which are not deemed credible enough without an expert's assessment. When the winter arrives to South Tyrol, only limited beds are offered to the local or migrant homeless. They are given priority if they have a certification of sickness, so they ask doctors to document their conditions. If obtained, such written documents can be a life-saving resource.

3.3.3 The case of medical emergencies

The extreme case in which linguistic barriers might have life or death importance, is the case of a complete communicative block during a medical emergency. If communication was hampered by linguistic barriers during an emergency, it could risk the physical and psychological wellbeing of the patient, and compromise the effectiveness of medical practice. A case has been provided by practitioners to this effect. A couple of Nigerian asylum seekers, recently arrived in Italy, with no knowledge of English or local languages, needed to have an emergency C-section, and there was no time to arrange translation services. Staff report the experience of panic of the couple, who continued to be terrified throughout all the night and calling for help, as well as the frustration of nurses, who lacked the resources to understand their needs or explain the situation.

> They had arrived very recently, she had given birth, neither of them knew any language, not even English. She was very scared, I remember, and she was also very young. ... neither of them understood what was going on well, if there were problems or not with the baby and so they kept asking for help, but we didn't understand exactly what they wanted, I mean, which were their requests, what they were asking for exactly, so we tried doing a bit of everything, but… we couldn't really understand each other. … She labored at nighttime, and the whole night it was tragic, for them and for us. (NN05)

This case shows that medical effectiveness and informed consent, as well as practitioners' and patients' satisfaction, are compromised by linguistic barriers. Healthcare organizations must prepare to provide reliable forms of linguistic mediation which can be used in a moment of need, including nighttime, because births and their complications cannot be scheduled:

> We have these services always on daytime, from Monday to Friday, from 8 to 5, but these problems might occur at any time. To explain to a mother that she cannot give birth spontaneously, that they must give her a Caesarean, in the

> middle of the night... what can you do? This woman is practically in the operating room and they make a C-section without her understanding anything... that is just... it is not right. ... This adaptation of the hospital, of the service, to the social situation, is missing. Because the services are provided during daytime. (NN05)

Babies aren't born during office hours. This is not an isolated incident, but a frequent need in Neonatal Intensive Therapy (TIN), when newborns are sick, and situations might evolve, or emergencies arise at any moment. Before the Covid-19 pandemic normalized videocalls, the expectation of an in-person mediator was the only recourse. Still today, there are privacy, communicative and technical objections to remote healthcare mediation. However, when decisions must be made suddenly, when mediators are not available, acquiring informed consent may be hard, and quality of care is on the line.

> It happens, that maybe a child is born that we have not known before that he is sick, or that something has happened. So, until we have admitted the child [to TIN] and we have done everything that at that moment is important from a medical and technical point of view, to set him up for... to... to care for his illness, maybe a lot of time passes. And in that time, for parents who does not understand our language, it is very difficult to calm them down, to explain. And maybe for us they are only a few hours, and we say yes, yes, we will explain everything later. But for them maybe they are... For a parent, two hours… it's a lot, isn't it? So there we have a bit of difficulty. And we try to call the mediator immediately. But until... There are technical times... and maybe she tells us today I don't have time, I'll arrive tomorrow. Of course, they have their own situations, too. (TIN 12)

Medical emergencies require immediate interaction with those involved. Today, mediation services have arranged remote interpreters for emergencies, alongside in-presence linguistic and cultural mediation.

4. Services for Migrants in Irregular Situations: The MIS Clinic

As previously discussed, Italy has a universal delivery approach to healthcare and that Italian policy ensures the provision of urgent or essential healthcare services to MIS, with a broad understanding of what those essential services are, and free of charge in case of indigence, as is the case for local patients. Also, such legal rights are often not enjoyable because policies in this area lack implementation strategies, appropriate resource allocation, as well as control mechanisms. Moreover, service provision is organized differently in each region, and this lack of uniformity in service delivery entails that migrants' rights are often not clearly known to all practitioners, and as a result, migrants experience a variety of access barriers. This can be confirmed in all migrant categories, but with greater severity and larger scale in the case of those that are undocumented.

Who are migrants in irregular situations (MIS)? It is a heterogeneous group of migrants, that have in common the fact that they are not in possession of a valid residence permit for the country they are currently living in. One can come to be in an irregular situation in several ways: entry without authorization is only one of them. Other situations include overstaying authorized periods, denied asylum request, loss of status because of administrative reasons on the part of the individual (e.g. failure to renew a visa, a work permit or residency paperwork), or because of policy changes (e.g. the humanitarian permits were suppressed in 2019, so when these progressively expired they could not be renewed and thousands of persons fell into undocumented status) or being born to an undocumented parent.

International studies have shown (Woodward et al., 2014 among others) how submerged and underreported are the healthcare needs of MIS, their higher exposure to health risks, and their significant barriers in accessing services, as well as the lack of preparedness of health organizations to respond to patients presenting various layers of migration-related diversity (Phillimore, 2015).

At the national level, studies concur with the fact that in the case of MIS "accessibility of public health services emerges as the key issue for protective measures" and suggest "proximity medicine for the groups that are hard to reach … aiming to create service networks connecting public and private organizations shaped on outreach models of active delivery" (Petrelli et al., 2017, p. 62).

This section documents one healthcare unit that had been doing just that during the period covered by this research. That is, between 2017 to 2020.

4.1 Origins and Activities of the MIS Clinic

In the early 2000s, a group of practitioners in Bolzano, concerned about the lack of healthcare services for MIS, created the Fanon-Balint Center. It was an NGO staffed by volunteer medical professionals that provided free healthcare to this underserved group. The main motivation of the doctors behind that initiative was that despite the 1998 legislation had granted migrants in irregular situations access to healthcare services in anonymity, through the STP code, at the time, no targeted services were offered by the healthcare system:

> For them [hospital administration], the STP code was basically just an accounting code for those who by chance had obtained services – by chance or by luck. Meaning that they [MIS] had obtained services, almost all of them through the emergency service, codes were opened and then closed. So it did not give the patient, in any way, the right to have continuity, but it was only a way to account to Rome for the services provided by the local healthcare system (almost always in Bolzano). (RP01)

Rome, in this context, means the national government, specifically the Internal Affairs Ministry, which reimburses services rendered to MIS through the STP code.

> Then in 2002, 2003 I realized that, without a correct application of the law and the STP code, it was impossible to carry on the substance of healthcare for irregular immigrants. That is to say, to be able to give continuity of care, and also to be able to give [MIS] access to outpatient facilities and therefore not only to first aid, not only to hospitalization because these have always been possible. ... the important thing was to be able to guarantee access to medicines, ... and also especially diagnostics, including blood tests and X-rays. And

> this was not possible before we had founded the STP clinic. And even before the foundation of the STP clinic, before having found an application of the law in the South Tyrolean healthcare system. (RP01)

Initially launched as a pilot project, the Fanon-Balint Center received annual funding from the Provincial government to cover essential costs of healthcare delivery. In 2007, South Tyrol's healthcare system was consolidated, merging four separate territorial agencies into a unified entity. In sight of the creation of this new integrated system, authorities offered to integrate the NGO's activities within the system, with prospects of financial stability and province-wide expansion to low-threshold outreach toward MIS. The proposal was accepted. However, members of the NGO were disappointed:

> There was a structure, but only on paper, without any economic implications ... there was only a decree from the General Director, nominating [*name*] as responsible for the STP clinic. ... they didn't create a figure that would really cover the issue in South Tyrol, because otherwise they had to actually do something. (RP01)

As this narration shows, the promised incorporation only amounted to nominating one of their doctors, already working in the hospital, as responsible for STP codes and service to MIS, without any dedicated budget. Under such conditions, they thought, it could not make a big difference, thus, the frustration still transpires. Only ten years later, in 2016, a dedicated clinic space with an allocated budget and staff was established.

Thus, despite the advocacy by medical activists and the 1998 law granting healthcare access to MIS, it took about 18 years for this group to receive a dedicated investment, and for services to be systematically delivered. The structural context explains why, at that moment, it became a priority. Internationally, in 2015, increasing migration flows of forced migrants fleeing from Syria and Afghanistan, as well as those escaping poverty from other regions, constituted a peak moment in incoming migration to European countries. Nationally, the Italian government responded by determining quotas of incoming asylum seekers in each province, determining a significant increase in the numbers and visibility of asylum seekers in South Tyrol.

Regionally, increased controls at the Northernmost border with Austria in the Brenner determined a stop to migrants attempting to cross to other European countries, which stayed in South Tyrol, to make further attempts. Reception centers were created in the city of Bolzano to host incoming migrants, managed by large faith-based NGOs and others such as the Red Cross, relying on both public funding and private contributions.

The direction of the hospital, informed by engaged practitioners, saw the urgency of rapidly implementing a sufficient structural response. In 2015, knowledge was gathered, and decisions were made, which resulted in the next year in the implementation of concrete investments. As said, space, resources, and staff were allocated to a budgeted clinic dedicated to migrants without a residence permit, both from asylum seekers incoming from the border and officially allocated by quotas and other MIS who found themselves in this province on their own at that time. A coordinator and two dedicated nurses organized the turns of about 20 doctors from different wards, which covered rotations.

The establishment of the MIS Clinic has developed a rapid increase in reach, shown by the number of patients and services rendered documented in annual reports, and shown in Figure 9.

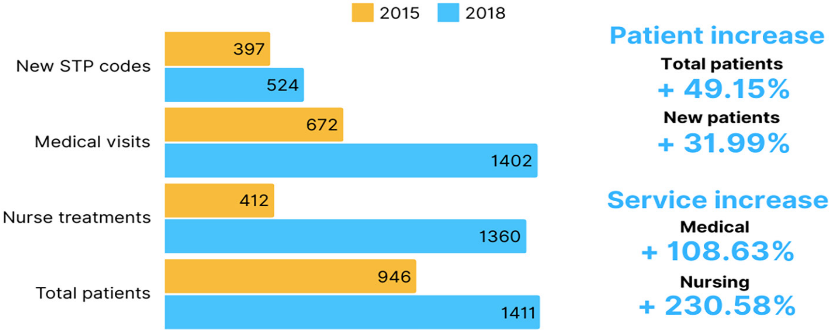


Figure 9 – Growth in patients and services in the Clinic from 2015 to 2018.

In the context of a city with about one hundred thousand residents, with a universal healthcare system, these numbers are significant. The clinic's work targeted those who were completely excluded and could not even be registered in such a universal healthcare system for lack of valid documents. An interviewee observed: “We thought it was the need of three. Now they are three hundred” (SD02). The strong leadership and efficient organization of the dedicated staff of the Clinic was behind this growth, because of their professional expertise and their advocacy, as well as their “balls of steel” (RP01). As a volunteer doctor observed:

> There is a need for people like them, who are ready for combat at any time of day. They are willing to do what is needed and have been doing it for a long time… It is really fantastic, what they have built, really, because they started from scratch. (SD03)

Moreover, the team had such high engagement that following their first reports, more resources were allocated. They received an additional multilingual nurse, and from a small room in a secluded area, they were allocated a larger more reachable space, with a visiting room, a counter and nursing space. As soon as the team had a collective assessment of the needs of the target population, they argued for the resources they needed to the hospital direction.

> We brainstormed with my team, and we have made a list of what the needs are and spoke with the hospital director. … We need to be careful not to propose for refugees any services that may not be already available for the local population, not to create unrest. (SCN01)

They took this very careful approach, because every time the media got hold of news of even the smallest investment on asylum seekers, let alone migrants in irregular situations more generally, criticisms filled local papers. However, the administrators knew that in the long run, investments would be smaller if primary care was granted. Asking for reasonable resources backed up with data-rich reports was a winning strategy. The motto in the team seems to be there is still work to be done: “There is really a lot to do” (SCN01).

As could be seen, the Clinic has filled a void of accessible and low-threshold healthcare services among asylum seekers and undocumented migrants. Until they obtain legal resident permits, they are given medical attention through the STP code, which is a number that allows for an anonymous chart of the patient to be created and managed on a separate server from regular hospital records. It allows to ensure continuity of care for the duration of the Code, which is unique to each person and can last up to six months. If care is still needed, then another Code is generated, but usually, matters are resolved before that time.

As described in a previous publication (Zadra, 2021, pp. 275–276) the main activities of the MIS Clinic, since its implementation were the following:

a. *Screening protocols*: A comprehensive screening, available to all patients at first contact, was critical to diagnose medical needs. It included a thoracic X-ray, a pneumological visit, as well as blood tests: complete blood count, HIV, HBV markers (hepatitis), AC tetanus. Children were spared X-rays and HIV testing, unless necessary. Upon receiving test results, patients were examined by a doctor, prescribed treatment or further testing when needed, and certified fitness for cohabitation, as required by reception centers.

b. *Weekly rotations in reception centers*: The Clinic organized weekly medical rotations in the main reception centers of Bolzano, to provide primary care to the [MIS] hosted there. Visits were coordinated with Centers and included medical and nursing staff, as well as linguistic-cultural mediators, based upon the languages of patients.

c. *Basic medical assistance to MIS*: Not only were asylum seekers in reception centers given basic medical assistance but it was also offered to MIS arriving directly at the Clinic during opening hours. Doctors were visiting twice a week but nurses were present every day to offer advice, treatments, and health education. They also created new STP codes when needed and helped in interfacing with the healthcare system.

d. *Infirmary*: For non-critical care, an infirmary with 11 beds was implemented in one of the reception centers to grant a form of "soft hospitalization". For instance, those patients who, in routine circumstances, would have been discharged from the hospital for recovery but could not be discharged in the promiscuous conditions of a crowded reception center (or the street), found in the infirmary an adequate healing space. The infirmary was managed by a doctor of the Clinic, and nursing rounds ensured patient care.

e. *Preventive initiatives*: Prevention of further damage to recently arrived migrants was one of the priorities of the Clinic since its inception. Doctors were appalled that many arrived in Bolzano without ever seeing a doctor throughout the whole migration journey, even at Italian stops or even at first contact at the border. In contact with patients, medics contributed to identifying risk factors in the conditions of reception centers, which they contributed to resolve. The clinic has also organized targeted preventive events, such as vaccination campaigns and sex education initiatives.

f. *Documentation of "vulnerability status"*: Persons with a history of torture, persons that have been trafficked or sexually abused during their travels, may have a slightly more favorable outcome in immigration proceedings, provided that these are attested by doctors. The juridical system requests medical certificates to attest to specific situations of vulnerability, such as the certification of signs of torture and the estimation of the age of minors. Doctors awarding such certifications follow current methodological guidelines and contribute to such guidelines with trauma-informed relational considerations to avoid re-traumatizing patients. For instance, in estimating the age of minors, doctors apply the Tanner-Whitehouse 3 (TW3) protocol[11] as part of a multidisciplinary holistic assessment[12], as recommended by Benso & Milani, 2013. Guidance has also been provided by the Council of Europe (2019)[13], the European Asylum Support Office (EASO, 2018), and other agencies (UNHCR et al., 2009). Among other elements, these sources of guidance advise using diverse, corroborative evidence, instead of a single method, ensuring equal treatment for all minors, and granting a right to appeal, to ensure procedural fairness. The Protocol of

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[11] An overview of various legislations of EU countries in this regard is available at: https://www.easo.europa.eu/asylum-report-2020/63-age-assessment-minors. The advice of the Health Superior Council in 2009 mandates the Tanner-Whitehouse3 Protocol (TW3), published in 2001, considered more effective than the Greulich Pyle, developed between the two world wars, and found less accurate as it was sampled on white subjects only. On the Italian front, see Accorinti, 2015.

[12] The procedure itself was discussed during a convention in the Hospital on Medicine and Migration in 2019, described as a symptom of a "neo-colonialist pathology" and "a dilemma for us doctors". The practical suggestion was to include the X-ray of the wrist, still considered a very unreliable measure, in a multidisciplinary holistic assessment, which includes, beyond the X-ray, a social interview, a pediatric-auxologic visitation, endocrinological testing, and neuropsychiatric-psychological evaluation.

[13] See also https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=24273

age estimation in Italy has been defined in Law 47/2017, approving the available guidelines (Conferenza delle Regioni e Province Autonome [CRP], 2016). When documenting signs of torture, doctors follow UN protocols, such as the Istambul Protocol[14], national guidelines which refer to it as the standard of care (Ministero della Salute, 2017), and legal medicine indications (Bracci, 2009).

4.2 Accessibility Practices

Other than the inclusive legislation, which allows it all to happen, the feature on the Clinic that helps the most to overcome barriers in access to asylum seekers and undocumented migrants, are the *multiple, differentiated and low-threshold entry points.* In the case of hard-to-reach populations, word of mouth and low-threshold services are essential, and the fact that mobile clinics, outreach workers, social services, info points, and reception centers can reach out to undocumented persons and point to the clinic as a safe haven to get free treatment anonymously can save lives.

However, not only is outreach a channel, but the clinic also functions as a *drop-in point,* where at certain hours persons can go without an appointment and be supported in accessing the care they need. The first comprehensive health screening can be accessed in those ways, but also through formal or informal referrals, through NGOs, through reception centers, through transference from the E.R. or other wards, or at the moment of arrival, when relocated to the Province by governmental quotas. Doctors engaged in the STP clinic explain that the screening "starts automatically and it is available for everyone … and then the individual can decide if he needs something more. We do the visits in general, a bit for all the problems and then we filter" (SD03).

The Clinic also helped contrast barriers originating in lack of local knowledge, particularly important for recently arrived migrants, who may find hard to seek services by navigating a complex and unfamiliar healthcare system. A doctor explained that facilitating procedures not only favored migrants, but also other categories of marginalized locals, that were not able to access through regular entry points: "Some people find it difficult to express

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[14] First published in 1999, the protocol has been updated in 2001, 2004 and 2022. Its latest version is available at: https://irct.org/istanbul-protocol/

their vulnerability. … If there is already a procedure that was designed for these people who have now come here and there is a diagnostic procedure that is already established, it can be used" (SD02).

However, support did not stop at entry points. When the screening protocol has identified the needs, and patients must understand, locate, and access services, practitioners offer *navigational assistance* (see also Green et al., 2014). They explain existing pathways by coordinating further appointments or involving intermediates or advocates. They may also create new *facilitated pathways* when a group of users find it challenging to access specific services they need. These strategies aim to overcome service fragmentation through bridging activities and to help recently arrived migrants get acquainted with the healthcare system and its pathways.

The STP Code used in the Clinic grants *anonymity*, and all staffers abide by the legally binding principle that prohibits health practitioners from reporting MIS to the authorities.

As said in Chapter 3, the literature shows that language barriers significantly affect the quality of care and patient safety (van Rosse et al., 2016) and interfere with informed consent (Schenker et al., 2007). Therefore, staffers *prepare for linguistic accessibility* by recruiting multilingual doctors and nurses and by using the hospital's intercultural mediation program. For key information and health education, brochures and materials are translated into the most represented languages, and remote interpreting by phone or video is immediately available in case of emergency. In the literature, it is referred to as RSMI, or *remote simultaneous medical interpreting,* associated with patient satisfaction (Gany, Leng, et al., 2007) as well as being perceived as faster and resulting in fewer errors than other methods (Gany, Kapelusznik, et al., 2007).

4.3 Identifying and Responding to New Needs

For patients in vulnerable situations—such as unaccompanied minors, the homeless, or those who do not speak the local language—identifying health issues and accessing healthcare can be challenging from the very beginning. Through visitations, screenings, and outreach initiatives, healthcare professionals can bring attention to some of the often overlooked needs of mobile populations, making it possible to better tailor services.

An example of identification of new needs is when it was discovered that many new arrivals suffered from grave dental issues. A coordinator of nursing services in the Clinic explained: “Of every 10 new arrivals, 5 have dental problems; we need to do something about it” (SCN01). A new streamlined pathway to the hospital’s dental clinic was introduced. While it did not offer preferential treatment, it provided targeted access to essential services that were also available to the general public.

The needs identified may also be environmental. For instance, a nurse observed a pattern of digestive issues among residents in reception centers: “In the last few months, ten of them came in with stomachache, so you ask yourself, ‘How come everyone is sick in the stomach?’” (SN02). In response, information was circulated, leading to an improved nutrition plan that included adjusting the center menus to better suit residents’ dietary needs and habits, paying special attention to malnourished pregnant women, and encouraging increased water intake. A nurse explained:

> In Nigeria you are not used to take the water and drink it just like that… I mean, they are not used to do it, because water is a scarce good… instead here you try to tell them: ‘try to drink more water, two liters a day’ and they look at you with those big eyes… because they are not used to it. They often have dry skin, right? It looks like scabies, but it is only dry skin. They are not used to our food or to our shampoos. (SN02)

A psychiatrist active in the MIS Clinic has also given consultation to Reception Centers about structural environments that may be more suitable for asylum seekers reception, early identification of mental health needs, and conflict de-escalation.

New needs can also be identified during the procedures of certifying signs of torture or documenting the age of minors. During these sensitive contacts, when previously undetected physical or mental health needs may emerge, targeted services are made available. The Clinic is only an intermediary of these services, as they pertain to various wards.

4.4 Avoiding Re-Victimization and Aiding the Healing Process

Certification of signs of torture usually starts in dermatology, as the skin is most receptive to signs of harm, such as " "abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal" (UNHCR, 2004, n. 176). A doctor working in the Dermatology ward explained:

> So, to begin with, we see above all the skin lesions, because then there are also lesions to the teeth, bone fractures, seen by… the orthopedist, the gynecologist, those, or the dentist. We [in dermatology] have linear lesions, which can be caused by blows, i.e. cutting lesions, it can be a knife, it can be a... a glass bottle, or sometimes they are blows: for example it can be a stick, it can be a whip, it can be a piece of wood or metal... kicks, sometimes we see. It's these forms, we see here. Gun bullets, too. Cigarette burns… those come to mind, now. (SD06)

Specific measures are taken to protect victims of torture, and to avoid re-traumatization, as the Istanbul Protocol establishes:

> Examiners can prevent and mitigate retraumatization and psychological sequelae with effective communication, empathy and by allowing individuals control over their narrative account of the alleged events. Applying these and other essential interview skills are of paramount importance in conducting an effective interview and in avoiding retraumatizing a torture survivor. Despite efforts to prevent and mitigate retraumatization, torture survivors are likely to experience some level of distress during a clinical interview. Clinicians, together with the individual, should balance the potential traumatic effects of an interview with the potential benefits of a comprehensive medico-legal evaluation. When the interviewer suspects that retraumatization has occurred, it would be important to acknowledge the concern, mitigate ongoing retraumatization (such as with breaks, breathing exercises and redirection to less emotional topics), offer psychological support and refer the alleged victim to appropriate follow-up care. (OHCHR, 2022, p. 71)

Aside from following international protocols on these processes, attention is given to relational dynamics. These spaces are managed with trauma-informed relational approaches, to help identify and care for particularly vulnerable patients without creating harm. A doctor explained:

> People from central Africa come to us smiling in the clinic and shake our hand. They ask us how we are. You see, they come to certify signs of torture they have endured, and they ask us how *we* are. It's crazy. They make small talk and establish a friendly relation before they have to show us very ugly things, perhaps to understand if we are able to handle it. (M&M01)

This observation entails the doctor's empathy towards the patients in this predicament, without labeling them as victims, appreciating their resilience. It also shows an ability to respond to the empathy the patient grants him, and to locate himself in a position of recipient of the patient's kindness. He elaborates:

> It is important to ask for their permission to see the scars, to take a picture, so to give back a sense of power and control over oneself. Healing comes through a process of reestablishing control over one's body and building new bonds with others. What gives us some consolation is that after torture there can be healing. (SD06)

Contributing to the patient's healing process during this brief encounter is important for the practitioners of many different specialties involved in the certification of signs of torture. They are aware that healing occurs in a relational context. Particularly in psychiatry, interviewees explained that elaborating memories in the dialogue with others, rebuilding the discontinuities of biographical narratives, creating new connections and meanings through positive social contact might contribute to healing processes. In fact, healing from trauma also entails a reconnection of memories into a biographical narrative of one's life which makes sense. It entails recovering the memories of traumatic experiences, which have been isolated as a defense mechanism, and finding a place and a meaning for them in our individual and collective memory. A psychiatrist who works with asylum seekers elaborated on this concept:

> There is also a fundamental dimension of rediscovering meaning in our lives, because we then [in PTSD] dissociate ourselves, because we give our minds the possibility, also from a neurophysiological, neurobiological point of view, to try to contain, survive... and therefore at a certain point the recovery of memory is a process that takes place... a memory that tries to recover what is recoverable… never happens in the context of an isolated mind, but it is always very important that it happens in a context of a relational network… where there is also the possibility of having a proper recognition of what you have endured. And that meaning can also be experienced, in terms of its connection or with the people to whom you belong… people from the territory, from the familiar and social context from which one comes, but also among the new society in which one lives. (SD07)

The consideration of the healing effect of positive social contact to overcome traumatic experiences is rich in practical applications. One of the suggestions given by the psychiatrist to the committee handling refugee and asylum seekers welfare entailed the involvement of long-term residing immigrants from the same countries of origin to assist settlement processes of those recently arrived: "members of the community who already have had a journey towards integration might serve as a bridge between refugees and the local community. It may help in breaking the isolation" (SD07).

The Clinic has partnered with the psychiatric ward to offer courses to health practitioners and reception centers' staff to train them in recognizing signs of PTSD or other mental health challenges and help facilitate their detection through a sensible referral to appropriate diagnostic pathways. The principle "do no harm" is communicated to professionals involved in migrant reception, to prevent instances of institutional violence (Alegrìa et al., 2016).

4.5 Collaborative Networks for Advocacy and Change

It has been interesting to document the collaborative side of the MIS Clinic. As mentioned in the literature review, scholars (Greenhalgh & Papoutsi 2018, Greenhalgh et al., 2017) explain that change in healthcare organizations does not always occur in a predictable and orderly way from the top down. They are often unpredictable, nonlinear, and influenced by the interplay of multiple factors. Rhizomatic, Deleuze would say. Networks of change generate connections between actors moved by similar forces, facilitating the growth of collaborative actions that are often unplanned, born from serendipitous connections, opportunities, and communication channels. For instance, the doctors who volunteered to dedicate hours in the MIS Clinic serving as general practitioners, were specialists from a wide variety of hospital wards, and their informal connection generated facilitated referral pathways towards their respective wards, when special needs emerged among asylum seekers:

> We serve in this clinic, and we are often involved, because obviously if a colleague sees a kid that has a hole in a lung… he calls us and he says “this one has tuberculosis”, it is obvious that he will end up here. But during rotations we work there more or less as everyone else, even if it is about issues that are not our specialty. (SD05)

This generated a functioning network within the hospital, that helped contrast barriers and fragmentation within hospital services.

Outside the hospital, as well, the Clinic fostered functional connections in the face of fragmented services. Although welfare systems are fragmented, creating challenges, particularly for the most vulnerable, new and diverse forms of collaboration have emerged between healthcare and social service providers. While MIS are not formally included in social services—since they lack a valid residence—many public and private organizations that serve homeless and marginalized individuals rarely require proof of documentation. This flexibility has been crucial to the STP clinic’s operations, as word-of-mouth referrals enable those in need to move between different forms of support.

Moreover, the Clinic has organized events to promote health prevention, in collaboration with different entities. One example is an initiative to promote reproductive care and literacy among women, in which the Clinic partnered with Reception Centers and an NGO active in promoting safe sex and HIV prevention, testing, and post-diagnosis support. It was a low-threshold event designed to host only women so they could feel free to ask clinicians questions about sexuality and reproductive care about sensitive topics. Day-care workers were involved to ensure childcare during the event. Intercultural mediators were involved to ensure linguistic accessibility, and multilingual materials on sexual health, STDs, and birth control were distributed.

Verification of vaccination status needs attention in the case of asylum seekers, as memory is not always detailed enough, documents are not always available, nor always linguistically accessible. Vaccination-related collaboration with the Department of Infectious Diseases and the Public Health Services office to conduct vaccination campaigns in reception centers, and include vaccinations in the conclusive steps of screening protocols. During the Covid-19 pandemic, the Clinic was instrumental for the hospital administration, in coordinating with all the NGOs that handle reception centers for asylum seekers and outreach toward MIS, as well as mobile clinics and medical volunteers, to organize low-threshold access to Covid-19 information, testing and vaccination. They organized "vaccination days" and "vaccination weeks", in which medics and linguistic and cultural mediators went out in outreach initiatives with a medical camper to public spaces targeting specifically marginalized groups.

The Clinic has also fostered stable institutional partnerships, influencing policy. For instance, the Clinic's coordinator participates in policy networks related to welfare for asylum seekers and refugees, noting, "I have meetings in the Province with all the heads of reception centers, with the SIS (Social Integration Service), and the Refugee Advisory Board" (SCN01). Additionally, the clinic has made connections on a scientific level by organizing international conferences, such as Medizin und Migration in 2017 and 2019, with hundreds of attendees, to share knowledge, resources, and best practices for providing healthcare to migrants.

Furthermore, a local chapter of the Società Italiana di Medicina della Migrazione (SIMM) was established, bringing together healthcare and social services to create coordinated responses to emerging needs and to contribute expert knowledge to local policy. These interdisciplinary networks strengthen response capabilities by pooling knowledge, practices, and expertise, thereby transforming *de jure* entitlements into *de facto* access for migrant populations.

4.6 Difficulties and Resistances

When the MIS Clinic was created, an invitation was sent by email to all doctors, inviting them to join the program by giving general medicine assistance in monthly rotations. This no-pressure invitation had a selective effect which ended up involving only committed and socially sensible doctors from different wards. The engaged doctors were surprised, that among the hundreds of hospital doctors, there were only about 30 who joined the initiative. They believe that hospital management could have made a greater effort to recruit and support participation:

> I was very impressed that the request to participate in this... STP clinic was sent by email to all the doctors of the hospital. And in the end we joined in... how many?... thirty? I mean, this is also a very, very, very significant sign in my opinion. Then many may have their own... their own motivations that are obviously due to the family, or other. But... it's really sad as a result, isn't it? ... It's kind of a counter-message [of the administration] sent just to check a box. (SD05)

The lack of explicit structural support to the initiative from the administration, expressed on the little investment in it in the initial stages, cascaded down to the medium levels of management as well. Ward chiefs were not asked to engage and support the project, so any leeway for participating practitioners was left to the good will of individual chiefs. Even today, when the project has evolved and expanded, receiving resources and support from the hospital direction, some of the doctors experience difficulties negotiating time with their ward chiefs. These structural pressures make it harder for doctors to collaborate with the Clinic, to participate in the rotations, as they sometimes face resistances or indifference from their colleagues or superiors, which have to manage their short absences. As the hours they dedicate to the clinic are comprised in their working hours, they need to negotiate with their ward chiefs, not all of which are supportive, apparently due to bureaucratic worries. A doctor explained:

> It is during working hours, but anyway, you have to justify your absence to your ward chief … He asked me... "But... if you really want to do it, do it... But I don't... it's something that I don't share, that I have to justify your extra hours... Because you should only do x amount of hours..." … he didn't stop me, but he wasn't happy … That's the difficulty of doing this work here during working hours. Because it's work and time that you take away from the ward, and from your colleagues … Second class patients, right? (SD03)

This is partly explained by the grave understaffing of the healthcare system in South Tyrol, due to the mandatory bilingualism in the Italian and German languages for all persons employed in public services in the province. Only in 2024, some flexibility in this regard is being tentatively introduced. Several practitioners mentioned time constraints and overworked practitioners as adverse factors to supporting actions that facilitate service in the clinic:

> As a defense, I must also say that here in the ward there is a lot, a lot, a lot of work. And what you take away from the department creates a burden. … It's not like you're taking it slow or having coffee, so they won't miss you. No. It makes a difference. So if you miss the afternoon, or you can't do the work in the ward because you have to follow another thing in the clinic, the ward gets burdened. *R: – The hospital is understaffed?* – Yes, that is the problem with the whole South Tyrolean health system. (SD03)

Understaffing may also affect other structural pressures concerning time constraints and the need to demonstrate and quantify performance in service delivery through bureaucratic means. This gave little flexibility to the time practitioners could spend facilitating access and had to divert the task of guiding the patient through the system to volunteers and NGO members:

> In theory, I should show that I have occupied my time in some way. Therefore, NGOs often help us because they take the time to register these people at the cash counter if they have the fiscal code, or maybe they get the STP code, so I can perform my service so that at the end of the year my ward chief sees that I have worked in that time. Otherwise… you know. (SD06)

Another doctor felt that the bureaucratic mentality of some administrators which tried to exert control over doctors regarding time management in unreasonable ways, such as trying to raise productivity by standardizing visit length at fifteen minutes per patient:

> Healthcare is becoming a business… it is more important that there is a bureaucrat, who may have no training, really none at all, in the health field, except that of the pure accounting. But he has to tell me, and it is *he* who tells *me*, how many minutes I should devote to a visit. Because that is how it works. That's it. So, I have fifteen minutes for every patient who makes a follow-up visit. I must put my watch there and say... "oh, sorry, look, the fifteen minutes are up..." [laughs] … if this is the system … you can't have the quality … It's as if they thought we have a homogeneous sample of people: because if you give everyone the same, or about the same period of time, it means that those people have all the same characteristics in terms of... diseases, essential problems, or else characteristics... as demographic, country of origin… (SD05)

Not only does this standardization make no sense in medical terms and has a detrimental effect on service quality, but it also interferes, for instance, with the time doctors could invest in overcoming language barriers when meeting patients with limited proficiency in local languages. Apart from ward chiefs and bureaucratic issues, doctors in some wards face a lack of understanding and support from their peers:

> Some of them might think that it would be better to be three hours here in the ward and be helpful, seeing that we are in shortage, instead of going out for visitations … I have to be honest, that in the ward… from my colleagues here in, no one has said to me: "well done" or "that's a good thing" or… "it's important work"… I only heard about this work: "But why are you doing this? Are you crazy? What are you going to do next?" Yes, I have heard comments like that. (SD02)

Another doctor pointed out the part disinformation played in creating resistance: "There are also many colleagues who can't believe there are so many people who need this service. I've heard that. Or that homeless people are living on the streets. Maybe a bit of information should be spread more widely" (SD02).

The lack of information is for sure a critical point, as factual data about the conditions of immigrants and its handling by the provincial government are not easy to acquire, and the authorities seem to handle numbers and reception centers on a very tight need-to-know basis, especially regarding independent researchers. Knowledge about the absence of coverage does not circulate easily in a province that prides itself on efficient and well-functioning services.

Commenting on service shortcomings among general practitioners, doctors involved in rotations in the Clinic pointed out that in contrast with themselves, who signed up to assist refugees and undocumented migrants, general practitioners are assigned *ex officio* such patients once they are attributed a fiscal code and gain entry to the residents' healthcare system:

> We are doctors that have actively chosen to provide assistance, or somehow follow these patients. The general practitioner… has been forced… and sometimes it is much more complicated because of the language, the language barrier, it requires more time and it is much more exhausting [than local patients]. (SD02/03)

Despite the motivation that engaged doctors show in the time they devote to the Clinic, several doctors considered the service should not have to rely on the goodwill of individuals, expressing the opinion that doctors should be permanently assigned to the service of the Clinic.

Regarding restriction of resources, not only staff and time but also budgetary concerns affect the ability of doctors to treat their patients, especially in the context of mobility. A doctor explained, for instance, that although HIV is a serious and contagious illness, treatments are expensive, and the budget is limited. They also need to be offered in continuity, which can be hard with a mobile population that is being constantly relocated or chooses to try to cross the national border, particularly in the case of a border region. Practitioners in infectious diseases are confronted with a dilemma due to the inconsistency between the European and Italian dispositions of law regarding the obligation to provide healthcare, specifically HIV treatments, and the limitations of the assigned budget:

> We have an article in the Constitution that tells us that we must be able to provide assistance to those who need it, when they are on our Italian soil. … And as you say, it is a principle of human rights. … Of course, the problem is that the money is limited. That is, the budget is not... infinite. … Both those who work and those who don't work in the Clinic in this department are of similar minds... we agree that when a person with a positive diagnosis of HIV comes to us, this person becomes a part of our treatment circuit. Because here we are talking about a disease that is contagious. (SD05)

The shared pathway of doctors of not avoiding treatment provisions for migrants despite budgetary restrictions, bureaucratic complications, and mobility challenges is the only ethical choice they can live with. Considering the investment of millions of euros dedicated to the new hospital building – which would not break any laws if it was slightly postponed –, who can blame them for choosing to protect public health as lawfully mandated?

Whatever the challenges and structural limitations, it could be said that overall, the fact that the service is not mandatory but requires voluntary participation by doctors, has contributed to creating a climate of personal commitment: "one thing is to have a duty that has been somehow… assigned from above, and another thing is to carve it out for yourself, because you believe in it or because you think that it is important" (SD05). So enacting a choice to subscribe to a program (even if it is not voluntary work, because it is performed within their working hours), can be also seen as a positive element, as it has operated a selection of those most inclined, experienced and socially aware to offer sensible and comprehensive health care to disadvantaged populations.

What are the motivations that drive such an engagement in practitioners? There were mainly two dimensions to that answer: a more objective dimension, regarding the awareness of a situation of social injustice, and a more subjective dimension, regarding personal ethics and the need to take a stand in order to make sense of their lifeworld. Both dimensions are often intertwined in their narratives, as the first is their interpretation of the situation, to which the second constitutes their personal response.

Practitioners described the emerging needs and the dramatic situations which many immigrant patients had to endure, as well as the insufficient resources that were invested in satisfying them, either by the healthcare system or more frequently by the government. About insufficient resources dedicated to the management of reception centers or to serve the health issues of such a marginalized part of the population, a doctor expressed that such service shouldn't be left to the willingness of volunteers: "Volunteer work cannot turn into exploitation, and cannot replace a proper service … Volunteering can also be a good thing, but never a substitute for a public service" (SD04). One considered it was not fair that the undocumented were considered "second class patients" (SD03) and another said:

> If you ignore their needs, you are denying their rights. You are denying them when you don't serve them. You are being negligent, omitting to help them. A person needs you, and you pretend that you don't see her. … This is a population that exists, and it is futile for us to pretend not to see them. It exists, and it is a population that needs us even more. Because they have not been able to enjoy -for ethnic or social reasons- the fundamental right to health of every citizen. (SD05)

Descriptions of undeserved suffering populate the narratives of engaged practitioners, who show an empathic response. A nurse spoke about a man who arrived with very swollen, ischemic legs, because on the boat he had two dead bodies on his legs, and unfortunately, he was not an exceptional case. She also reflected on the emotional management that such experiences require on her part:

> When you see this 25 people that tell you, in their first visit, the episodes that happened during the journey, the dead they have seen… it is hard … Sharing these experiences… one is touched by their suffering. You also must be able to take a distance, or you wouldn't make it. These people attach to us, and it is normal. For them, you are the one that lend them a hand, and they give you their cell phone number, as if you would call them … I have built myself a wall: I am friendly but I try to keep a distance. But certain situations are stuck inside of you, especially minors, without parents. … They think we can handle all this, but it isn't easy. (SCN01)

In the conversations with members of the Clinic I noticed that the prevailing feeling was not pride. Most showed anger narrating about colleagues who praised their engagement as if it was an extraordinary or generous commitment, when they feel it is their obligation to give equal treatment. A nurse described her response to such comments from colleagues:

> We have racist people, here. I hear many things, they say to me "well… [mimicking arrogance] what a passion you have, doing all this work… why would you do so much?". And I answer "well, they keep coming, so we have to do something. Do you want us to leave them around with hepatitis or scabies, going around? Our population would suffer too". These are the things I have to say… I have to put it that way, to them… but they come for serious reasons, also because of poverty. They expect a better life, and they don't find it. (SCN01)

Practitioners seem to feel they were doing the least they could do, considering what their patients had endured and how little resources were invested in responding to their needs despite the entitlements defined by the national law. Resources are available in this rich province, but still, people were left vulnerable, in extreme indigence, or discriminated against. There was a painful awareness of the harm that the society they are a part of (by origin, but even more so by effect of their professional role) is contributing to generate on their patients, whose poverty or illness is considered not deserving of a response only because they were not born here.

When asked how they started to engage, some spoke about the inspiring example of their role models in medicine: famous doctors or scientists with a life of social commitment like Fanon or Balint, or their own teachers or chiefs, or even groups of medical or social activism (DWB, SIMM, MAGA, Caritas, and others). Almost all engaged practitioners referred to ethical principles and their struggles to live up to their professional and personal ethics while facing the systematic discrimination of migrants. They described such situations to me with a feeling that I would call "ethical suffering" or the moral disappointment in the society one belongs to, and the need to join a network that contributes to repairing the consequences of discrimination, social indifference, or social injustice by committing to redistributive practices.

It entails empathy but of the enacted kind. It entails moving to a position in which one's actions can be a part of the solution rather than the problem.
The ethical values they referred to were expressed in different ways. For some it was expressed in a refusal to follow discriminatory patterns evolving in society, and trying to take an individual stance, by joining inclusive efforts:

> I have thought, reading a bit the newspapers and following social media… it seemed to me I was facing a situation where us, as a population are having difficulties … encountering these new people, and trying to integrate them or somehow show them that we are here, and are also willing to welcome them in a human and decent way. I mean, not… "come here, so we can put you in a room and lock the door"… So I thought… what can I do? I mean, I really wanted personally to contribute, I really wanted personally to say… what can I do, within my possibilities, to make a contribution? So I arrived to the Clinic, because this is what I know how to do. (SD03)

For some it entailed a more structural and collective positioning, within professional traditions of social commitment, in order to reform a damaging pattern in society. They located their activities as a part of a greater effort to repair the broken connection between the social and the medical world:

> Saurer had a very social vision of medicine … this division is one of the great deficits, it always has been, in fact, in the world of South Tyrolean healthcare, but we had the vision of the old councilman Saurer, which was about the encounter between the districts, the social areas, the social workers, the elderly, and so forth, with the medical area … Because health practitioners without the support of the social area are not equipped to respond to people that need to overcome very high gaps. (SCD01)

This concept has been practiced in various areas. For instance, a dermatologist spoke about the inclusive culture created by his early ward chiefs, who created traditions of "social dermatology", open to marginal sectors of the population:

> We have always had contacts with volunteer associations, with Volontarius, and Caritas, with centers for recovering addicts, and so forth. It is a tradition of ours, right? Here, my old ward chiefs, as doctor [name] especially, had this idea of social dermatology. The homeless were often hosts of our ward … We also have a clinic for sexually transmitted diseases, so we have always had a relation with marginal populations, so to speak. … So we have always had an openness towards those who were called different, or the sexual minorities … As we had contact with these associations, now they send these migrant people that are asylum seekers. (SD06)

Ambiguities in motivations and ideologies towards migrants affect service provision in different ways. Perna notices a tension in service providers "between a medical-humanitarian logic that legitimates providing healthcare to vulnerable migrants, and a control-oriented logic targeting immigration and health expenditure" (Perna, 2018, p. 1). In the Clinic, the humanitarian logic seems prevalent but, as could be seen, both mentalities do collide in the hospital field. Practitioners' efforts were consolidated around the emergence of a network of change, centered on the work of the Clinic. It circulated new interpretations of problems and new packages of expert knowledge while applying it to create new services and practices. It started with angry and disappointed practitioners who created a common vision, turning anger into commitment, trying bold experiments with high symbolic impact, being followed by others, and eventually changing the opposing structures. The collected data also showed the fear and anger that such changes caused in resisting practitioners who tried to maintain control by ignoring new needs they didn't feel able to respond to, or by creating discriminatory practices towards those patients who did not behave in ways they expected. And even if the research documents sporadic occurrences of discrimination, it consistently shows the inclusive practices of those practitioners who are functioning as brokers of social innovation.

4.7 Takeaways and Further Growth

To summarize, the main strategies that have been examined in this chapter, which may be replicable in other contexts are the following:

1. Differentiate and multiply entry points to services.
2. Investigate barriers and lower thresholds in accessing healthcare services
3. Generate medical outreach among severely marginalized groups.
4. Generate drop-in points as safe havens where medical care is provided on a culturally and socially sensible manner, with a non-judgemental attitude.
5. Render basic screening protocols available to all, to identify undetected needs.
6. Offer navigational assistance to patients that are not familiar with the system, to avoid them getting lost in red tape and bureaucratic processes.
7. Create facilitated pathways by creating referral patterns and connecting different services, by medical advocacy for vulnerable patients.
8. Grant the anonymity and protection from reporting, required by law particularly in the case of MIS, throughout the healthcare process.
9. Prepare for linguistic accessibility, with multilingual materials, polyglot staff and mediation services, in-presence or remote.
10. Avoid revictimization, through trauma-informed approaches to medical relations.
11. Cultivate networks of change for inclusivity and advocacy, starting from small collaborative actions, practices and events, fostering knowledge and practice exchange within hospital services and with local actors, particularly those related to social services and migration.
12. Participate and connect with advocacy networks at the national and international level.
13. Experiment inclusive practices for accessibility, and embed in the system those that are evaluated as effective.
14. Offer robust information to decision-makers about emerging needs and challenges of vulnerable groups, and demand the needed support, resources, and discretionality to enact responses.

As for the direction for further growth, I would quote the founder of the Clinic, as he identified some strategic areas to develop the Clinic's work:

> We create a multilingual signage in the hospital, we create a database to be able to... let's say... to obtain an informed consent in several languages on the usual procedures that we have all identified in German and Italian, and it is not so difficult to make a translation. We are going to improve especially in some specific areas: prevention of cervical cancer – pap test, so to say, right? They are young, productive populations. We will have the problem later, and what a problem! It is one of those very devastating cancers. ... Also improving access to family planning, for example, family and gynecological counseling to reduce also abortion rates. (RP01)

That contrasting linguistic barriers is a first and paramount measure, has been proved by the reviewed literature. Moreover, that reproductive health is a key issue in which healthcare service access must be improved among migrant populations, has been documented in a recent report (Cernigliaro, 2024, p. 26). Both aspects will be addressed in the next chapter.

Time has shown that it is ill-advised to consider the accessibility measures that were implemented as temporary, as relating to a moment of crisis. During and after the Covid-19 pandemic, a large disinvestment in the Clinic has driven a significant reduction in its staff and activities. As practitioners explained, these are efforts that originated in practitioners' advocacy but could not be sustained without a more structural support from the healthcare system. This publication is motivated in part by the hope that it could serve as a roadmap for practitioners to rebuild the important and effective work this Clinic has done in the past, and that the hospital administration would commit the necessary resources and allowances to support such efforts.

5. Maternity Services and Accessibility Measures

Inequities in women's health are significant, as shown by reports such as Sen & Östlin (2007). From an intersectional perspective, gender interacts with other factors of disadvantage in generating social determinants of health. In the case of maternity, in which services are specifically targeted to women, the differential of ethnicity and other migration-related variables, may come to the fore, by stratifying the access to service delivery, and compromising ist quality, in disadvantaged groups. The complexities of delivering maternity services in the context of superdiversity have been studied by Phillimore, in the challenges of novelty and newness: the healthcare system as new to migrants, and migrants as new to healthcare systems (Phillimore, 2014, 2016). Maternity services are particularly relevant, because reproductive health in women is one of the main critical healthcare issues among the immigrant population, both in Italy as abroad, as documented in the literature review. That includes not only gynecological visits but a lower use of screenings for breast and cervical cancer[15]. The indicators of poorer outcomes and lower service access among immigrant women during maternity compared to Italians are significant, as shown in Figure 10.

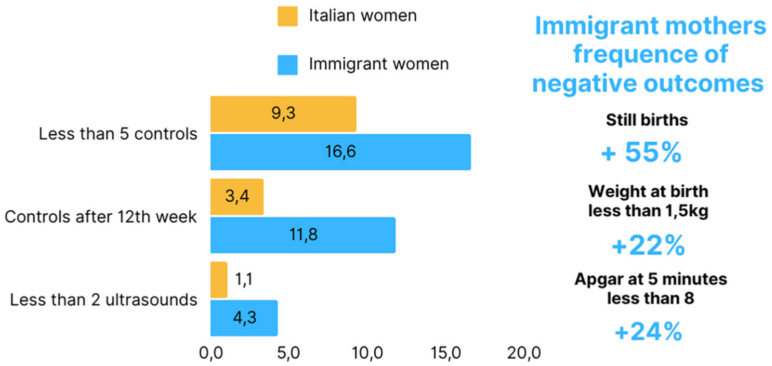

Figure 10 – Comparative indicators of access to maternal and neonatal healthcare and outcomes between Italian and immigrant women based on Cernigliaro (2024, p. 26)

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[15] For Italian data, see Cernigliaro et al. (2024) and Petrelli et al. (2017), while for international data, see Rosato et al. (2024).

As mentioned in the section about barriers, several taxonomies of access barriers are mentioned in studies. A study on disparities in cervical cancer screening participation of immigrant women included "economic, cultural, language, healthcare system-related, knowledge-related and individual-level barriers" (Rosato et al., 2023, pp. 9–10). Another recent systematic review identified the most common barriers experienced by migrant women in accessing sexual and reproductive health services:

> The most common barrier to SRH services identified in the reviewed articles was lack of information (57 %), followed by language issues (43 %), cultural differences (39 %), economic status (25 %), administrative barriers (25 %) and discrimination (14 %). … For many migrant women, it was common not to attend preventive services as they were unaware of their existence, or access routes. … Many women did not know where and how they could obtain long-acting contraceptive methods, limiting their access to contraception. They were also unaware of their sexual and reproductive health rights, such as the right to pregnancy care and the right to voluntary termination of pregnancy. (…) Other studies have mentioned barriers related to lack of knowledge by health professionals due to their unfamiliarity with the legislation; cases have been described in which staff did not know that undocumented migrants had the right to access the emergency services. … In the case of pregnant women, experiencing discrimination has been associated with premature births and low-birthweight babies. (Pérez-Sánchez, 2024, pp. 1, 9–10)

Despite the significant challenges of reproductive care during and after the migration journey (Grotti et al., 2018), and the barriers they face in accessing services, migrant women have a significantly higher maternity rate than locals. EUROSTAT data (2021) shows that in 2020, the fertility rate among foreign-born women in the EU was around 1.84 children per woman, compared to 1.49 children per woman for women born in the EU. The trend is similar in Italy, where official statistical data (ISTAT, 2022) documents a fertility rate among foreign-born women in Italy at approximately 1.89 children per woman, while for Italian-born women, it was 1.21 children per woman. Although foreign-born women make up only about 9% of Italy's population, they accounted for 20% of births in the country. South Tyrol is the province with the highest natality rate in Italy. In its main hospital, where approximately 5,600 babies are born every year, according to documentation from the maternity ward, one in four babies were born from at least one foreign-born parent. Maternity goals, among immigrant women in South Tyrol, have been framed in the context of a wider life project, within the boundaries of available social spaces, including educational opportunities, work conditions, social networks, and the development (or not) of a sense of belonging to South Tyrol (Zadra, 2014).

In San Maurizio Hospital four wards are involved in reproductive health, which are closely connected (Figure 11).

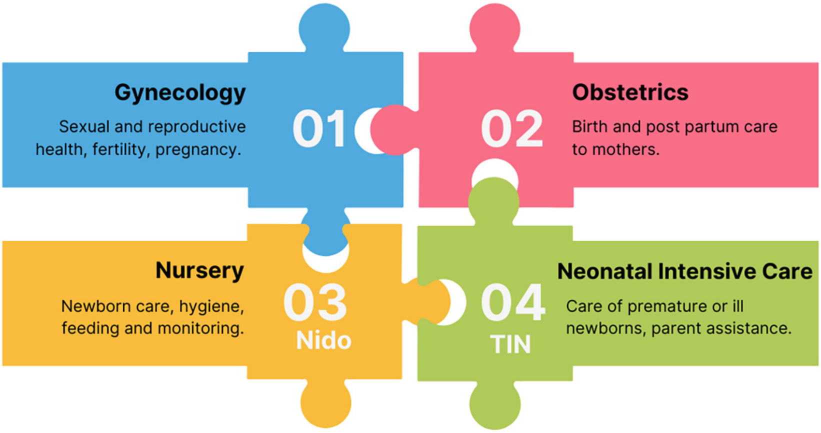

Figure 11 – Wards connected to reproductive health in San Maurizio Hospital.

Obviously, gynecology takes care of sexual and reproductive health more widely, concerning female sexuality, fertility, contraception, pregnancy, voluntary interruption of pregnancy, as well as preventive screenings related to the female reproductive system. Obstetrics assists mothers during birth and in the first days postpartum in hospital, which may last usually from 3 to 5 days. Newborns are cared for in the Nursery, locally called Nido, where nurses support mothers in breastfeeding and infant care, monitoring the baby's health during their first days. Premature, underweight (less than 1,5kg.) or ill newborns (overall, approximately 60 babies a year) are taken to the Neonatal Intensive Care unit, which is referred to as TIN, for *Terapia Intensiva*

Neonatale. In this ward, only authorized personnel and patients' parents have access, through strict sterilization protocols upon entry, since most babies suffer from immunodeficiencies.

The case study focused on Neonatology, both in the Nido and in TIN, (3 and 4 in the graphic), because those were the wards in which practices for the inclusion of immigrant families originated and disseminated. As many interviewees pointed out, the head of Gynecology and Obstetrics at the time was strongly opposed to inclusive measures toward migrant women, and so were some members of the medical and nursing staff (even if such position was criticized by a large portion of practitioners). Exploratory interviews in those wards confirmed it.

There was also difference between the work environment in the Nursery (Nido) and the NIC (TIN). The blissful and relaxed environment of the Nido, with its giggling babies, and nursing mothers, is in contrast to the sanitized, alert and efficient environment in Neonatal Intensive Care. Here, a small kitchen serves as a break room for nurses and parents together, being allies in facing the tragedy of gravely ill or dying newborns. It doesn't seem a coincidence that medical activism for intercultural communication started in this setting. Nurses in this ward speak about the "patient family". In fact, the newborn patient cannot speak for itself, and decision-making processes go through distraught parents, often surprised by a premature birth, complications, or undiagnosed congenital defects. The ward is staffed with two dedicated psychologists which support parents in facing their worst fears, surrounding a critical or dying newborn. Practitioners themselves are not indifferent to the hardships of such circumstances. A nurse, who has worked in both the Nursery and the NIC, compares the very different experiences of parents in the two spaces: the joyful environment surrounding a healthy baby and the fear and uncertainty surrounding a critical baby:

> Here [in the Nido] it is about the joyful moment. … That is, you keep these three, four or five days, the child is fine, he is discharged healthy … it is pure joy, really. Compared to intensive care [TIN] ... There are great anxieties... great anxieties, on the part of the parents, and many times you live them a little yourself, as well, because especially in some cases, maybe you take them a bit more at heart, you talk a little more with the parent, so you perceive a little

> more the fears, the difficulties, the question marks. Because then, no one can guarantee how this child will develop, (because neither can the doctors... for that matter). (NN04)

This empathic experience gives an account of how the nursing professionals make sense of their interactions with families in this very delicate biographical moment, in which a child is born but its life is threatened. Another nurse explains that the difficult context of this service has become a motivation to be sensitive to immigrant parents who are suffering because of their baby's health issues:

> Maybe we have also a sensibility given by the context, by what happens here. It makes you more sensible, more open to those who arrive to this ward. At least in my experience, one feels sorry of not being able to give a hundred percent, a bit because of the language, a bit because of the knowledge. (TN 06)

Practitioners in this ward are generally empathetic, hoping they were able to alleviate the pain and suffering that parents go through when their child's life is on the line. It becomes harder for practitioners in this context to generate barriers, social conflict or discriminatory practices, or to justify those by framing the migrant patient as an "undeserving" or a "welfare pirate".

5.1 The Origins of Medical Advocacy in the Maternity Ward

The growing exposure of maternity services to immigrant mothers brought the experience of communication difficulties with patients who weren't fluent in any one of the local languages (Italian or German). Practitioners also felt the need to better understand different cultural beliefs, customs, and behaviors related to birth and death, illness and medicine, and especially regarding the care of mother and child after birth. Two women, a doctor in Neonatology and a former coordinator of the Nido nurses, were particularly sensible to the linguistic and cultural barriers of the immigrant mothers they were assisting. The latter recalls the problems experienced by the staff in relating to the increasing diversity of patients, and how the frustration of not being able to resolve issues on their own eventually led to solution-seeking:

> As the coordinator, at the time, I saw that colleagues came to me to say: "It's unacceptable! We waste a lot of time talking with these mothers, we don't understand each other, then comes the dad and says something else", right? the usual talk about the dad who does not translate, why? But why doesn't he translate? Now we know. Because the dad doesn't enter in the female sphere, neither at home nor outside. So, everything we said to the dad, he didn't tell the mother. But if we don't know these things, we waste a lot of time talking. And back then it was frustrating, because the numbers of people who were obviously not Italian began to increase, and the number of Italians decreased. And so, it was a frustration for those who worked with them. And they said "how can it be? I spend more time with foreigners, and yet they go home, and we're not satisfied with the work we've done". Whether for breastfeeding, because we didn't understand each other... or because you spend an hour explaining and then you don't get up... the typical things. So, then we spoke to [RP03], and we saw that in Merano there was this... one of the first courses on intercultural mediation … which we attended. (NN10)

The increasing presence of migrant patients brought new needs that practitioners did not quite identify, familiar relations that functioned differently, and made their usual communicative strategies unsuccessful. That was frustrating because service required greater time and service quality was not attained. Familiar and gender relations were structured in a very different manner in the various cultures, and understanding family relations was paramount: "The direct patient of ours, strictly speaking, is the child. But ultimately, we take the whole family into our care, not the child alone. The family is equally or even more important, sometimes" (TN06). The mother needs to be most directly addressed by medical and nursing staff, but immigrant mothers exhibited less fluency in local languages, with respect to their male partners, who were more frequently and intensely engaged in the labor market. However, practitioners felt that breastfeeding, neonatal bonding, and post-partum recovery must be addressed directly with mothers, and in the case of immigrant families, relations and communications were functioning differently:

> A father does not necessarily tell the wife what I have told him. ... We have learned this sort of things. Often their roles are divided, and this can create… I mean, we have to be careful, right? This creates a need to have direct contact with the mother. That is what we have learned: that while a local couple is not such a big problem, even if the mother is in bed and I tell the father, I can be sure the information arrives, right? (TD04)

In the context of different gender roles, it was a challenge, the fact that linguistic barriers prevented a direct contact with mothers, and using family members made communications incomplete and inaccurate. The two main avenues that helped with these issues were intercultural training courses and linguistic-cultural mediators.

The first intercultural courses stimulated cultural learning and curiosity, as well as a less judgmental approach to diverse gender roles and relations. Healthcare staff are not expected to become anthropologists, but they need to develop some cultural awareness and communicative strategies that help them to handle cultural diversity. Therefore, having access to bits of information about diversity in family dynamics in many cases has been instrumental to creating awareness in staff about their own expectations and paradigms, as well as practicing flexibility in relating with patient families. The fact that in some groups, the voice of the father in the public space took a predominant role, and the voice of the mother was seldom heard was a matter of different interpretations. An initial observation of diversity [albeit stereotypical] and a practice of cultural curiosity brought to the acceptance of (and eventually adaptation to) different cultural patterns. For instance, a nurse described a different role distribution in Muslim families, and how she adapted her communication strategies:

> if at home the woman is in charge, I mean, within house walls, she handles the whole family, and on the outside the contacts are handled by the man. To me is essential to know this, because I am considered as part of the outside. And so, sometimes I must explain breast stimulation to the man. Because the woman is not authorized to interact with me. And for me this, at the beginning ... I used to say… "excuse me, please, now I need to talk to the mother!"... instead… no, it is important. To me, it was absurd to have to explain how to stimulate

> the breast to a man who would not do it … If only I had known before, that for them it is normally handled like this, it would have been easier for me. (TN06)

Moreover, a mediation service provider had at the time a contract with the hospital, which had been arranged by the head of the social services office, however it was only used in a very limited number of cases for the first few years. Very early in the use of mediation services it was apparent to practitioners that embedding the service was not as simple as calling them: relations had to be structured into compatible and complementary roles.

Starting from these issues and motivations, some key actors decided to get invested in improving the access of migrant patients to services of quality, through better intercultural training and communication. The measures they have introduced have taken years to develop, and are still work in progress, but today a network of practitioners who have embraced such practices are reporting decreased conflict incidence, significant improvement in interactions with patients, a greater sense of self-efficacy and workplace satisfaction. This study considers it a social innovation network, as practitioners have created new accessibility strategies for need satisfaction among groups that experienced difficulties accessing service quality because of linguistic and cultural barriers. According to their narratives, they have achieved positive results and continue to improve service provision, through the creation of self-organized initiatives and multilevel cooperation. The strategies that have been introduced and expanded to other areas are synthesized here, but the next sections will document and analyze those practices:

- Linguistic accessibility
  Practitioners of maternity mobilized several available resources to contrast linguistic barriers, and they worked to incorporate linguistic-cultural mediation services in regular practice, considering them part of the medical team.
- Intercultural training programs
  Practitioners in maternity services created and organized annual training programs that promote knowledge about migration processes and offer the opportunity to develop intercultural skills. At first, such programs targeted maternity staff and mediators, and later they were rendered widely available for the whole provincial healthcare system.

- Negotiation of embodied spaces of care
  Some areas of maternity services are incorporating the point of view of patients to approach educational and regulatory practices with greater openness and flexibility. Becoming aware of the impact of cultural background and habitus on newborn care, a more negotiated and sensible approach to breastfeeding, rituals of birth and death, nutrition and therapy is being applied. Some tensions still remain, especially in those areas where training programs have yet not been implemented.
- Connecting health and social networks for continuity of care
  As the maternity ward is receiving an increasing number of migrants in poverty or irregular situations, as well as asylum-seekers, the need of a greater connection with other healthcare services as well as with the social work and welfare network arises. Cooperation and communication strategies with other areas of service are in great need, and some steps have been taken, among which the protected discharge of patients to their local maternity clinic (consultorio materno-infantile).

5.2 The Role of Mediators in Overcoming Linguistic Barriers

After a literature review on linguistic mediators, this section contextualizes the emergence of the intercultural mediator in the Italian context, and their introduction in San Maurizio Hospital. Thereafter, it discusses the process of their embedding in the provincial healthcare system, as well as the perceptions and expectations of practitioners, regarding this service.

5.2.1 Linguistic mediators in healthcare

In the third chapter on barriers, current literature on linguistic barriers was gathered. In this section, the literature on linguistic mediation services, and their effectiveness in overcoming such barriers is reviewed. In healthcare settings in which no professional interpreters are available, both family members and multilingual staffers are regularly used. However, serious drawbacks have been reported (Bischoff et al., 2003). With *ad hoc interpreters,* such as family members or accompanying friends, serious communication problems can emerge. Omissions and errors by them are more likely to have adverse clinical consequences than those committed by hospital interpreters

(Flores et al., 2003). However, they are reported by practitioner to be useful in translating non-sensitive information exchanges such as bedside, day-to-day information, not for diagnostic or medical treatment information (Pines et al.,2020). While many still regularly rely on untrained interpreters (Bischoff & Hudelson, 2010), particularly in small and rural practices (Kuo et al., 2007), in some healthcare settings, it is prohibited (Pines et al., 2020) or at least strongly discouraged (Gutman et al., 2020).

The use of professional linguistic mediators has been attributed an overall equalizing effect on the use of healthcare services, between patients fluent and non-fluent in local languages (Karliner et al. 2007). It is associated with a higher perception of quality in healthcare services, as in a lower risk for patient safety (Van Rosse et al., 2016; Schyve, 2007; Bischoff et al., 2003; Bischoff & Hudelson, 2010). It also brings advantages for the efficiency of the healthcare system, and prevents the escalation of healthcare costs (Bischoff & Denhaerynck, 2010; Hampers & McNulty, 2002) by facilitating rapid and accurate diagnosis, avoiding the condition's worsening, or unproductive visitations that have to be repeated. Moreover, "interpreter services lead to more targeted health care, concentrating higher health care utilisation into a smaller number of visits" (Bischoff & Denhaerynck, 2010, p. 1).

Despite the use of professional interpreters has proven to increase quality of care, satisfaction and compliance, as well as to reduce risks for patients' health, there seems to be a hesitation from practitioners to arrange such services (Blay et al., 2018). A literature review has gathered some of the reasons behind this:

> An impediment to medical interpreter use has been the difficulty for healthcare professionals to understand how the system of scheduling interpreters works (Choe et al., 2020) and the lack of integration of interpreter services at clinical sites (Dungu et al., 2019). Unpredictable availability and access to interpreters have also been noted (Cheng et al., 2021; Williams et al., 2018). In one study where interpreter services were integrated within the clinical site by a dedicated trained interpreter who simultaneously acted as a family advocate, self-reported outcomes in terms of standard of communication and trust were positive (Gil et al., 2019). (Ogunnaíke et al., 2022, p. 12)

Other than logistic and bureaucratic pitfalls, gaps in practitioners' knowledge about linguistic barriers, their underdocumentation in charts, and an organizational culture that normalizes underserving non-fluent patients are mentioned as a cause for the underutilization of interpreters (Arpin-Gemme et al., 2023). For instance, when adequate training on the use of interpreters was not provided, or when practitioners are unfamiliar with patients' right to medical interpretation (Dungu et al., 2019). Incidents were reported where an incorrect recording language on admission resulted in a mismatch between the language of the interpreter and the family.

The confidence in the quality of the interpretation service seems to be an additional driver of hesitation. Reservations include:

> misinterpretations, incorrect translations, and inabilities to translate medical terminology (Jungner et al., 2021); incomplete translations (Cheng et al., 2020; Williams et al., 2018); uncertainty regarding interpreters' competency levels and accuracy to translate (Hernandez, et al., 2013; Abbe et al., 2006); rigid structure and 'diluted' dialogue (Guerrero et al., 2018); lack of agreement around the interpreter role as advocate or mere translator (Williams et al. 2018); and lack of professionalism (Pines et al., 2020; Jungner et al., 2021). (Ogunnaíke et al., 2022, p. 13)

Another issue reported causing the delayed pickup of linguistic mediators is time: "time needed to organise interpreter services; wait time to initiate the service; and time needed to complete an encounter, as well as the impact of the use of technology on time" (Ogunnaíke et al., 2022, p. 13). Moreover, the introduction of remote interpreting systems may save time in the long term, but the introduction of phone and video technology take time and training to learn and brings added workload in the short term. However, these considerations may have changed after the Covid-19 pandemic, which familiarized many professionals with remote communication. The use of interpreters has been found to be higher for some linguistic groups and less for others (Bischoff & Hudelson, 2010). Third-party reimbursement for professional language services has been found to potentially increase the use of trained interpreters and quality of care (Kuo et al., 2007).

5.2.2 The intercultural mediator in Italy and in South Tyrol

In Italy, the role of the intercultural mediator was introduced in the main legislation on immigration (Decreto legislativo n. 286/1998), which encourages in

> the State, as well as regions, provinces and municipalities … the employment within its facilities of foreigners, holders of residence cards or residence permits of not less than two years' duration, as *intercultural mediators* in order to facilitate relations between individual administrations and foreigners belonging to different ethnic, national, linguistic and religious groups. (Art. 42, 1d)

The specific guidelines on this issue[16] delineates the concept of intercultural mediation in these terms:

> [It] places the emphasis on aspects more properly of "bridging" and synthesis between two different polarities, rather than on aspects of compromise or renunciation on the part of the parties involved (as, for example, may be the case in situations of exclusive conflict mediation, or in legal or family mediation). The difference between mediation and "intermediation," the latter meaning that suggests the acquisition of benefits, or profit or power, for the intermediary agent, must also be clear. In the concept of intercultural mediation, the term culture must be understood in its broadest, anthropological sense (cultural and religious dress, traditions and lived experience) by including language as a primary factor that is evidenced in languages and metalanguages of the body and proxemics. The concept of identity, particularly cultural identity, is not challenged by the practice of mediation: identity solidity must be considered a value and not a hindrance. Dialogue between diversities, with the help of mediation, does not give rise to forms of deconstructive relativism or identity fragilities, but on the contrary allows for enrichment and confrontation aimed at developing intercultural relationship skills useful within the framework of global citizenship. (Art. 4)

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[16] Other than this general legislation, there are specific instruments dealing with the recognition of the role of the intercultural mediator and guidelines for such recognition (Riconoscimento della figura professionale del Mediatore interculturale – Documento approvato dalla Conferenza dei Presidenti delle Regioni e delle Province Autonome (doc. 09/030/CR/C9 dell'8 aprile 2009), available at: https://www.giustizia.it/giustizia/it/mg_1_12_1.page?facetNode_1=0_10_3_2&contentId=SPS156904&previsiousPage=mg_1_12

This definition entails a cultural work that goes way beyond linguistic interpreting. The keyword bridging seems essential to this definition, as positionally generating a new contact between disconnected areas, which allows for new avenues of exchange, without asking any of the areas to renounce their positions in any way. The attention to avoiding an affirmation of superiority, in a context in which, materially, power asymmetries are exceptionally high, seems to be contributing more to concealing than to resolving such asymmetries.

The guidelines discourage the use of *de facto* mediators, or informal, untrained mediators, and encouraging the use of trained professionals, to qualify intercultural mediation with basic prerequisites, such as "efficacy, effectiveness, reliability, transparence, rigor and neutrality, as well as complex competences and sufficient knowledge of the specific context" (Art. 5). The guidelines also describe the main competences, skills and knowledge to be developed during the training of intercultural mediators, as shown in Figure 12.

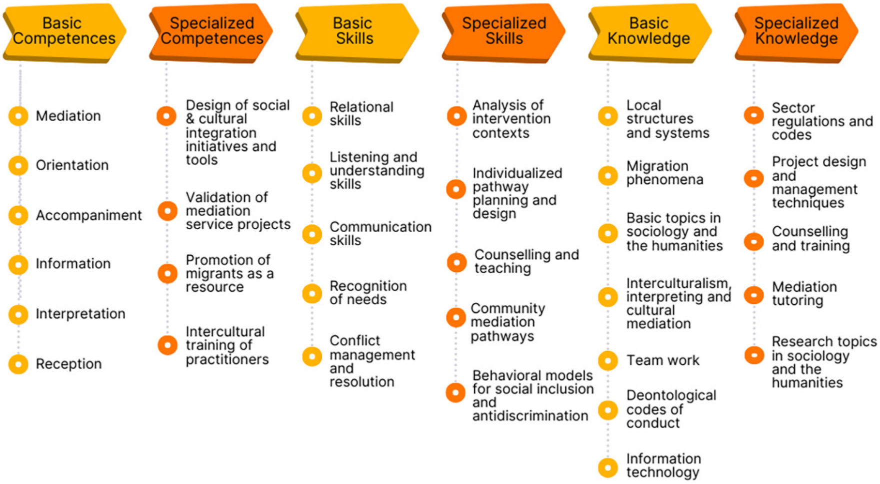


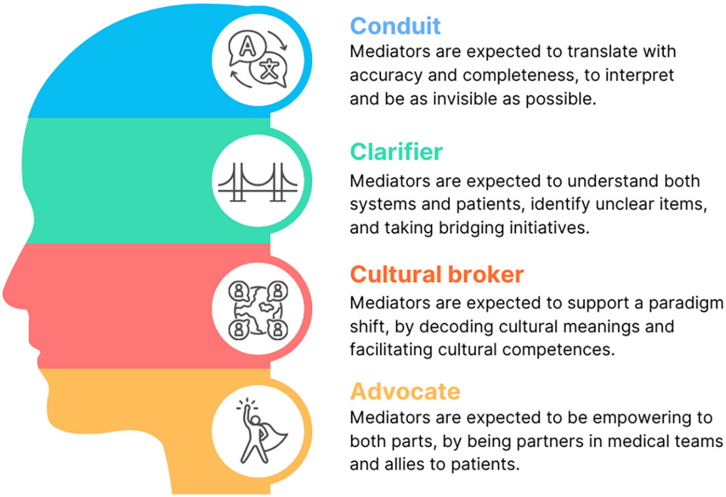
Figure 12 – Competences, skills and knowledge developed in training programs for Intercultural Mediators, according to the National Guidelines of 2010.

The guidelines also specify the various sectors in which intercultural mediators are needed, and the activities with which they should be tasked:

- Reception support in hospital facilities (facilitation in accessibility and usability of services)
- Assistance in communications (including decoding culturally determined meanings of illness and care)
- Fostering the institution/family relationship (also in an effort to bring out attitudes toward female genital mutilation)
- Accompaniment to services
- Facilitation, assistance, accompaniment in health care pathways (birth, gynecology, pediatrics, long-term care, emergency rooms, counseling centers, mental health centers, mental health departments)
- Awareness raising and information regarding prevention
- Intercultural training of health care personnel.

In Italy, the first experiences with intercultural mediators in healthcare arose in Milan, in the 90s, preceding legislation. However, the delayed implementation of standardized training, recognition, and evaluation of such professionals, hampers an adequate quality control, and the remedy of their precarious working conditions. A systematic study of the processes of professionalization and implementation of intercultural mediators in Italian healthcare is necessary.

What appears with clarity from the documents presented is that legislators in Italy were not thinking of mere interpreters when introducing the profile of intercultural mediators, and studies has noticed the multifaceted role they play in facilitating access, not only in linguistic terms (Ottaviani, 2015). The negotiated and contextualized nature of this role has been discussed in terms of "interpreter assemblages" (Bell, 2019). Literature also noted the complexities in managing role expectations, and in overlapping a variety of roles in provider-patient interactions (Hsieh, 2006, 2007). A study has identified four functions of mediators, showing incremental engagement in initiatives in favor of non-native service users: they may be conceived as a) a conduit, b) a clarifier, c) a cultural broker or d) an advocate (Roat & Creeze, 2015) as shown in Figure 13.



Conduit
Mediators are expected to translate with accuracy and completeness, to interpret and be as invisible as possible.

Clarifier
Mediators are expected to understand both systems and patients, identify unclear items, and taking bridging initiatives.

Cultural broker
Mediators are expected to support a paradigm shift, by decoding cultural meanings and facilitating cultural competences.

Advocate
Mediators are expected to be empowering to both parts, by being partners in medical teams and allies to patients.

Figure 13 – Mediator role expectations, based on the four roles of the mediator by Roat & Creeze, 2015.

Interpreters are usually associated with the first two, and intercultural mediators the last two, those with a greater engagement level, as “a promoter of participative processes and citizenship development” (Luatti, 2011). However, expectations about the role of mediators fluctuate between the four functions, and great adaptation, precision, and skill is expected. Such role expectations would require greater training investment and conditions of stable and dignified employment, which are often not the case (Zadra, 2021a). Professional interpreters receive longer training and higher pay, but they are not used in the context of migration, where intercultural mediators, while valued in words, are not afforded professional security and respect.

5.2.3 Embedding mediation in South Tyrol’s healthcare system

In South Tyrol, a first professional program for intercultural mediators was activated in 2001[17]. It resulted in the certification of a first group of intercul-

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[17] See the Deliberation of the Provincial Government, n. 4266, 26.11.2001 (Provincia autonoma di Bolzano, Giunta provinciale, 2001), where the access requisites, selection procedures, course structure and qualification tests are defined. Aluffi Pentini (2004) documents the professionalization process of the first group of mediators in this province. The thesis of

tural mediators, who created a local cooperative, that has won consecutive public tenders, with triennial duration, to deliver on-call mediation services in San Maurizio Hospital[18]. In the first years, the use of mediators was sporadic at best, while later on the annual cap in hourly engagements had to be progressively increased. The organizer of the service explains that the use of mediators within the hospital it went “from a couple of times a month to ten times a day, as a minimum” (OHS07). Interviewees involved in the process helped us document how this process unfolded.

Practitioners in our study recall that during the first years, they were not aware of the role of intercultural mediators, or of the workings of the service delivery. Therefore, many questions emerged, which can be summarized as follows:

- Which advantages and possible pitfalls does using mediators entail?
- How can we organize and prepare for the relevant languages if we cannot predict the patients’ country of origin?
- What position should linguistic-cultural mediators occupy?
- Are they advocates for the patient? Are they part of the healthcare team?
- Will they be professional in handling sensitive information and respecting privacy regulations?
- Can we trust them to deliver precise and complete information, without errors or misunderstandings, without alarming the patient or sugarcoating the news?
- Can we delegate to mediators the task of orienting patients through healthcare services, as case managers?
- Which behavioral and communicative strategies which would create the best conditions for a satisfactory outcome?
- Can we use male mediators in the maternity ward?

Such questions were addressed gradually, and an important setting for discussions to that regard were practitioners and mediators joint traning programs, which will be later discussed. Familiarizing practitioners with the

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Lintner (2006) documents the work of intercultural mediators in the Gynecology ward in the hospital of Bressanone.

[18] In 2019 it lost the tender for the first time, as a national organization offered to deliver additional remote interpretation services in emergency contexts.

practice of including intercultural mediators in main exchanges with non-fluent patients took time. Gradually, practitioners got to experience the benefits of the system, and the service itself was adapted in response to requests, criticism, or emerging difficulties.

At first, practitioners felt the bureaucratic process to activate on-call mediators was too time-consuming: both to formulate the request and to receive an answer on availability took time. The recourse to family members was a regular practice, and is still used in times of particular need or urgency: "Sometimes we even have to ask for the dad's phone number, because if necessary, we have to call him, even at night, to communicate with the mothers, because otherwise, we can't make it" (NN05). A doctor added:

> We use the mediator, a mediator that is easily accessible, we also have to deal with emergencies, so if there is an urgency, not always, but if it happens at night or on weekends, that, of course, is difficult. But then if there is the father or some relative, somehow we manage. (TD06)

However, there are significant objections to use untrained family members, especially children, to translate, because it is un unfair position to put the family members in, or because it might be unreliable, or yet again for reasons of privacy:

> Or during the night, in fact, in urgency, those... because they also explained to us that... having the children translate, it's very bad and it's very wrong, and every now and then it happens, because you have to say certain things to them, right? (NN10)

The main objection practitioners reported to the use of children as translators is the damage that it can create to put them in a position of such responsibility, to parent their parents, or by dealing with the impact of sensitive medical information about their family members. In many public services where interpreters or mediators have still not been implemented, children are in fact used often as translators: "Children learn it [the language] because they go to school, and it is they who are the interpreters afterwards, sometimes, after they have been here for years" (TD03). However, a fluent child is still a child, and public service institutions in general but especially healthcare services should not place a potentially emotional and disruptive burden on them, only because they are more fluent:

> Some keep saying "but yes... but there is the son who can translate or there is the uncle who can translate", which is the wrong thing. Then investing a child – who speaks Italian better than his mother – with this responsibility is not the right thing to do. Then also the knowledge of medical language, not only in a child but also in an adult. (TD02)

Privacy concerns regard adult family members as well. Nurses asked questions about family members who inserted themselves as intermediaries, to make sure that the patients were actually comfortable with it:

> It's also difficult, because if you don't know someone, but maybe the aunt says to me: "Yes, yes, I know everything about the family". It's difficult there too, isn't it? Because maybe the mother can't express herself, and she doesn't want her aunt to come in, right? (TN12)

Eventually, the process of booking intercultural mediators was rendered more efficient: it was no longer needed to file request forms: in the moment of need, an email was sent simultaneously to the cooperative for service delivery and to social services, which accounted for the allocated hours. The email was a formal request that in some cases was preceded by informal coordination about compatible timings, through a roster of most frequently used mediators. The nurse explained that they have a binder with mediator profiles, containing "the picture of every mediator, their name and phone number, the country of origin, the languages he or she speaks" (TN02). Practitioners tried to carve out spaces of greater autonomy also in bypassing intermediaries when they were not needed, for instance, in arranging meeting times directly with the mediator involved instead of going through the agency's channels but keeping the agency in the loop by email after the fact, so that everyone involved in the process was kept informed. With these small tweaks the system was more flexible, and the shortening of waiting times contributed to a more frequent activation of the service.

The process of booking the service still entails several steps. It starts with the request by the healthcare professional on charge, a nurse or a doctor. The document trail and appointment setting are handled by nurses, who need to send an email request to the mediation service provider and forward it to the Social Services office in hospital for time accounting. The agency contacts the mediator with the schedule of the visit and send the available mediator. However, in cases where follow-up is important, the same mediator is favored, and the hospital might change the visitation time to allow the specific mediator to be present, to give the patient continuity with a trusted professional. A mediator explained:

> They give you the appointment already set by the hospital and you have to give your availability, confirming by email or phone, but it often works with the email. Availability is given, and if the mediator of the competent language is not present, is not free, another is sought. Then it depends on the list of mediators you have. But the agency does not change the appointment for a mediator who is not available. Unless it is a follow-up case. For example, if I follow a case, if I am not available, the hospital can change the appointment. For me, the hospital has changed more than once the appointment. (MH01)

In the maternity ward, the frequent need of mediators and the unpredictable timings of birth brought a desire to incorporate a mediation service within the ward itself: "Having in-house mediators. That would be the best. Because then they would be readily available, precisely, since the very first day" (TN08). Having multilingual mediator staff recruited permanently in the hospital is one direction in which actors would like this service to grow (TN02, TD02, TN08), as it is practiced in a hospital in Milan. Mediators there have a more stable position which has allowed them to specialize in the medical field and gave them incentive to increase the quality and variety of their services. They are also readily available in emergencies, as well as better integrated in hospital structure. This high level of embeddedness is difficult to achieve, and may take a long time, going through an evolution in phases, as mapped by an interesting case study (Bischoff, 2020).

A complete incorporation was difficult, because of the early development of this professional profile, the diversification of the needed languages, and the administrative difficulties involved. However, several forms of embeddedness were experimented in the maternity ward, regarding the most frequently needed languages, while keeping the on-call mediation for other languages. Weekly rotations were established for Arab, Urdu and Igbo.

The stable presence of mediators in the maternity ward allowed to create a synergy with the healthcare staff: "The mediator is essential. And they are also people who are nice, and available to us, they don't… so this is also important, that the network that has been forming is good" (TN06). Firstly, the exchange of information between mediators and healthcare professionals increased significantly, as mediators were included in case analysis, involved in problem-solving as context experts, their opinion was asked about emerging cultural issues, and they had the chance to acquire a closer knowledge of the most common messages and instructions practitioners gave to new mothers. Secondly, they are not always busy, because of the unpredictability of births: "We have stable mediators, but it can happen that they are here, for instance, from ten to twelve, and there is nobody. Instead, the next day, there are maybe four" (NN02). However, since they were in-house, they have been involved in collaborative projects, such as the translation of documents and information materials, or the organization of rituals when a newborn died. Consequently, they were increasingly perceived as "a part of the healthcare team", or "one of us": "we see the mediator as a person of our team. For us, she is a person who belongs to our team, understands privacy as us, only that she is called when there is someone from a different culture, or that doesn't speak the language well" (TN12). Moreover, even those who were not quick to trust the mediators, and expressed doubt on the accuracy of their translations, were more ready to trust those mediators they knew because of the recurring presence in the ward:

> The mediator is not always an intermediary. Because as I said, either the husband doesn't want it, or maybe all things are not translated in a manner... because after all I don't know what he translates... (laughs) that is, if I speak Italian and you translate into your language, you could be saying anything. But apart from the regular ones that are here, that are the ones that we know well, for example the Urdu one, the ones that we have here permanent, that we have a relationship that we know, about them... we trust, because they are always here… ... they also know a bit from the medical point of view, what to explain. (NN06)

The recurrent reliance on the same persons for intercultural mediation services, contributed to normalize cultural and linguistic diversity within the ward, deconstruct prejudices, and generate a level of human connection and friendly collaboration: “For Urdu and Arab languages, the two people who are always at the Nido, are two wonderful people I have known for many years now, with whom it is fantastic to work” (TN13).

In cases of emergency, other wards tapped into maternity’s mediators on rotation, appreciating a resource they could access with less procedural burden and no waiting times. The service is now available in all hospital wards, and in healthcare settings throughout the province. A mediator interviewed mentioned the hospital wards she has worked in:

> So... diabetology, gynecology, and neurology. Now, that’s it... and in paediatrics too... The most requested fields are those of gynaecology, because so many women come, that’s how they don’t know how to speak. Endocrinology too. Now so... these come to mind because it was a case to be followed many times. Then... child psychiatry, too. And in the ward of... now I don’t remember, but it was to do a test for an elderly person for Alzheimer’s. (MH01)

A non-spatial form of embeddedness of mediators in the system, was the activation of remote interpreting, for emergencies. In the literature it is called RSMI, or remote simultaneous medical interpreting, and it has been found effective by several studies (Gany, Leng, et al., 2007; Gany, Kapelusznik et al., 2007; Jones et al., 2003). At first phone interpreting was tested by the toll-free number for healthcare emergency responses, and it was then expanded to different hospital wards, and to the system in its entirety. Since the pandemic, video conference was also rendered available.

The diversification of the engagement areas (mediation during medical encounters, case analysis, translation of informative materials, support in organization of rituals) and activation channels of mediators (on-call, inward rotations, and remote) the increasing familiarity of practitioners with it through different means (exposure, training, referral, word of mouth), all of these factors brought a growth in the uptake of the service. Moreover, a participation of the healthcare system in the employment of mediators, their selection and qualification, the stabilization of their labor conditions, and the implementation of quality controls, would give this profession the structural framework needed to develop their services up to their full potential.

5.2.4 Expectations and assessments about intercultural mediators

The first almost unanimous observation was the positive impact of the linguistic-cultural mediation service on the quality and efficiency of healthcare services, and in facilitating the flow of information with patients:

> It changed us a lot in the sense that we succeed... because earlier, at times a bit of gestures, a bit of this half English, maybe one sided... maybe the practitioner knew English, but the family didn't, or he got by with a few words. Every now and then they have this fear of the uniform, and they say "yes, yes... yes, yes... yes, yes..." And afterwards it's obvious that they didn't understand anything, and that's why... And this has changed a lot now with these mediators, in the sense that now we can get to know the family better, their thoughts, they also manage to ask all the questions they want. And we can understand not only the condition of the child but also a bit about the family. So, this was also a qualitative leap that they made... I mean, that we made. Or better, that we did thanks to them. And now we really have mediators for all languages, and this helps us a lot. (TN04)

The reported reasons for their effectiveness may vary, but the reported examples underline the difference they make during critical moments of doctor-patient interaction around serious medical issues, emergency interventions or dubious diagnosis. They are considered more effective than informal interpreters or family members in various aspects: the accuracy in medical terminology, the precision and completeness of the information transmitted, the avoidance of family dynamics interference, the transparency and effectiveness in eliciting patient needs, as well as the necessary protection of privacy about sensitive medical information. Another important advantage in the use of mediation, particularly valued by doctors, is the access to a more abundant, detailed and deeper pool of information regarding clinical histories, present condition, and health-related habits of patients. Nursing staff tend to underline the greater freedom of the patient in expressing needs and questions, as well as the creation of a trusting rapport with healthcare practitioners.

As shown by the literature, in this case study it is widespread, the perception that mediators contribute to the quality of the delivered services, to the therapeutic compliance of patients, and their satisfaction with healthcare. They also perform the function of cultural brokers. Practitioners have said that "through mediators we are able to better understand the culture" (TN04), or that mediators "are an important resource because they sometimes are able to clarify to us some specific… customs, let's say" (TCD01), and that they are "open and available to explain to us the dynamics, depending on the country they come from, and what their needs may be, more or less" (TN03). Moreover, the dialogue and collaboration with mediators has favored the critical revision of attitudes and practices on the part of practitioners, in terms of cultural inclusion. Mediators interviewed explained that their work is not limited to visitation, as it includes orientation, accompaniment and follow up activities, and patient training on the effective navigation of the healthcare system.

Practitioners expect absolute confidentiality from mediators, and only a couple of the interviewees had doubts about it:

> In cases like this it happens that the father knows, speaks the language, the mother maybe doesn't speak anything, and he then tends to replace the mediator. In the sense that they tend to reject the mediator. Because they see him as an external person, or maybe even see him as... as if we thought that he was lacking in the translation to the mother, and therefore they see it as an... almost an offence. But we often explain to them that we are those who need the mediator, precisely to clarify to both parents the function of the mediator. (TN08)

It can be seen that patients' trust on the mediator is regularly supported by practitioners, when doubts are expressed by patients or their families:

> At each interview, when the interview begins, it is emphasized that the mediator works with us. So, like us, he has the obligation of silence, to respect privacy. Because here the communities are very small, and on the part of the patients there is often the fear that then what emerges is then in some way

> spread in their community. This fear exists. And so, this concept must always be reiterated, that there is an absolute obligation to silence and respect for privacy. (TD02)

The trust that patients may place on mediators might be greatly influenced by their own professional preparation, but also by practitioners' position towards them and by the place they are given in the hospital setting.

Interviewees reported some criticisms as well. First and more common issue is that there are not enough mediators to cover all communicative needs:

> Then we call them when we need them, and they come to help us, but they only come in the morning, for an hour at most. So, we try to concentrate as much as possible, but it's not enough. Yes, because then of course you would need all day to communicate, but they don't... poor thing, of course. Then those who know English obviously can manage a bit better. (NN05)

They especially underline the difficulty of recruiting a mediator immediately in case of emergency:

> A baby… I mean, can change colour, can have a temperature. How can she tell me this if she doesn't speak? These are very important things. And then we can't wait for the mediator to arrive two days later or the day after, if the problem is right there, right? (NN02)

A disadvantage practitioners mention in the use of mediators is the time invested in the process of booking a mediation, as well as waiting times, however, it is recognized that the system has improved in time in those regards. Another issue reported by a doctor was the impression that the translation was not complete and precise as needed, or that the mediator modified in some way the message, downplaying the gravity of a diagnosis. The absence of a systematic quality control mechanism on mediator performance was noted, suggesting that the hospital may support the mediator cooperative with that function, in sight of the limited resources available to the latter. A doctor was critical of a tendency of some mediators to soften the blow of bad news, which had a detrimental impact on relations with the patient:

> If I have to communicate a potentially serious diagnosis, the tendency is a little bit to downplay things, which is dangerous: if I do not tell the truth, for the next encounters I have lost credibility. And I often get the impression that our translators are diminishing the truth (TD04).

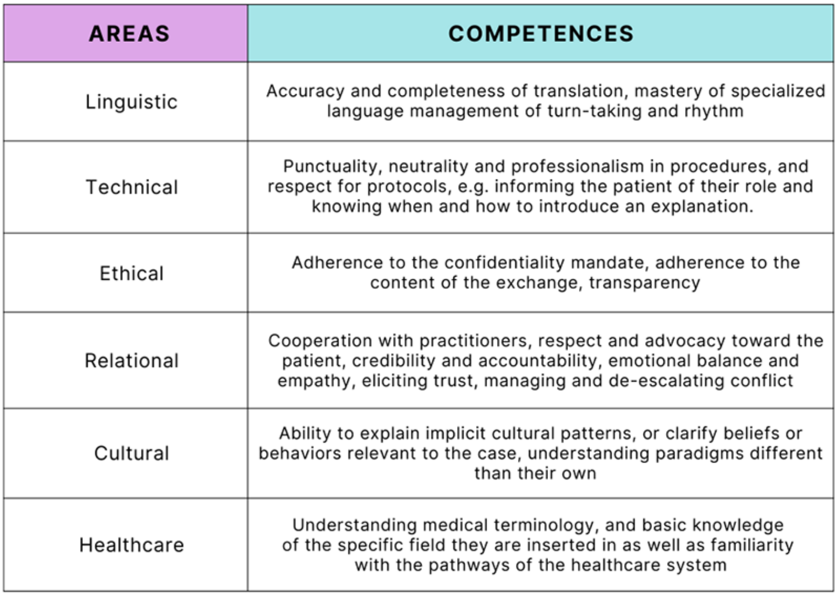
Whenever possible, the agency selects not only a person fluent in the language, but possibly from the same region, to facilitate comprehension, and to avoid potential hostilities arising from known interethnic conflicts. The importance of language concordance has been underlined in literature (Ngo-Metzger et al., 2007). However, at times this was not successfully managed. A TIN nurse recounted that some years prior to the interview, conflict arose between a parent and a mediator coming from two African countries that were having a conflict. The conflict was a source of distress: "the father felt very shocked and it took a very long time for us to rebuild the trust" (TN13). Another doubt that was raised regarded the mediators' training, which was perceived by a nurse to be superficial, and in need of further specialization:

> The problems I see are that... so, we often have translators who have not studied officially translation, they have not officially studied medicine, nor have they officially studied psychology. This brings three problems. First, a truly professional translator should know about the words... moreover, he should translate exactly what I say, which clearly I don't know how to say, but often I have the intuition that they don't say... a hundred percent of what I say. Medicine, in the sense that... if you don't understand the problem behind the disease then you have trouble translating, don't you? that is... even if you know the language well, you don't understand... that's it. And the third thing, which above all has psychological elements... that is, our mothers often had traumatic experiences, often the things we communicate are not beautiful, they are traumatic, and those are difficult to communicate. (TN04)

The desire and need of mediators to receive context-specific training contrasts with the precarious and unreliable on-call employment they have. With a full time employment that brings reliable income, specialization would come more easily. In any case, expectations of specialization are high.

The perception of competences needed in mediators constitute informal quality indicators, which emerged consistently across practitioners, and are collected in Table 6. These criteria do not constitute a list of established quality standards. They emerged from the analysis of most common quality criteria implicit in interview data. However, it is hard to generalize, in the context of the variety of priorities and role perceptions assigned to mediators.

Table 6 – Expected competences of intercultural mediators by practitioners.



AREAS	COMPETENCES
Linguistic	Accuracy and completeness of translation, mastery of specialized language management of turn-taking and rhythm
Technical	Punctuality, neutrality and professionalism in procedures, and respect for protocols, e.g. informing the patient of their role and knowing when and how to introduce an explanation.
Ethical	Adherence to the confidentiality mandate, adherence to the content of the exchange, transparency
Relational	Cooperation with practitioners, respect and advocacy toward the patient, credibility and accountability, emotional balance and empathy, eliciting trust, managing and de-escalating conflict
Cultural	Ability to explain implicit cultural patterns, or clarify beliefs or behaviors relevant to the case, understanding paradigms different than their own
Healthcare	Understanding medical terminology, and basic knowledge of the specific field they are inserted in as well as familiarity with the pathways of the healthcare system

As discussed earlier, expectations have a high variance, along the continuum of engagement presented by Roat & Creeze (2015). Thus, the study documents the expectations that were voiced by practitioners. The double alliance that their bridging role implies, with migrants and with public services, is not devoid of ambiguities and potential conflict (Hsieh, 2007; Seale et al., 2013). Practitioners were aware of that, and they made conscious efforts to include the mediators as part of the healthcare team, while understanding that their advocacy on behalf of the patient was an added value. The ubiquity of practitioners' request to have mediators with employment stability inside the hospital, is hard to satisfy. However, it can be understood as originating from the need to generate a greater interprofessional synergy, that allows for shared expectations of role and performance. If mediators would have the professional skill and experience to perform a variety of different roles, adapting them to practitioners' and patients' expectations depending on the context, it would be extremely effective in generating accessibility for migrants.

Occasionally mediators offer much needed navigational assistance. As their work brings them to different services, inside and outside of the healthcare system, they accumulate experience on the workings on local systems and frequent pitfalls or misunderstandings with foreign users. Mediators develop the skills to establish a trusting relation with public services and to acquire updated information. As a manager of mediators commented, public servants are diffident and prejudiced, but when you have the right skills, and show you are there to give and not to receive, trust and cooperation arise (MM01).

Many aspects of healthcare procedures are assumed to be known or obvious, but they change and require constant learning. For recently arrived migrants, mediation services play an orientation role that makes access possible. Functions that locals have normalized, and consider intuitive, are not transparent to new arrivals. Mediators say they spend much time explaining how to read hospital signposting, or that the patient's part of healthcare costs is called "ticket", or that when you arrive to the cashiers' windows you should take a number and look at the screen to find out what window to approach. Simple procedures, when you are well informed, but they require a learning process:

> For those who have not yet learned the system, it is chaos. Even finding the cash desk. ... We do these things with them. We go to the cash desk, first we bring them to the clinic, take the papers, then we go to the cash desk… The patient doesn't have to worry about anything, because the mediator would do all of it for him, the first time, or the second. Then one learns how it is done. ... To live here, one has to learn how it works… develop bureaucratic literacy! Because it is difficult, even getting on the bus, get a ticket, there are all systems that we don't have. I mean, us in Syria, we had, when I was little, there was this ticket inspector on the bus and he used to sell tickets as well. Here, you never know. First you can't buy the ticket on the bus, from the driver. Then, you can do it. Then they installed machines. Then… I mean… it is very nice, because there is always a revolution, a change, an improvement… but… (MH01)

Changing systems can be challenging for all, but locals must learn one, while recently arrived migrants must learn a whole new world. Moreover, public service systems are not learned once and for all, because they keep changing, and in Italy, bureaucratic novelty seldom comes with clear explanations[19]. Thus, mediators are implicitly expected to contribute to the *bureaucratic literacy* of recently arrived migrants.

A key element for the evaluation of mediator performance is their responsiveness to the role expectations expressed by practitioners, which may vary notably, among departments.

Immediacy and accuracy were the priorities in the *emergency services*. In this context, according to an emergency doctor, a mediator needs to be rapid and precise as an interpreter, and leave the patient handholding to a minimum, only when it serves the purpose of facilitating patient compliance. The incoming process to emergency requires a *triage* that cannot be managed without a common language. A misunderstanding in early charting can be devastating to the patient diagnosis, treatment, and outcome, and some interventions cannot be delayed waiting for mediation. It is as unethical to perform medical intervention without informed consent, as it is to harm the patient's outcome by omission, by delaying intervention. That is why immediate remote interpretation may be lifesaving in these situations.

In *maternity*, instead, it is a priority to establish an empathic and direct communication with mothers, to transmit infant care practices with respect of cultural diversity. Women mediators are preferred, which may be able to reach mothers, in the different positions that women occupy in the various cultures. Moreover, caring for a woman's body after birth, and with the symbolic meaning weighing on a variety of maternity practices, female mediators are perceived to bring a female alliance, that make them particularly apt to speak about breastfeeding, and post-birth ailments.

Continuity in mediators is favored among most wards, as it helps with specialization and knowledge exchange. However, in *mental health*, where the main therapy goes through words, and the psyche manifests by symbolic expression of cultural worlds, without such specialization, the work is

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[19] Edward T. Hall (1976) conceptualised *low context cultures* in which communication, including public communication, tended to include all the necessary information explicitly rendered in the message, and *high context cultures* in which communication rested greatly in implicit information which circulated through relations and connections.

more difficult, on both sides (Alegría et al., 2016; Dune et al., 2018). Mediators need to be prepared to handle the emotional impact of therapy, as well as be informed about secondary trauma. Mediators in psychiatry need to be able to have a deep dialogue on the symbolic meanings implicit in the patient's worldview, functioning as cultural brokers. As the therapeutic relation is the main instrument of diagnose and cure, relational competences acquire a priority respect to linguistic competences.

In the work with *migrants in irregular situations*, as detailed in the previous chapter about the MIS Clinic, the consolidated multilingualism of the staff and information materials, still requires on-call mediators for the languages that are not spoken or not encountered frequently. In every context, the professionalism of mediators regarding privacy in treating sensitive information is of paramount importance. However, in the context of migrants in irregular situations, it is even more delicate, as the service is rendered anonymously, and the law forbids healthcare practitioners to report the undocumented status of migrant patients to the authorities. A suspicion that such mandate would not be respected fully, and the clinic may lose its reputation as a safe haven among MIS, with detrimental consequences for continuity of care. Moreover, trauma-informed assistance must be prioritized in this context of care, which includes victims of torture and violence, as well as minors in vulnerable situations.

To conclude, this section has addressed how the understanding of intercultural mediators, of their roles and skills, as well as the indicators of their performance are very different across practitioner levels, and across healthcare departments. It has also documented how, over time, the service was partially embedded in the hospital setting. The service evolved, as practitioners and mediators got better acquainted with each other, and started collaborating more fluently. One of the main factors contributing to the wider use and to the evolution of the mediation service were the joint training programs, that will be discussed in section 5.3. This section concludes by covering the other communicative strategies enacted by practitioners in maternity to improve communication with patients.

5.2.5 A repertoire of communicative strategies

As shown above, intercultural mediators are critical to quality of care in essential medical exchanges. However, they are not the only tool available to foster linguistic accessibility, and on some occasions, they are not readily available, or not quite necessary. Upon need, practitioners deploy verbal, nonverbal, and digital communicative strategies to facilitate linguistic access. When discussing with non-native speakers about key medical information, doctors in Neonatology activate different strategies. One of the accounts seems particularly rich in its description of communicative efforts deployed to communicative with the Iranian father of a baby born with liver failure:

> He spoke very good Italian, so I thought I could do without the mediator. And I spoke to him in a very simple way, because I am used to all patients speaking in a simple way, in non-specialized language. So, I talked to him about the liver of his child, which was not good, which had problems, that we had to see about that. And I spoke to him several times -because I was on call that week- about this liver, several times. And he would say to me: "Okay, all right" that he had understood. Then maybe the fourth time I went there to talk, he said: "Excuse me, but what is this liver?" ... It means that he just didn't understand anything! So I got a book where there was a picture of the human body, I brought it to him and showed it to him, and then it was all clear. From this you can understand... I hadn't talked to him about strange things... the liver! ... So it must always be considered that those who speak Italian well and get on well in everyday life may perhaps have difficulty with some medical term – although simple – and not understand it. ... I don't say that you have to call the mediator every time. But maybe check what you're saying because maybe he didn't understand. (TD02)

In this narrative, the doctor used a variety of strategies with her patient, who appeared at first to be fluent enough to sustain a dialogue in Italian:

- Avoiding complex structures: *I spoke to him in a very simple way*
- Avoiding uncommon words: *I wasn't talking about strange things… the liver!*
- Avoiding technical terminology: *…using non-specialized language*
- Repeating key messages: *I spoke to him several times about this liver*

- Checking understanding: *check what you are saying, because maybe he didn't understand*
- Using visual aids: *I took a book containing a picture of the human body and I showed him, and then it was all clear*

Additional techniques that practitioners report using to facilitate understanding are:

- Using the "teach back" technique
- Paying attention to speed and clarity of pronunciation as they speak
- Taking enough time to explain key aspects without rushing
- Pausing, to give patients enough time to formulate their thoughts and concerns
- Asking patients if they have any questions or comments

These communication strategies reported by practitioners, are close to current guidelines on verbal clarity in medical communication to promote health literacy[20].

Linguistic accessibility is not only about clarity in spoken language, but also in written language. For instance, in the Nursery (Nido), written materials about basic knowledge on newborn care are available in several languages, and are occasionally used to offer overview information to mothers. Topics as breastfeeding or curves of growth are detailed in these multilingual information resources:

> We also managed to create all the documentation because we also have information sheets that we give to mothers. ... We have printed materials, and we have them in... Italian, English, German, Arabic, and I also think Chinese. We managed to print all of these information resources to hand out. ... We clearly had the assistance of the mediators, who helped us in the compilation and drafting of these documents. But... then maybe it's the mother herself who asks for it in another language. Maybe we propose Arabic to her, but maybe she can read English, etc. But, in short, the possibility of choosing a document in one's own language. (NCN01)

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[20] *AHRQ Health Literacy Precautions Toolkit* (Brach, 2024) and *Health Literacy: The Solid Facts* (WHO/Europe, 2013a). See also Allen et al. (2023), on patient's preference for non-specialized language.

The use of mediators in maternity rotations to translate basic documents in foreign languages (such as informed consent forms or informative material) seems to be a good practice, in the light of an expansion of the role of the mediators in creating opportunities for knowledge circulation among practitioners and patients. In Neonatal Intensive Therapy, however multilingual written materials haven't been produced yet, and they consider it to be a useful tool. There is not enough information available to migrant patients which do not speak Italian or German, the two languages in which all public information is offered. A doctor in Neonatology suggested that information flyers should be offered in several languages about healthcare services but also explaining the basic functioning of the welfare services to migrants. They should inform doctors as well, because they are not well informed of social services and resources, and the knowledge would be useful to help connect their patients in need (TD05). One of the first documents which is considered helpful to translate is the ward brochure and rule guide. It contains detailed regulations and sterilization practices for accessing the ward: that entrance is limited to the parents of the baby, and they are required to sterilize and wear protective gowns, masks and shoe covers. It also explains the advantages of Kangaroo Therapy, the skin contact between the premature newborn and one of the parents, by placing the baby on their bare chest. It is said to foster health, growth and bonding. At the moment the ward brochure is only available in Italian and German (TN08), and having it in more languages would be helpful.

The choice of languages, however, has caused pause, as there doesn't seem to be an accurate data collection about the languages spoken by patient families, and the impression is that the proportions might shift in time. Languages with a greater global presence, as English, should be added in any case:

> We should also consider which information to… and we should also have actual statistics of user percentages which… and they change ... It would be optimal to have the guide book of the ward in several languages. Only that, in fact, on what could you possibly base the choice… so we do it in Urdu, or what? ... In fact, English for sure would be a great idea. (TN07)

Limits of written resources have also been pointed out by the ward chief, who observed that even though many written materials have been produced and translated, for many purposes they are not enough. The education of new mothers to take care of their baby cannot be achieved by distributing flyers, he said. Instead, newborn care actions have to be repeatedly and patiently shown in practice:

> There's a part that's already been translated and done. Then a lot of things have to be explained and done, I think, so. We can make an entire phonebook of informative material for parents, which then nobody actually reads anymore. Anyway, they do not comply or at least do not understand certain things, because it is one thing to read something, another is to do it. So, in my opinion, we have to evaluate very well which information we have to put or are able to put, or we want to put in writing. Because for example many things in educational work, must be taught, I mean, shown, made visible. Not only delivering a brochure and that's it. (TCD01)

The observation that there are types of content which is not helpful to translate in other languages was interesting. An instance of this happened in the Nido, where it was discussed whether it was feasible to produce translated versions of the health book of the baby. It is a binder in which all the medical information, measurements, screenings and checkups done to the baby are in the mothers' hands and are available for the pediatrician as well because she is to bring the binder to every visit. It would be good for mothers to better understand the information about their child, but the main purpose of these documents is to inscribe fully and accurately the medical information to communicate it from one practitioner to another. Digital solutions might arise in the future to address this problem, but the item is still on its paper version and although the system has all the relevant information available to the pediatrician in digital medical histories, usually the patients go from one specialist to another carrying the whole package, which practitioners consult directly, as it seems completer and more accessible. Therefore, a foreign language version of such a book would probably create more problems than it solved.

In producing multilingual written material, several criteria have to be considered:

- *Expiration date of the content*: Namely, if it is a subject matter subject to frequent change, the investment could also turn out to be superfluous.
- *Foreign language choice*: In fact, there should be a rationale which follows data on the actual target population of such efforts, if it is somehow stable.
- *Accessible language style*: If they are materials for public accessibility they should foster health literacy by explaining and hopefully also illustrating any specialized terms that are being used, in favor of accessible language. It defies the purpose to translate informed consent forms when they are incomprehensible for the average patient.
- *Maximizing dissemination*: Several mediums including digital means could be used to render available and discoverable such information, not only handed out on paper.
- *Upgrading to video tutorials*: The obvious question to address information topics which cannot be explained but need to be shown, is why not upgrade the idea of the simple flyer to a video tutorial? Adding subtitles to video tutorials made in-house, in a choice of languages, should not entail a significant expense. It would generate a much more user-friendly access point for digital native mothers. If for any reason the hospital wouldn't like to make the videos discoverable in Internet they can also be circulated internally through a tablet.

However, digital tools were being discussed by practitioners on several communicative contexts. On the one hand, it was mentioned that practitioners had used digital tools to learn languages, both through apps on their phones, through paid e-learning language courses, some specialized in medical communication, and through free websites with resources for language learners (TCD01, NN08). Moreover, digital means of interpretation were said to be used, as google translator, deepL.com and other apps or translation software, in the case of non-sensitive but urgent information exchanges (NN11, TN13). The main issue around which it was discussed, however, was the need of a faster interpretation service for emergencies, which would be possible in distance by phone or by digital means through video conference.

5.3 Preparing for the *Trialogue:* Intercultural Training Programs

5.3.1 The first training initiatives

Training initiatives started between 2009 and 2010. Two Neonatology doctors and several nurses participated in an intercultural training course which was organized in the city of Merano. The course addressed the complexities offering healthcare services to different cultures, and had a positive impact. A nurse recalls the experience:

> We started it, you know, five or six of us. And in these courses, this [name] was very good, because she didn't immediately explain to us what the mediator is. She started with the basics: she showed us some films, she showed us where she worked in Africa, she explained to us Neuropsychiatry, spoke about some renown French scholars, and really explained that, for example, we have here an understanding of depression... but the depression of a woman from Ghana is not recognized, not by a long shot. This person can die inside, and no one notices, because it is not a thing... according to them, it is not seen as a disease. So many things like this. She really instructed us. (NN10)

After that positive encounter, they realized the value of such information for their practice. Therefore, the ward started organizing in-house initiatives with this speaker, involving mediators in staff training. During the years 2011 and 2012 meetings were organized in the neonatology ward, where mediators were asked to describe the beliefs and habits of their cultures of origin about childbirth, newborn care, family structure, health and illness, among other topics. according to their nation of origin. These dialogues were an initial effort to perform a "cultural mapping" of the main cultural features of the foreign cultures which were most represented among the patients of maternity services. A nurse recalled the summaries they produced about each culture and how they hanged them on the wall to create a common knowledge base about cultural diversity.

> So we decided to do it with her, to ask for courses in Bolzano with her as supervisor. And to do it like every few months with mediators from every ethnic group. They would tell us all about their culture, food, everything. So that

> every three months... once there was Pakistan, then there was Arabic, then there was I don't know... and we did this for a couple of years, until we understood all the cultures, we made summaries, where our colleagues then had to read, to understand, then, of course, how to deal with death, and so on. (NN10)

As she describes these efforts, aimed at building knowledge about different cultural views of health, illness and motherhood, she sees it as a stepping-stone to go beyond. It helped de-normalize their own view, and gain awareness of other points of view. She understands the assumptions behind this attempt were naive, as they thought that all they needed was standardized cultural knowledge. However, she also explains how this simplified knowledge they gained about the perspective of minority patients made them better understand the motivations behind their choices and introduce small adaptations to their service provision strategies accordingly:

> So, even oversimplifying, you say the Arab mother has this idea of childbirth, the Chinese mother has this other idea. So, in general, I already know how to go there and how to ask her about things. Because if I know that the Chinese mother wants artificial milk immediately because she thinks that hers is poison, I cannot keep arguing for two days and insist, if she refuses. I see that she does not want to breastfeed. Because otherwise we waste time, and she goes home without having ever tried the artificial milk, isn't it? We can't have that. I mean... So we adopt a different approach. (NN10)

For sure, the expectation of producing a "map" which distributes beliefs according to area of origin is pointless, one could argue. It may even reinforce stereotypes, instead of contrasting them. However, noticing and accepting diversity are important first steps towards developing intercultural sensitivity (Hammer et al., 2003; Hammer, 2015; Harvey et al., 2013). These were the first collective initiatives to representing cultural diversity as legitimate and taking it seriously into account in doctor-patient relations:

> we sometimes criticize or in any case adopt a certain approach because we think that everyone thinks the same or has the same background as all of us. While if maybe we just knew each other better... Those we see most around here are Muslims, at the moment. And, for example, a dad who doesn't change

> his baby, a dad who doesn't touch the baby, takes very little care of it and spends little time with him, here in the ward, is very criticized. ... But now this culture... we start to know it a little better, here, because it is the one that is more present in TIN. But perhaps one thing that would help us, would be to take stock of these four or five ethnicities, or populations which are more present, and get to know them a little better. (TN04)

Cultural sensitivity trainings have certainly evolved beyond cultural knowledge. However, it is still highly valued, because it is regarded as a tool to cultivate reciprocal understanding and overcoming judgment in healthcare staff (Hill, 2010), which is deemed unproductive:

5.3.2 Joint programs to develop synergy and intercultural sensitivity

As useful as they were, these "cultural maps" soon were replaced by deeper training regarding overcoming ethnocentrism and cultivating cultural sensitivity skills. Then, in-house training courses involved experts which offered a wider sociological and anthropological perspective of migration, as well as opportunities for the development of competences in intercultural communication. These were organized through the hospital platform for staff training, which had a strong bottom-up approach to training, meaning that each ward had training resources to allocate according to their needs, and the training department offered support on the organizational process.

Regulations about public service training have been modified. All healthcare staff is expected to get 50 credits of training each year, where three hours of lecture (CFU) correspond to a credit, while only one hour of interactive workshops (ECM) amounts to a credit. The more interactive the training is, the more credits they acquire. Recently regulations have been modified to require 150 credits every three-year period. The overall amount of credits has not changed; however, the enhanced timeline allows flexibility in credit acquisition and a strategic planning in professional development. An interviewee, manager of staff training programs, reported the change:

> Before, people rushed to get their credits through whatever course was available at the end of the year ... It was a hunt for the credit, as if people were collecting points for prizes at the supermarket. Now we have the training dossier,

> which allows you to plan your professional development, based on your real problems or needs, or your desire to develop a specific competence ... One can have long-term objectives, not only short- term ones. (OHS2)

Another recent change has been the adoption of a top- down approach for hospital-wide initiatives, to complement the bottom-up approach which is department-based. It is meant to create common practices in the hospital, mostly with regards to risk management, quality control and security standards, implementing mandatory training for all. The staff training supervisor commented positively on these initiatives because "there is a need to pursue objectives which regard the entire organization. An institution which doesn't know where it's going cannot be well managed. It is important to anticipate problems and not only react" (OHS02). He explained that a centralized reflection is taking place about staff training priorities, in which some of the courses which were proposed for all nursing staff, as issues regarding professional ethics, psychology and communication strategies are being considered for medical staff as well:

> For doctors there are no hours reserved to psychology and communication courses, but doctors would greatly benefit from those. With a top-down approach, doctors should have mandatory communication courses, as nurses, which have at least 30 hours of communication and psychology. (OHS02)

Many interviewees throughout the maternity ward expressed the need to make migration workshops mandatory as well, and it was a discussed hypothesis, before Covid, which suppressed all in-presence training. In any case, most trainings are still designed and organized on-demand by each ward, tailored made around their perceived training needs, however they are always open to other healthcare practitioners, as the training platform is unified for the whole province.

The effects of those initial experiences of training were so beneficial that professionals decided it was worth to go bigger. They included courses on intercultural sensitivity every year to doctors and nurses as well as mediators working at the hospital, to enhance the cultural appropriateness of healthcare services and to learn to work with mediators as a team. In fact, the mediators present at the hospital had undergone a training program in mediation and were given a short informative course on the hospital setting where they were explained vaccinations and other general health-related issues, but training together with healthcare practitioners was in hindsight a powerful initiative which contributed to the knowledge circulation process and to a better disposition of doctors towards working with mediators.

In time, those who were the most effective trainers and got regularly called were coming from an experienced mediation agency operating in Milan as in-house mediators in several hospitals. Since 2012, until the pandemic, in partnership with this agency, three full-day workshops per year were regularly organized, to offer training to doctors, nurses and local mediators together. The assumption was that training together would bring them to better interact during medical consultations, based on a shared vision of the difficulties and resources of migrant patients, the communicative dynamics of the medical encounter and the role of intercultural mediation in such setting. This concept of this program was a workshop, not a mapping of cultural beliefs, but aimed at a paradigm shift away from ethnocentrism. While providing knowledge about the migration process and its hardships, the main objective of the courses remained centered on building intercultural abilities in practitioners, to interact effectively with their diverse patients. The doctor who was most instrumental in setting up such training program (and still keeps it up and running) explains:

> These courses are open to nursing staff, doctors, health care workers and those working in the area. Even for mediators. This is essential: that mediators and health workers hear the same things. It is fundamental. Because working with the mediator is a model of practice that must be learned. We have always been accustomed to having a doctor-patient relationship. Here, it's a triangle, it's a three-way relationship. And therefore, it is essential that the mediators also hear those things that the health workers listen, that there is this deontology, there is this specific training they must have. (RP02)

Overcoming ethnocentrism in healthcare practices is the long-term objective. To Bennett and Castiglioni (2004), ethnocentrism is "assuming one's culture is central to reality (…) ethnocentrism is a physical state as well as a psychological disposition, a condition we have referred to as embodied ethnocentrism" (p. 261). Moreover, "the most fundamental fact of ethnocentrism is that things simply 'feel right' in one's own culture. To counter ethnocentrism with cultural self-awareness, it is insufficient merely to know the values and common patterns of behavior of one's own culture. It is also necessary to become sensitive to the *feeling of appropriateness* that accompanies those patterns" (p. 249). It is precisely such kind of self-awareness that hospital workshops aim to elicit. Program organizers expect doctors and nurses to develop the capability to suspend judgement and give equal treatment to minority patients. This requires challenging the assumption of a shared worldview, especially around health and illness, and recognizing that patients are not by default centered around our cultural assumptions:

> The point is to de-center our culture. Basically, we think that our culture is the best. It is only by de-centering and accepting that there are other points of view that I might not share, but it is the only way to get to the patient. Because clearly there is a whole different view of disease itself. ... And if I don't at least keep it in mind... It's not that I must transform my way of thinking into that of another culture, but I must keep in mind that in that culture there is this vision of disease, and of the origin of disease, which is different from the one I have. And if I don't keep that in mind, I won't be able to reach the patient. (RP02)

Such self-awareness requires both an internal work, and a personal and collective examination of practices. It is both individual and organizational work. Hill (2010), in discussing how clinicians handle moral judgements of patients, and their impact in clinical practice, observes that while having a mandate to treat patients equally, personal feelings interfere daily with such goal. Physicians are told they have a moral obligation to recognize the unconditional value of patients as persons, but they are not trained to handle the internal work which is required to deal with their own feelings of disgust or contempt, when faced with "hateful patients", or those deemed undeserving. In fact, "many clinicians struggle earnestly to control their emotions and judgments in order to meet these professional standards" (Hill, 2010, p. 5). The study describes available studies in this field, showing that there is still much consequential work to be done to come closer to service provision equality. Not rarely, individual blame is assigned to patients for structural disadvantage, and the person is negatively judged and receive sub-standard care, because of not being able to conform to expected behavioral scripts. The combination of social consensus on nonjudgmental ethical norms and a strong self-image as a moral individual are mentioned by a study as factors related to professional equality in healthcare relations (p. 5). The study showed that "staff will take moral judgments into account unless discouraged from doing so by the organizational arrangements under which they work" (Hill, 2010, p. 3). An environment that does not participate in the normalization of patient judgement, moral or otherwise, does contribute to encourage equal treatment. Regarding our topic, often cultural prejudice is hidden behind moral judgement, just as social disadvantage is. The promotion of a collective ethos of nonjudgmental relations towards diverse or disadvantaged patients is therefore an impactful goal for training, as it has been in San Maurizio Hospital.

Trainings have not been free from resistance. However, having group leaders reinforcing equal treatment standards and encouraging staff to participate in cultural sensitivity training workshops has had a positive impact on communication with immigrant patients, according to most narratives. Among dozens of interviewees, only one nurse found the courses not helpful. That is why organizers consider the program should be compulsory:

> I would render this courses mandatory. I think it is should be like that. Because only if they are mandatory... Many of the people that haven't participated yet don't have any objections, it is just didn't work out. But when it becomes mandatory, one can say: 'you have to do it within a three-year period. Not today, but in a three-year period you have the obligation to participate'. In my opinion, a new world would open up before their eyes, as it has opened up for me, because I have learned so much. Without training, I wouldn't have any understanding. (TD02)

Acquiring a new perspective on cultural diversity to better communicate with minority patients is one of the main drivers of these workshops, not only to benefit patients. Practitioners themselves consider it beneficial, and find their work more effective and rewarding, because a trusting and effective relation with the patient in turn becomes cost-effective and time-effective: "It should really be considered that it is very important to have patient compliance. Because in the end, everything translates into savings, if you have patient compliance" (TD02).

Another reason motivating these trainings is to raise awareness of the advantages of using mediation services with patients with a limited mastery of local languages, and to conceive them as part of the healthcare team, serving as "cultural bridges" towards minority patients. It has improved collaborations and helped with the uptake of the service. At first, trainings were held within the different branches of maternity services, and then they were extended to the whole hospital, and beyond:

> Healthcare workers need to undergo a long training to be more aware and sensitive. In the sense that... things are working here, now. Both here [in TIN] and more or less at the Nido as well. Here is where the whole project of having mediators in a more permanent way started. An awareness has been promoted in all the staff, of the importance of having the mediator not only as a translator, but also as a bridge, let's say, towards another culture. … This training, which we do every year, is certainly useful in that regard. We are doing it again this year. (RP02)

Not only practitioners but mediators themselves needed training. It was useful for all, clarifying the role of the mediator in this negotiated space between the therapeutic agenda of the medical team, the rules and conditions of the healthcare organization and the needs, beliefs and positions of patients. According to several interviewees, during the first years of service it was apparent that standards were not adequately set, and mediators had not been prepared sufficiently to understand their role and play it with the expected competence. One of the mediators active in the hospital recalls:

> It is really important for mediators to work through a good training. Now, [agency name] does it because the hospital requires it as mandatory. [agency name] participates in these three training days with the hospital, and the mediators have the obligation to participate. You cannot be absent. But for [agency name] it would be sufficient that you speak the language correctly, and they would allow you to do the job. (MH01)

Interviewees from a different mediation service cooperative were very critical towards the quality and ethical standards of the agency active in the hospital, especially regarding a lack of staff training to go beyond basic translation, towards mediation work aimed at "keeping communication flowing and negotiations going between migrants and public services" (MM02). Since the courses started in the hospital and became mandatory for all mediators, a general improvement on quality standards has been noticed by practitioners. However, improvements were not enough to secure continuity of provision, which is handled by public tender. In 2019, the evolving requirements of the hospital along with heightened quality standards caused the contract not to be renewed, even after many years of service and joint training. Mediators of the new service provider had the same requirement to participate in mandatory training sessions alongside practitioners, until Covid measures brought training to a halt.

The training sessions' methodology is predominantly based on frontal content delivery, which is hardly the only or the best strategy in the field of intercultural education, in which participatory methods are available and effective (Zadra, 2015). With more than a hundred participants per session, it is not easy to implement interactive training strategies, but attention should be brought to this issue, as digitally assisted participatory education strategies evolve[21]. The environment was reflexive and informal, and questions or comments by the public were welcomed and addressed. The contents were pre-planned, and they were delivered through case-based narratives of mediation experience, accompanied by slides. A mediator commented:

> It is nice, but not really interactive. … There's a lot of talk, a lot of slides. There are two of them doing the workshop. One speaks more about the medical side, and the other speaks more about the social side. There are many slides, many stories, and there is the chance for the public to participate, those who have an experience to tell which is similar, or those who have a question to ask. In

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[21] Current digital platforms for collaborative learning and content creation are helpful tools in facilitating participation despite high numbers. Gated content hubs and repositories, interactive boards, network facilitation apps, and instant polling platforms, as well as gamification strategies may contribute to audience engagement, and continuous learning. Some useful examples today are: Kahoot, Mentimeter, Padlet, Mural, MeetingPulse, Slack, Catchbox, Slido, but the collaborative learning digital space is constantly evolving, and platform turnover is frequent.

> the end they made it possible for each one to write one question on the board. And finally, they answered the questions publicly, so everyone could hear the answer. (MH01)

The workshops appear by this description centered on speakers' narratives and reflections. The positive side is that speakers have years of experience in training medical practitioners and mediators together, and the case-driven content does resonate with them, by answering implicit questions. That is why they are called back every year, over academics with sociological or anthropological discourse, which are sporadically included. The content they bring is practice-related, open to reflexivity, and immediately applicable. Participants of all persuasions appreciated the fact that speakers stayed on topic, without an explicit political agenda on migration as a whole and focused on contextualized practices instead of abstract principles. As an anonymous participant during a course break observed: "we don't need ideological programming, or declarations of equality, but training to make communication flow with patients that are different than us" (fieldnotes, 17.04.2018).

However, the advantages of having doctors, nurses and mediators together are limited when the methods of the course do not allow for interaction between them. In any case, efforts are made to foster participants' input directly by taking word in the plenary discussion or indirectly, through questions written on the board. These strategies allow the incorporation of the participants' desiderata, topics and questions in the workshop. Methods of delivery remain a space for growth of the delivered training, as well as having no scientific evaluation as a measure of effect, other than a feedback survey on participant satisfaction.

The trainings are accessible to all healthcare staff in the Province, and they can access the program planning through their common digital training platform and book their participation. The hospital workshops on migration are mandatory for mediators and strongly recommended to all doctors and nurses of the hospital, but healthcare staff from the entire province is welcome. Doctors are proportionally less present than nurses, and the promoter explains the reasons:

> Courses are open to everyone, all the hospital, but also to the other territorial divisions [*comprensori*], as Merano, Bressanone. And including the neighborhood maternity clinics [*consultori materno-infantili*]. Doctors are more resistant to come to these courses. It is not all unwillingness, because they are overburdened. There is the duty of doctors to do specific training on the medical profession, in relation to one's specialty and super-specialty. As one cannot do everything, maybe this part is neglected. (RP02)

Workshops are held in a large auditorium, and reports confirm they have slightly more than a hundred participants per course, for the most part not repeating attendees from healthcare organizations all over the province. However, according to a training official, the first time the course was replicated in the city of Merano, around 2013, the healthcare system administration received harsh criticism from the German-language media, arguing that a public service institution should not invest resources in trainings regarding immigrant patients. The doctor who organizes the courses has also received direct and indirect criticism, mainly by outraged members of right-wing parties which "do not approve of the hospital investing resources on immigrants. They don't understand that we are doing this for ourselves, simply to be able to do our job" (RP02). She brushes off such opinions as predictable and inconsequential, because everyone who attempts to create something new is going to be criticized. She has trusted her former and her current ward chief to stand up for her actions, which both supported and praised as a valuable and effective contribution to service provision. In fact, today she continues to offer voluntarily her time and effort to organizing the training workshops, taking upon herself to keep everyone informed by email and personal connections. Reflecting on this process, she describes her faith on change, which requires an initiative, but is often followed by unexpected new resources and alliances:

> You only have to start, to give that first step, to have faith that things could change. Then, on the road, you find people who will join forces, you find unexpected resources and problems get solved. But you need to start. (RP02)

Thus, a community of practice in maternity services has been carefully and steadily cultivated.

5.3.3 Perceived effects of training programs

The training programs appear to have produced a twofold effect. Firstly, on a symbolic level, workshops have fostered in practitioners a more nuanced perception of cultural diversity and structural inequalities, improving their understanding of the position of migrants as well as inducing self-reflection. Secondly, on a material level, it has offered instruments to overcome barriers in communication and material access to services, through the introduction of new services, creative practices and adaptation strategies. Both aspects are deeply interdependent.

It is important to observe this reciprocal relation between knowledge and action, between symbolic taxonomies of migrants and related practices of inclusion or exclusion, by making a comparison between the discourses and practices narrated by practitioners who went through training, and those of practitioners who did not. The difference may be explained aside from causal logic, of course, as practitioners with judgemental narratives about migrant patients probably self-selected out of training programs on intercultural communication. However, the difference is quite notable, concerning the following aspects:

Nuanced representation

Firstly, the untrained showed to conceive migrants as a homogeneous group, described with a condescending tone as opposed to their own: “they live in a whole different world, for them being here is as for us going to the moon” (TN03). The moralized contempt expressed by some practitioners with no intercultural training, was apparent: “If they would just cooperate and be grateful to have been accepted into Europe… they are just boors with no education whatsoever! … They respect nothing, the only demand services!” (OHS05). Overcoming the “us vs. them” approach, trained practitioners tended to have more nuanced language, and more detailed taxonomies of migrants, showing awareness of general information about migration processes and diverse experiences, even in the case of those who generally opposed migration-related investment.

Awareness of structural factors of disadvantage

Unlike practitioners that did not participate in intercultural training, trained professionals often mentioned factors of structural disadvantage among some migrant groups. For example, the difference that social and familial ties can make in the conditions and resources available throughout immigrant trajectories, and how isolation can create a precarious situation:

> It is very different to have a migrant family here that has a little bit of support… Moreover, they are often strong, very strong. Those which have brothers here, and those who are alone. This is what I have learned… it makes a big difference. If you have a family, it is more grounded, it is easier. Therefore, if you have support, is easier than those who are here on their own. (TD05)

Some practitioners showed the understanding that between migrants from the same country of origin a great diversity could be found between different educational levels, genders, ages and socioeconomic status. A doctor observed different levels of vulnerability created by socioeconomic conditions:

> There would be so much that we need to learn. Above all, that clearly an immigrant who has a stable life here economically ... obviously, nobody is rich, but at least a bit safer ... [compared] to those just arrived, slammed into some… temporary center… that is more difficult. (TD04)

A nurse referred to the different between migrants coming from urban and from rural areas, another nurse mentioned the difference between generations, observing that when they arrive younger, they are more receptive toward the host society's systems and cultures. Not conceiving all non-local persons within one group of generalized "migrants" seems a step forward.

Reduction of prejudice, judgement and conflict

The realization of structural disadvantage experienced by various groups of migrants involves coming to terms with one's position, recognizing privilege or disadvantage in one's own situation. That is not easy. Migrant blaming has, after all, been normalized in the media, and untrained professionals feel what may be called "victim envy", or "victim standardization", expressed when a disadvantaged person is criticized because it does not always fit perfectly with one's expectations of victimhood. For instance, a non-attending nurse explained her reservations to be educated in intercultural relations, when it is migrant patients, she thought, who needed educating:

> Here they keep doing… there are courses to educate us… on understanding the immigrants, and offering knowledge on this. ... Now, if I wanted to know how people live there, or such, I could read it in a book, if I was interested. In order to work here, I don't need to know that for them when a baby is born they need to gather thirty people and eat from a big pot with their bare hands… I could even read about it on my own time, but I don't need to have a course. You can't do that here anyway! That's it. Instead we always have to understand them all. That's not right. Then instead… let's do something else, like… I don't know. There are this big centers, with their managers. Let's put some people there to educate -if I may use this word- on social behavior these people, when they go to the hospital, to show them how to behave. (OHS05)

A trained nurse described such attitude in these terms:

> I might think "so I have to dedicate myself even more, and this person renders my work even harder" but I am not being free to look at the person, to know the person, and being able to say "it is ok to serve and help this person". Because often there is this idea, which is absurd, that they get everything for free. It looks like a sort of envy, sometimes. It isn't true. It is not true what they say that they are given everything there is to have, and instead Italians don't get anything at all. (NN08)

When structural disadvantage is hidden from view, barriers or redress measures are not understood. Training programs have clarified the consequences of discrimination, socioeconomic disadvantage, and the social determinants of health. Considering practitioners during their professional training are usually shielded from the humanities, such concepts are often new and useful information that contribute to a perspective change.

Containing discriminatory discourse and practice

The thematization of ethical principles of equal treatment in public service, as well as structural disadvantage, cumulated inequalities during the life-course, and other social justice concepts, even in simple terms, has helped contain the disparaging rhetoric previously described, as well as the discriminatory practices that some professionals enacted, and transparently described and justified in interviews. An untrained nurse viewed linguistic barriers as the patient's fault, therefore the patient's problem. It was not for the hospital to be resolved. She stated that non-fluent immigrants should bring a relative who speaks the language, without burdening the hospital with their lack of skill. According to her, mediation services should not exist, so that "maybe in this way they would be more motivated to learn the language" (NN07). In fact, she was not aware of any barriers for immigrant women in learning local languages, and their failure to do so was associated to a lack of will to integrate:

> There are persons who come here, who have been here in Italy for many years and still don't speak our language, and they demand to have services anyway, and they are very knowledgeable about what we can give, what we can offer. Those who really want to integrate are people who have arrived very recently and here they learn the language in very little time. In my opinion they are abusing a little the services we offer ... In my opinion they are here since many years, but they have not learned the language, because they have not wanted to learn the language. … If I see that they have been here for many years and they don't want to integrate in our country, I won't call the mediator … they do not need a mediator, and still they ask for one. And it creates a great amount of work to us ... It takes away a lot of time from other mothers, who have an Italian mother tongue, or a German mother tongue. (NN07)

This account is an interesting data point, as it allows us to understand and deconstruct the logic behind discriminatory practice. The identification of the language proficiency of long-term residents with their willingness to integrate, is added as a selection criterion for activating mediation services. The assumed lack of a "*will to integrate*" shown by the lack of proficiency justifies in her narrative the withdrawal of available services, implemented precisely to respond to linguistic difficulties. As contradictory as it appears, in this account, migrants who do not take upon themselves the work of linguistic incorporation are not deserving of interpretation services (or even healthcare services tout court?): "[they] *still don't speak our language and they demand to have services anyway*". The practitioner holds immigrant women responsible for the development of their linguistic skills, as if no barriers to linguistic learning existed, and consequently, when they fail to do so they shouldn't be rewarded with interpretation services, but punished by less time investment: "*it takes away a lot of time from other mothers*". Local mothers are more deserving of the scarce nurse time resource than long-term immigrant mothers, who haven't adapted to the prevalent language. The discourse about deservingness is further rendered explicit, as exploitative intentions are assumed: "*they are very knowledgeable about what we can give… they abuse a little the services we offer*". The symbolic representation of migrants as welfare exploiters is linked to the material practice of excluding them from accessing mediation services. As can be seen here, prejudiced representations are not only a matter of personal opinion but determine the activation (or not) of services. The trained narrative, instead, interprets the same situation differently:

> Women are lonely. We see in maternity charts, they come in with antidepressants. … The extreme poverty is not only linked to scarcity of money, it is scarcity of relations. Women that are always home can't learn the language. They reject their situation, being here. They experience it as a transitory situation, it doesn't favor language acquisition. … We should offer them possibilities of getting out of the house, to contrast isolation. (TD02)

The visibility of barriers, and the willingness to participate in responsibility and to take action, shows a different approach to the language learning issue.

De-centering the self and overcoming ethnocentrism

Realizing and accepting the fact that cultural paradigms are different is a simple yet powerful step, especially in the healthcare setting, where protocols reign unquestioned. That is true even in elective practices such as newborn care styles. However, diversity training has introduced the notion that there are different paths to accomplish newborn care, and diverse motherhood traditions are not to be discarded: "We don't attempt to persuade them: we say our piece, and they say theirs… but when they show such conviction of their practices, we accept" (NN02). This respectful form of health education that is able to listen to different approaches, does not only apply to migrant mothers: "it is even worse if we continue to do things our way, in a way that she does not understand. Because of course once home, she will do what she wants, but this is the same for all mothers. So, you have to be careful" (NN10).

The intercultural program, paired with the mediation service, was to some an eye-opening experience, that explained why some practices work and some did not, and offered insights on effective relational strategies, taking into account different worldviews, without necessarily approving them. A nurse offers a before-and-after picture:

> Speaking about myself: before, I didn't know anything about mediation, I didn't know anything about other cultures, really nothing. So, my difficulties were linguistic and also not... maybe I wasn't even so interested in finding a better way to get in touch [with immigrant patients]. Then, afterwards, there was this thing about... of this possibility of calling a mediator, then getting in direct contact with these people. And then I opened my eyes a bit more and I was a bit more aware of this role of the woman, of what I could have done better or worse, of what is missing. Also to allow the husband to have a role without... -or to the partner- without... let's say... without belittling him. Because if he is used in his context to being the decision-maker in everything, and I want to get in direct contact with the woman, it seems like an exclusion. (TN06)

Different family dynamics and cultural practices are not to be approved by practitioners, just considered as a matter of fact, as they learn to adapt to a new reality, as they also expect from migrants.

Deploying inclusive practices

An understanding of cultural background or structural disadvantage brings a new approach to practices in service delivery. New relational patterns and practices of accessibility, as well as spaces to patient's voices and belief systems become available. For instance, when it comes to a gravely ill newborn, making space for diverse religious beliefs alongside medical therapy, seems a sensible practice:

> I try to explain: “this is how we do this therapy”. When you see that the situation does not go forward or backward, I try and ask directly: “What about where you come from, what would be done in this case? If you were in your country, what would you do?” “We would make a special prayer” “OK, how about you call your family and have them do this special prayer, and in the meantime you also do this therapy? And then we’ll see how it develops”. So the patient follows you, a little bit. Otherwise, the patient thinks that you do not understand his position, that you ridicule him. On the contrary! I mean: I am a believer and I know very well that, to treat an illness, I have to find the specialist, I have to take the medicine and listen to what the specialist tells me. But I also deeply believe that I can have a different kind of help. I believe it deeply and I have also experienced it. So I don’t think we need to be diminishing. (TD02)

Deconstructing medical hierarchies and approaching the patient as a person (in this case the patient family), making space for their resilience strategies, throughout the care process, fosters collaborative relations. The reciprocity in this exchange goes from an *either-or* mentality to a *both-and* mentality, which is helpful in building trust in medical relations, essential in shared decision-making processes.

To conclude, again, the study does not assume that the difference in attitude is a consequence of training. It may well be the other way around, or there may be no connection at all. However, through practitioners’ narratives it is possible to get a sense of the impact and effects of intercultural training programs, both on practitioners’ symbolic representations and knowledge about migrant patients, and their accounts of material practices of service delivery towards them.

5.4 Negotiating Culturally Diverse and Gendered Care

5.4.1 Embodied and gendered communication

In medical relations, the embodied nature of communication is especially visible. Maternity nurses notice that many elements of the education they provide to mothers on newborn care are best physically shown than explained verbally or in writing. Therefore, they model specific gestures repeatedly, so that new mothers may learn through practice how to change a diaper, position the baby for optimal breastfeeding or medicate the umbilical wound. Written information might be useful, but video tutorials would help even more in standardized, replicable, and targeted educational and preventive initiatives.

Medical communications with the patient often involve intimate topics, which are gendered and embodied, especially in post-partum contexts. The mother's body becomes an object of scrutiny by the medical gaze. Following Foucault's "medicalization critique", medical sociology since the 90's, shows increasing attention to power asymmetries mediated by the body, by exploring the classical topic of the "clinical gaze" (Bunton & Petersen, 1997) especially in the strongly gendered context of maternity (DeSouza, 2013 among others). The body becomes an accessible field of scrutiny to the sight and the touch of doctors, who can exercise decisions to intervene on it by applying testing instruments, therapies or even surgery. The unilateral direction of this gaze introduces an unspoken but palpable element of asymmetry which permeates medical communications.

In the wards pertaining to reproductive health, even if female presence is overall comparatively higher with respect to other wards, male presence among practitioners still increases along hierarchy lines: no male nurses are found, some doctors, and both chief wards, in neonatology and gynecology are men. In any case, the gendered work of maternity care implies that many women are more comfortable discussing their needs with female practitioners. Particularly, their issues regarding post-partum pain, vaginal or anal lesions as well as breastfeeding techniques. In the ward, female mediators are not guaranteed but preferred if available.

Immigrant women are perceived to have a higher preference for women doctors in gynecology. This preference is often associated to cultural or religious stereotypes, particularly regarding women coming from prevalently Islamic countries. It is also associated to gender aspects, beyond cultures: having the most sexualized parts of the body closely examined or medicated by a man, practitioners say, can provoke a wide range of emotions as shyness, arousal, repulsion, or fear. Some consider that female practitioners might have an easier intuitive comprehension of the feelings associated with those parts of the female body, especially if they are mothers as well, and therefore the hope to establish an emotional context of communication which is less of a doctor-patient formal consultation and more of a woman-to-woman trusting confidence. Others consider it might also have to do with previous experiences of aggression, rape, or other forms of violence. An interviewee, protesting the objections of the Chief of Gynecology to facilitate female doctors to patients who made that request, said "what he doesn't understand is that a woman asking for a female doctor has more to do with rape than it has to do with Islam" (OHS08).

Gendered aspects of communication are a debated issue by practitioners in the maternity area. They reflect on which types of information can be exchanged through male partners. Scheduling, for instance, is safe, but intimate topics regarding the post-partum condition of their bodies or their minds are often uncomfortable for women to address with partners in the room: rhagades, breastfeeding pain or anxiety, hemorrhoids, overweight, body form and perception, post-labor pains or depression. The need to have time alone with post-partum patients is a priority for nurses:

> we often cannot have a private communication with the mother. And with private I mean intimate, to say many things… because things are told to the husband, and then the translation, you don't know well how it goes. That is a problem. For instance, breastfeeding, or if the woman has problems… let's say rhagades. (TN02)

Even male mediators, in the view of some nurses, brake the gendered intimacy of post-birth support between nurses and patients:

> Sometimes it happens that they send male mediators, which I don't find right, because if I have to have a talk about breastfeeding to a woman, I find so absurd to use a male mediator! I mean… I think that a man cannot even understand certain things or translate them correctly to a woman. (NN06)

Therefore, rules have been enacted to limit visitation to the father of the child, and only in short visitation times. Using family members as mediators is not a very effective practice, in their experience, and communication any case a practice which is not well regarded, especially since professional intercultural mediators are available. As previously noted, the inappropriateness of asking children to translate medical information is shared by practitioners, and they cannot trust adult family members' effectiveness, due to unknown educational level, propensity to sugarcoating, inattention to detail or even manipulative intent (the controlling mother-in-law is a cited trope). It depends, however, on how sensitive the subject matter of the interaction is.

The embodied nature of medical encounters also involves nonverbal language. In all medical encounters, physical gestures of doctors may reassure patients or put them on the defensive. Even more so when there is no common language: body language acquires a new relevance. The way a doctor handles proximity, his tone and gesturing may constitute the only signals the patient can comprehend. Because of the intimate nature of medical encounters, patients may feel exposed, particularly if they have experienced violence or discrimination, or if they are carrying the effects of past trauma. It needs to be remembered that trauma does not only originate in countries of origin or during transit, but in destination countries as well, not only with regards to social risk, or exposure to racism, but also through experiences of institutional violence, as well as conditions of marginalization in life and work (Aragona et al., 2012; Zadra, 2023; Santone, 2010). An aggressive gesture or tone in such a delicate and asymmetrical context can function as a negative trigger.

The embodied nature of neonatal communication also affects the choice of medium, which needs to be adequate to the content, as well as to protect the intimate and emotional context in which communications arise in the maternity ward. Nurses report being able to sort out many practical topics through gesturing, as showing how a diaper is changed, or how the umbilical wound is to be bandaged. But more complex topics as feeding patterns and techniques or topics referring to what isn't present, as health risks for the baby, are more difficult to address by gesturing: "With some people it is possible to find a communication channel that is not only verbal, but also a strong non-verbal communication with which it is possible to understand each other, despite the linguistic diversity" (TN13).

Sometimes, the need to establish fluent and direct communication with the mother in sensitive topics can only be appropriately addressed through mediation services. While filling out a form or changing a diaper might be handled through a limited English proficiency, or by gesturing, without professional aid, some more complex or upsetting topics, such as a diagnosis or the length of the baby's life expectancy, require a high linguistic proficiency or the use of interpretation services, to be discussed in detail and in a sensible manner, "because you can freely speak with the person without this touristic English that I speak ... To give bad news, a situation that changed without the expected outcome, I mean… having a mediator is fundamental" (TN06).

5.4.2 Negotiating times, spaces, and practices of motherhood

Healthcare professions entail a fair amount of negotiations with patients. They negotiate to get the patients' cooperation in painful, complicated or time-consuming procedures. They negotiate allowances into very private spheres of personal information and into more or less invasive physical contacts. They negotiate workload with co-workers, decisions with family members, resources with hospital administrators. Even their ethical boundaries are the result of a negotiation between the professional code of conduct taught in medical or nursing school, the regulations of the organization they work for, the expectations of their superiors and peers, the conditions of effectiveness of their work, their personal characteristics and emotional states and the circumstantial material constraints of everyday practice, because despite their better intentions, resources are limited, particularly time.

In maternity services many negotiations of healthcare professionals are located on a woman's body: get her to heal from childbirth, get her walking as soon as possible, get her to breastfeed the baby, give her an initiation on how to keep the baby clean and healthy, being able to put the baby's needs before her own. There is a before and after in a mothers' habitus, in the embodied culture of self-care that she is used to practice, and adjustments can be hard. In pre-partum courses mothers often hear about the joys of motherhood. Little preparation is given for the amount of pain, work, sleeplessness, and sacrifice it will entail. That used to be transmitted through family wisdom, but with increasingly fragmented and disperse families, and, particularly in the context of migration, intergenerational knowledge circulation about maternity can be compromised by distance.

Nurses in maternity are tasked with giving a preventive health education to new mothers and train them on baby care. This section explores the specificities, and the embodied nature of the cultural negotiations related to maternity that doctors and nurses have narrated. Cultural beliefs about motherhood, customary practices with newborns, different styles of occupying spaces, rituals of birth and death, are often negotiated with parents in maternity. If nurses are unaware of their own cultural patterns and expectations in the delivery of the set of knowledge they propose to the patients, and work under the assumption that there is only one correct way to handle a baby, then they are bound to be disappointed by foreign or local mothers who present resistance to their proposals because they have contrasting preferences, uses and customs. Surely there are some safety precautions and regulations which are mandatory while they are in the hospital, and boundaries that are not allowed to be crossed. For instance, sterilization prior to entrance in the neonatal intensive care unit is mandatory and non-negotiable for the safety of the babies, while the amount of walking the mother does after delivery or the hospital menu are negotiable matters. However, in the realm of health education, it has seemed that in the maternity ward, where practitioners have been mostly trained in communicative skills and intercultural dialogue, staff conceives health education as a collaborative process instead of a unilateral delivery and are ready to start from the knowledge base of the patient family and earn their trust and compliance:

> I've always made myself heard. If I had to perform a service on the mother, on the child, and maybe the father didn't agree with it, I managed to convince them that as a professional I had an idea that is better for them to listen (…) Maybe there was an initial resistance, there are some dads who want their wives to breastfeed at all costs, but not all breasts are made to breastfeed from the beginning very well. Sometimes you have to make compromises, but you just have to explain them the process in detail, which will eventually come to the end of breastfeeding. If I invest a little time to explain it, I think anyone understands it. (NN08)

In hospital logic, staff time is a scarce resource, that need to be managed carefully. And so are spaces. Healthcare practitioners in maternity tend to frown upon a high number of family members accompanying a patient, which seems to be a more frequent occurrence among migrants. However, in other contexts, such as emergency services, practitioners understand company may serve different purposes. Those who are not fluent in local languages might bring family members to translate for them. Those who do not know the city well might need companions to orient them through public transport. Those who are not familiar with local public services and do not know what to expect, might bring along someone they trust for navigational assistance. Negotiating the presence of family members, neighbors or acquaintances in the various spaces of communication, and limiting it in spaces where sensitive data is discussed, is important for practitioners to follow privacy regulations. However, discretion must be applied to make sure the patient feels safe.

Unlike the main hospital of Merano, which offers single rooms, in Bolzano's main hospital new mothers are received in rooms of four, and it does not help mothers get the privacy or silence they would need. As mothers are encouraged to keep newborns with them as long as possible, day and night, babies exercise their newly discovered voice by waking up their roommates. There are a few small recesses in the corridor, where some chairs are available, that mothers use during visiting hours, but it is not enough to accommodate families. Therefore, strict visiting regulations are in place: it is only allowed a few hours a day and only the father can enter.

Albeit the fact that regulations can't be effectively enforced as the ward doesn't have an entrance door, there is much unrest of obstetric nurses regarding what is perceived as an unruly occupation of spaces on the part of migrant patients, which are reported to be rude and inconsiderate because they bring other sons or the enlarged family members, they stay beyond visiting hours, they bring smelly food and talk loudly. Naturally, boundaries have to be established, for the health and wellbeing of all patients, and the staff should be capable of doing it within a communicative climate of reciprocal clarity and respect, which makes it easier on everyone. Moreover, boundaries must also be established about the level of control and interference that practitioners may pose to personal choices, like nutrition or the use of spaces. Commenting on colleagues' criticisms about immigrant patients bringing "smelly food" into the hospital, a nurse commented:

> It's their own damn business! Wow, I mean... if I want to get a croissant, I'll get it extra too, if I'm hospitalized. If they are used to eat chicken soup, then let

> them eat it! … It is the non-acceptance... Yes, but it's just the idea that bothers people, it's not that people are affected by the fact that they eat something different or refuse our food. It's just their idea, it bothers them that they do something different... well, it's childish. I mean, we can't waste time on that. (NN08)

Migrant patients were also accused by obstetricians of arriving at all times to see new mothers, accompanied with family members, despite regulations. Most maternity nurses and doctors, though, explained that it is a practice of all families, local or not. The scarcity of resources such as time and space, they thought, should be contested to the organization's management, and not become a contested issue towards patients in general, nor migrant patients. In fact, breastfeeding rooms as well as spaces for kangaroo therapy are scarce. The latter consists in holding the premature baby on the bare chest of the parent (either parent), creating a form of contact which is said to have positive effects on the baby's physical health and offer a sense of protection that could potentially contrast the effects of a traumatic birth. Breastfeeding rooms and private spaces used for kangaroo therapy are often managed as modesty spaces in which only women are allowed to aid women in intimate forms of newborn care. It is not hard, as male nurses in maternity are only 4 out of 35. Including culturally diverse views of maternity is necessary, for a public hospital in a diversified society. The habitus of maternity and newborn care is different even within the same country, between one region and another, between one generation and another, between one class and another. Education and professional background of parents has also an impact in parenting style. In the case of parents of foreign origin, customs of newborn care may arise perplexities among locals, but be perfectly normal within the family or community of origin, and it would be wise of practitioners to take them into consideration. For instance, a doctor might be perplexed finding a high glycemic index on a newborn, if he did not know that in some cultures parents use to give honey or dates to newborns. During interviews, maternity nurses and doctors observed several areas in which new mothers had different customs regarding newborns, and referred to the need to respect their habits, while at the same time educating them on some local specificities, like dressing adequately the newborn for the local climate or the risks of sudden changes in altitude when using cableways (TD03).

In some discourses, however, women's bodies become moralized cultural battlefields, in the sense that there are physical experiences which seem to enucleate strong ethical discourses and judgements. The symbolic significance of "good motherhood" appears to revolve, in nursing culture, around willing self-sacrifice, embodied in the bearing of post-partum pain, and around gratuitous giving. This is embodied in practices such as raising up from bed and walking, and in breastfeeding. Mothers should know and embrace the gendered pain that comes with motherhood. The cost of reproduction in a woman's body is hidden in societal discourse, in representations of maternity:

> you always see these attached photos of the chubby child and the happy mother. But in reality, it's not like that at the beginning, it's not like that at the beginning. Also… breastfeeding… it hurts! It's painful! This topic of pain… it's a lot of mothers that... they say: "It hurts! It hurts too much! It hurts! I want the nipple protector because it hurts!". But the nipple protector is not used to put on when it hurts, it is used when you have rhagades, or when the nipple is too short, not because it hurts. Clearly, at first, it often hurts. It also hurts to give birth, it hurts! ... everything is expected not to hurt, everything must be beautiful, be perfect. (NN06)

The socialization of new mothers in overcoming self-preservation tendencies in favor of a complete and utter dedication to the newborn, keeps coming up in the discourse of maternity nurses, with greater or lesser critical awareness, especially in relation to those two topics: pain and breastfeeding. Even though men which do not collaborate in baby care are frowned upon, only women are expected to completely embrace self-sacrifice, and continuous physical suffering. If a patient enquires about epidural anesthesia, she is frowned upon and discouraged by obstetric nurses who describe it as unhealthy, procedurally complicated, and potentially harmful for the baby. A surprisingly high number of nursing interviews (and none of doctors) contained veiled or explicit criticism of women who choose not to breastfeed, avoid pain, or seek forms of pain relief. In the following excerpt, the nurse wishes that pre-partum courses could prepare women to face the hardships of motherhood, instead of idealizing it:

> At night, for example, many people ask you, they tell you… "but I want to sleep!" However, the newborn, at night… it is the period that he eats the most. But I wonder, is this sort of thing explained in prepartum courses? That at night the hormone of breastfeeding works much more? And the baby knows that. That's why he wakes up a lot more at night than during the day. Then again, I understand that it's nice to sleep, but one... that is, when babies are born you don't sleep so much anymore, and this should be something that is said. … It seems to me that the society of now is very focused on itself, even women, are very focused on themselves, and the spirit of sacrifice... is a bit difficult. (NN06)

This expectation of embracing self-sacrifice applies to all women, but in the case of women of foreign origin, there is an added component, as known patterns are reproduced from cultural and biographical experiences (Bredström & Gruber, 2015). The cultural habitus of maternity experienced in the culture of origin might give mothers a sense of meaningful connection that does not involve demonstrating a pain-embracing maternal ethic. Some don't want to get up from bed, clashing with messages of nurses about how healthy it is to walk the corridors after delivery. Nurses trained in intercultural relations are aware of it, and reflect on the times they could not understand:

> Now, over the years we have understood, but initially we didn't. I'm talking about twenty years ago, it was just a disaster, we did not understand, because… "this lazy woman who does not want to get up!" or something like that. … Because we didn't know. If you don't know, then you judge, don't you? Instead, understanding it, you say: "well, you don't want to get up, it's ok" or... "we will help you, we will be at your side"... something like that. (NN09)

Through training and experience, staff acquired the knowledge and the skills for non-judgmental assistance. About breastfeeding, nurses are even more adamant. At the material level, medical sciences demonstrate the benefits of breastfeeding for the baby (it is rich of nutrients, helps the immune system, it is the most digestible, among others) and for the mother (release of oxytocin, burns fat, aids uterus contraction and post-partum recovery, among others). Plus, it is practical, is always at the right temperature, readily available, for free. At the symbolic level, breastfeeding is considered an important milestone in the bonding process between mother and child, which nurses need to foster in the few days of hospitalization after birth:

> In three days they need to learn to become mothers, they need to understand, to know the child, its needs, to bond with this child… It seems strange, because they have carried it in the belly for nine months but, in reality, they have never seen him before, right? So they need to smell each other, to know each other… (NCN01)

Breastfeeding is seen as an occasion of intimate closeness which perpetuates the attachment of the baby to the mother, often the main source of the baby's nutrition for the first six months. However, in nurse culture, it is made a test of motherhood, a moral imperative. It is even counted among their performance indicators. Nurses in maternity meetings discussed their "milk production" objective, and the announcement of numbers showing increased productivity was usually followed by an enthusiastic wave of applause. Naturally, they would encourage breastfeeding whenever possible.

This role assigns social meaning to breastfeeding, perpetuating it as a social reproduction practice, as a symbol of societal expectations on. In most nursing discourses, to not breastfeed is acceptable when it is not a choice: "not all breasts are made to breastfeed perfectly since the very beginning" (NN08); or due to infections or other conditions which may prevent it: "It can happen that mothers don't want to breastfeed, or that they can't, because of problems of the newborn, who can't be breastfed for some infection" (NN06). However, the choice of a woman to refuse breastfeeding in regular circumstances is often negatively judged or frowned upon, particularly among immigrant women: "most of these mothers have a lot of milk, really… and still, I don't know why, for what reason, … many of these Africans, they come and say: -I no milk, I bottle-" (NN04). Breastfeeding is particularly encouraged among women experiencing socioeconomic disadvantage:

> There is so much to gain… for the mom and the baby itself. Because then again, it means not being hungry. Because I only imagine, outside, in certain contexts, even just getting the milk powder, clean water and everything you want, or

> washing the bottle… I mean, there are so many problems, it is not only the jug of milk, so to speak, it is the whole context of preparation, autonomy, hygiene. And then, there are the risks of the child of getting sick. Here, maybe not in their country, because they have other defenses. But here the risk exists. It is really different. That's why we need to focus so much on breastfeeding itself: for a better future. (TCN01)

Beyond the medical advantages, a cultural pressure is applied on women to breastfeed, and even more for disadvantaged mothers and immigrant mothers: according to the narrative in the previous excerpt, they cannot afford not to breastfeed. Nurses have referred to cultural differences regarding breastfeeding among different groups of immigrant mothers. Chinese mothers are depicted as refusing breastfeeding (NCN01, NN02, NN11), Pakistani women breastfeeding only from one breast (NN02), Islamic mothers being uncomfortable breastfeeding in front of men (NCN01, TN03, NN10), Albanian mothers expecting milk to come immediately, otherwise switching to artificial milk (N11), some mothers refusing breastfeeding because of its association with poverty (NN04; NN06).

However, such practices have been less rigid, associated with intercultural training programs, a greater space for choice in expectations around motherhood has opened up: "We propose some things, and then we accept their choices" (NN02). A greater respect of diverse cultural beliefs has brought some flexibility toward gender expectations. The idea of compromise, of a reciprocal learning is often invoked by practitioners that are reflexive enough to ask themselves questions about their own practices:

> It is difficult… both for them, to understand and accept certain thing… because a machine on the breast also, for those who have never seen it, may also be the monster, so to speak. And on our part as well… we must be less rigid! In the sense that: "I told him to come down, that the child cries", but my five minutes are not his five minutes. Because in his reality there are different times. His "I'm coming" is different from mine. Because unfortunately we still should learn, sometimes. We're running too fast, always. So sometimes it's just... a concept of culture, a different way of life. Until we find a compromise, it takes a moment. (TCN01)

This nurse coordinator promotes a greater flexibility in supporting women to manage their own times, their own spaces, and their own bodies.

5.4.3 Negotiating rituals of birth and death

As discussed, maternity carries different societal expectations regarding the reproductive work of women. It is also a ritualized milestone in the life-course, as a feature of a new stage in adulthood. Birth is a social issue, thus, it is the community that welcomes a new person to the world. Across different geographies, the rituals to mark this event underline the social, psychological and cultural significance of the moment. Such rituals are typically handled outside of the hospital. Short visiting hours, restricted to the baby's father only, contribute to maintain this boundary. However, spiritual practices might enter the hospital, when parents ask to perform a small spiritual gesture at the moment of their first contact with the baby, or when the baby is born ill or premature, thus having to spend months in TIN. In some cases, sadly, this unit can also be the site of a newborn's death, in which other types of rituals might help families cope with loss.

Staff in this ward developed inclusive practices regarding the different habits, rituals and beliefs of patients, of local and foreign origin: "We are very open to this, they have their own traditions, as we do… we baptize children and they… these are accepted by us" (TN03). Therefore, a culture of allowance has developed, with regards to different kinds of spiritual practice that families desire to enact, in the context of birth or death: a prayer, a baptism, a sacred object under the baby's pillow, a moment of silence, or nothing at all. It may entail a negotiation with hospital staff, to arrange the conditions for it to happen, if compatible with the wellbeing of the baby. When a dedicated space is required, or if privacy is desired, or exceptions to the "parents only" rule in the Neonatal Intensive Care unit, for cultural and religious reasons, there is in principle a general policy to do so, whenever possible. During interviews, practitioners describe the Islamic ritual of whispering the prayer of *adhaan* to the right ear of newborns by their father, as they are considered the first words a person should hear: *"God is great, there is no God but Allah. Muhammad is the messenger of Allah. Come to prayer"*. They describe the tradition of shaving the baby's head after the first week, as a way to comfort the baby, to remove harm from him, and let new hair grow stronger. Different levels of understanding or familiarity with such rituals are present in the healthcare staff, but they have a general policy of allowing such practices to be organized by parents: “Some parents want to shave the baby’s head. And they take upon themselves to organize the whole thing. We allow these things. It is also strange for us to see a baby completely shaved” (TN08). A practitioner described various rituals and customs they have seen foreign parents perform, and their curiosity towards foreign spiritual practices:

> We had this experience, that someone asked to put honey in the baby’s mouth. It was of Pakistani ethnicity … we are quite open to this. That is, if they want to shave their heads, if there are no health-related restrictions, they do so. At least they do... the Quran under the pillow … a very small Quran book is placed near the child’s head. We had Indians putting a pebble... a stone... whatever. But we are just... that is, if there are no real situations... that is, hygienic barriers, in which case we have to be careful, etcetera, we are quite open, but for us, it’s all a learning experience. (TN04)

The flexibility of practitioners, as this account signals, is not without limits. *If there are no health-related restrictions.* And it is surely easier to negotiate such limits when there is a trusting relation which allows for reciprocal understanding. One nurse gave an example of a moment of tension when a religious practice collided with a medical protocol:

> There are those, for example after childbirth, there are the “moslemics” who care so much, for example to blow the Quran in the ear, and then you have to give space. … they usually ask for a sheet of paper, and they ask for five minutes, with the child alone. But sometimes it creates difficulties because it happened to me personally that a child who was not well, that we had to admit him to the intensive care unit, and his father absolutely didn’t want him to be taken away because he wanted to do this, and he created a certain tension, because the child was not well, the pediatrician wanted to move him, and his father didn’t... he said “no, no”. And at first it wasn’t clear. … we tried to explain to them that now the child’s life was a priority. (NN02)

In any case, healthcare protocols must be respected for patient safety, especially in the sterilized environment of TIN. In the Nido, where babies are generally healthy, there is more room for allowances for cultural and religious practices:

> During all the pathway, not only when the baby's life is in danger. There are certainly things where flexibility is required on both sides. … On the one hand, our standard of care, of babies in the Nido. We in TIN certainly have fewer problems because there is actually a clear medical guideline there, that is highly protocolled, standardized and needs to be followed. At the Nido, surely, then, many things that concern breastfeeding, that concern things more... Let's call them soft areas, which are more flexible, and there are many differences among cultures. (TCD01)

In the few occasions in which ethical dilemmas arise, which render incompatible religious beliefs and medical practices, the physical wellbeing of the baby is usually prioritized by both doctors and parents, and whenever possible a compromise is sought to give space or expression to the parents' beliefs as well. But this is a negotiated and delicate equilibrium. In the case in which end of life is imminent and inevitable, the space for beliefs grows in importance for the family, while medical interventions loose priority. In such cases the voice of the parents is allowed to participate more directly in structuring times and spaces, as decision-making becomes increasingly shared. However, sometimes, ethical dilemmas may generate tension, even under a shared culture and religion, as in the case of a Catholic family that was not allowing the child to be taken off the ventilator, believing it was a sin, and the medical staff explaining that keeping the baby artificially alive was only protracting in time a painful death (TN02).

End of life decisions, taken in consideration of both medical and religious arguments, elicit greater flexibility concerning regulations. For instance, if a newborn is in critical condition, it is allowed for a spiritual advisor or elder to enter the ward and perform a ritual, while still going through sterilization procedures. Especially when death has arrived or doctors see it coming, they try to prepare the families, and have meetings to inform them and to better understand and support their wishes:

> For example, at the death of a child, when a child dies, there are cultures that don't want to wash the child immediately, they don't have to wash the child, or they have to wash the child … In our field, where especially in the case of a death that is not sudden (I mean, perhaps we already knew that the child was sick), then we can work much earlier with the parent, with the mediator, and we might have had several interviews. Then it is easier for us to understand what the parents want, what should happen, what is important for them. And in those cases we do everything they want. If they want to get relatives in, if they don't want to wash them, or if they want to wash them. (TN12)

In the face of an infant death, staff members do more than just allow. They have made efforts to improve their quality of care, and the equality in the care they offer, whatever religious view the parents hold. Being prepared for rituals is one more way to support families who had lost a child. A TIN nurse explained that she felt well prepared in the case of the baptism, because she knew the ritual, and had a box with items gathered for such purpose. In the case of other religions, she had less information on how to assist:

> I don't know what my role is anymore. When unfortunately, a Catholic child passes away, I have the contacts and I can call a parish priest, or the spiritual assistant, to do a baptism, there is a box filled with all the things I need: the candle, the holy water. And I'm ready. If a child dies on my watch [*mi muore*], a Muslim little patient, or a Hindu, I have to ask the family... "So, how do you behave in this case?" … I'm a little sorry about that, because I'd like to offer the same service with the same quality to everyone, sometimes, and this thing does not seem to me ... as much as you work, however, you do not know, do not know, as well as they do not know… and they do not know you, or the hospital, or Italy, nor how it works. And they are here in transit, they do not want to stop, and are struggling to understand that, but they must stop because of this thing that has happened. (TN06).

The topic of preparedness is present in the discourse of nurses in TIN, in the context of birth and death. Being ready to predispose the conditions for rituals is the only way they can support parents during the loss of their child:

> With a dying baby, as well. Because then it is somehow… Now, we already struggle with baptism, because when you propose it in a critical situation, they ask "are we doing this because death is near?" But you maybe don't know… ... With foreign families, clearly, you try to find out a little about their religion, to understand if they have a specific ritual ... when there is a significant risk for the baby's life, because it is always awful when they are called at night, when maybe it is too late, and there is no time, it can't be done, it is difficult. So, when we see that the health of the baby is heading for a bad turn, then we try and propose it beforehand. We have had those who didn't do anything of the sort, and those who did ... The Imam and other men came and did this prayers with the baby. By all means, we handle it similarly as the baptism, I mean. Empty room, we give them a bit of privacy, and they do what they have to do. ... In these situations, we let the family… I mean, we try to do everything that the family requires. They say: "We want to bring here eight friends, or family members, uncles, to do the baptism"… we close the room, we get twenty people in the room, we bring the candle, I mean… obviously we try to do everything possible for the family, to face this moment in the best way possible. (TN04)

In the face of a tragic experience, like the loss of a child, invoking medical protocols or political agendas to restrict support for a suffering family, seems to practitioners "just petty and wrong". It shouldn't matter if the parent is local or foreign, black or white, gay or straight, legally resident or undocumented, Christian, Muslim, atheist, or anything else. Why, then, some practitioners ask, these distinctions should matter when there is no dying child but a dying adult or simply a sick person? It could be added: How are moral judgements impacting healthcare practice? (Hill, 2010) Why and where do practitioners trace the line that identifies and restricts services to an 'undeserving' patient?

5.5 Bridging a Fragmented Welfare

5.5.1 Dimensions of fragmented social and health care

The fragmentation of public services in Italy involves all levels and sectors[22], making them particularly difficult to navigate for users. These are often introduced to the everchanging functioning of services through trial and error, word of mouth or personal connections, more than through publicly available, updated, and clear information. Efforts of reconnecting services in favor of a user-centered approach, are short-lived endeavors.

In South Tyrol lack of resources cannot be held as justification, as this is the wealthiest province in Italy. However, the added divisions along linguistic group lines does not help. The mandatory bilingualism of public servants is not enough to breach the linguistic and cultural divide that political agendas work so hard to keep in place. A structural separation between linguistic groups starts from the top, touching every public service and office, from schools to sports and music.

The sector of healthcare does not allow for the creation of separated systems, and the need of performance has driven the system to an actual bilingual functioning. Tensions between groups are obvious, but the common ground of medical culture, language, and practice keeps a diversified system working. In fact, professional cultures can unite, or divide. Linguistic boundaries are not the only or the hardest separation in this context. A different professional culture and a lack of reciprocal trust disconnect medical and social practitioners (Fargion, Wielander & Pintarelli, 2017). The sublet of significant services to NGOs with highly rotating employees, as well as the fragmentation of local administration offices, without a real investment in information exchange or shared objectives, also pose obstacles to the

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[22] Not communicating, developing a separated milieu, easier to control, and functioning in isolation, as small, independent universes, has been so normalized, particularly in public institutions, that there is a special word for it: *campanilismo.* This word recalls an episode of petty rivalry, in which a church tower (*campanile*) was built without a clock, to deprive the neighboring town of the possibility to know the time of day, even if it meant depriving themselves as well. An affirmation of particularity over systemic logic explains a tendency in Italian public services (regarding migration as on any other issue) to be engaged and creative on individual cases, in which they are motivated to go to exceptional lengths to solve an issue, while being resistant to bring such practices to systemic implementation, where they could be expected and claimed by all, in ordinary circumstances.

connectivity between those services. This ends up costing the users additional access work.

The siloed approach to services has grave consequences on groups bearers of intersectional vulnerabilities, those most affected by disadvantage regarding the social determinants of health, such as poor conditions of housing, work, nutrition, among others. Complex needs cannot be resolved by one service alone. The most vulnerable end users are not able to connect the dots of the system, self-advocating, going from office to office to extract the services they needs (see also Lipsky, 2010). The first need is precisely navigational assistance (Green et al., 2014).

Several practitioners pointed out the fact that they knew nothing about how social services worked, and they were not informed about initiatives and processes going on in the hospital itself. Effective information channels at the micro level (communication between practitioners), the meso level (information circulation systems in the organization) and the macro level (network with other societal actors) should be an area of investment.
In the case of the maternity ward, connective initiatives were attempted at these three levels.

5.5.2 The micro level: Internal networks for inclusive practice

Despite the implicit role of intercultural mediators in facilitating accessibility for migrant patients, practitioners consider they should not be the only ones tasked with this, as they recognize that it is a task that should remain within the system. It is not fair to delegate the responsibility to guide patients into hospital systems to on-call workers, paid by the hour. In neonatal intensive care, practitioners planned to establish nurses as case managers, to follow a child from admission to discharge. However, they encountered difficulties, because of the serious responsibility this entailed, in the grave context of Neonatal Intensive Care, and the emotional attachments it created:

> We had difficulties when we have tried, of an emotional nature, really. I take a baby when it is born, I might follow him for four months, and it is a significant emotional pressure, I mean… goodness! I have taken this baby in charge, and I feel responsible for him. I feel responsible with the parents, I relate with the parents… it doesn't mean that I always have the baby. (TN13)

Continuity of care, it was decided, is to be handled collectively, not individually, with detailed charting for debriefing across turns, including details on emerging needs and questions, intercultural mediation services utilized, and more.

Inside the area of maternity services, some practitioners in neonatology with special expertise were recognized as project leaders and knowledge brokers around accessibility measures. A nurse with a Masters degree in migration studies, had formed and led a case study group, before the pandemic, in which nurses with interest in developing migrant-friendly strategies, or handling a case in which knowledge about migration was needed, could learn, reflect and discuss together. She offered problem-solving knowledge and resources, and practitioners valued her expertise.

A few nurses with a foreign background are active knowledge brokers, either by clarifying to the families of their area of origin the workings of hospital systems, treatment options or regulations, or by clarifying to other practitioners misunderstood responses of patient families, explaining cultural meanings, customs or beliefs.

Nursing coordinators collect training requests from their teams, and pass them along to the training office of the hospital. In that capacity, they sometimes have collected questions, cases or topics of interest related to intercultural relations, to discuss them in the courses. They interface with the training office to ask for the repetition of intercultural programs, to allow all to participate, in sight of the turnover. They have implemented the system of "training dissemination" (*ricaduta formativa*), by which nurses who attend specific training are expected to brief their colleagues on course contents and insights for practice, during the staff meeting, or through a written report available to practitioners. It is a measure that aims to maximize the impact of training and motivate participation. According to some nurses, it has been an effective tool to enhance reflexivity, knowledge circulation and updated standards of practice within nursing teams.

5.5.3 The meso level: System-wide connections

A neonatal doctor has taken upon herself the task to initiate, lead and expand the joint training courses between mediators and practitioners that have been described, which were eventually expanded to the whole organization, and to the whole provincial healthcare system. This doctor and her team also participates every year in crafting quality standards required to participate in the public tender for the delivery of mediation services. This has been since the beginning a service that started with the hospital's social services office, but soon became a cooperative effort between this office and neonatology. Doctors and nurses in this ward were instrumental in the uptake and development of mediation services and its progressive embedding in the hospital, to the benefit of the whole healthcare system, to which it eventually expanded.
Moreover, neonatology doctors connected with the initiatives of the MIS Clinic, inviting practitioners to training programs, participating in conventions about Migration and Medicine organized by the Clinic, and joining in some of the meetings of the local chapter of the national network on migration and medicine[23].

5.5.4 The macro level: Protected discharge and continuity of care

The ward gave a contribution to connecting hospital services with territorial services, as well as healthcare with social services, through the practice of protected discharge (*dimissione protetta*). It is a measure designed to bridge gaps in assistance. It consists in ensuring a follow-up of mothers on newborn care, until they are connected to the nearest neighborhood pediatric clinic, (*consultorio materno-infantile*) distributed in the territory. The role of neighborhood clinics is to assist new mothers and keep regular checks on newborns' health and growth. Before discharging a mother with her newborn, the hospital asks her permission to contact directly the pediatric clinic closest to their home, inform them of the birth, and transfer to them the clinical history of the newborn, as the nurse coordinator explained:

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[23] SIMM, Società Italiana di Medicina delle Migrazioni, https://www.simmweb.it/

> At the time of discharge, the mother is asked if she gives us permission to provide her data to the clinic of... of reference, depending on where she lives. Then the mother is immediately called by the clinic, and follow up begins. And this for us is a protected discharge, which is very important, which gives continuity of care to the work that has been done previously by us. (NCN01)

The support territorial clinics offer to new mothers includes a variety of services: a weekly weighing of the baby to monitor its growth by a pediatric nurse, health and nutrition advice, preventive and screening services, psychological counselling, support in obtaining aid of a social or economic nature, among others. Previously it was open to all, but only those who were informed of services and took the initiative to call and ask for them were in fact receiving the services, while those most in need were less likely to actively seek support. The direct contact between the hospital and the neighborhood maternity clinic takes away the connection burden from new mothers, and establishes a routine pathway of contact and support which helps monitor the conditions of early development, and favors the rapid detection of needs and vulnerabilities. The contact entails the hospital sending to the district clinic notice of the birth through a phone call and "a fax with some information on breastfeeding, if the baby has grown, if he has to get controls later on, so that they are well informed" (NN03). The service is free of charge, and optional, as mothers can opt out of contact or transfer of the baby's clinical history. It is handled by specialized pediatric nurses, and not doctors, because the service is additional to the pediatrician of choice, and it facilitates their work by covering general guidance and answering most common questions around newborn care. This form of healthcare outreach is embraced by most mothers. Receiving a phone call asking how they are, and inviting them to a regular weighing of the baby is a welcome form of support. The Clinic makes appointments to avoid overlap, as they are often full, but mothers can also drop-in asking for assistance. It started as part of a wider prevention program which promotes contacts among services for the continuity of care in the assistance of babies in their first three years, called Frühe Hilfen Südtirol[24].

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[24] See also http://www.provinz.bz.it/familie-soziales-gemeinschaft/kinder-jugendhilfe/fruehe-hilfen-suedtirol.asp

The measure has been firstly applied to all resident newborns, and later on it was extended to asylum seekers hosted in reception centers. Pediatric nurses facilitate the identification of undetected needs or challenges and facilitate connection mothers to further healthcare or social services, free resources or other kinds of assistance, when mothers need it. Preventing the isolation of new mothers is not only beneficial to the baby, but to the mother.

When local clinics have trouble connecting with the mother, the nurse that assisted them in hospital follows up with the family, to make sure they have the support they need and choose.

This form of bridging has proven essential particularly when a sick or premature baby is discharged in precarious socioeconomic conditions, or even in a reception center, and doesn't always have access to the needed assistance and resources:

> That is, all children must live in a healthy environment, but especially these here with an immunodeficiency … and so... that is, when it is discharged it's not that we can say... go, and continue your journey. It's not that simple. We still have territorial assistance that is activated. … there is a standard form, to which, however, parents must obviously give their consent. We cannot do this without consent. And so territorial assistance is activated. And then, in fact, they stay in hospital three weeks, one month, two months. Then, it comes to an end, and maybe … there is a structure behind, a network behind, which protects them. (TN06)

NGOs that manage reception centers try to make the best with their limited resources, rotating staff, inadequate funding and scrappy organization. Sometimes it is not enough for critical health issues. Practitioners understand but are frustrated by it, at the moment of discharge, when follow-up can only do so much. Time and resources are invested to ensure an effective connection with local pediatric clinics: they are better suited to coordinate social actors, maintain a social support network to assist isolated families.

5.6 Takeaways and Further Growth

Intercultural mediators have been reported in this case study as increasing accessibility and quality of care, therapy compliance, satisfaction with care for both patients and practitioners. Even when these professional roles are available, activation is needed on the part of practitioners, which requires training and bureaucratic simplification. Moreover, on the part of mediators, work stability, environmental exposure to healthcare practices, as well as sustained joint training, and incorporation into healthcare teams, may facilitate their effectiveness end enhance their performance and motivation. For this reasons, the embeddedness of mediators within healthcare systems is as challenging as it is important.

Even if a complete embeddedness is hard because of the unpredictability of languages spoken by patients, among other factors, forms of partial embeddedness may be applied, such as they were in this case: on-call mediation, in-ward rotations, or immediate availability of remote services. The coverage of mediation costs by healthcare organizations is a first and necessary step to overcome linguistic barriers in healthcare. A partial participation of healthcare organizations in processes of selection, employment, training and evaluation of mediators has been in this case a positive driver of development in this service. It has also contributed to improve the precarious work conditions, and the development of specialized competences in mediation professionals.

Joint training courses in intercultural skills for mediators and practitioners together have been in these cases a space of reciprocal learning, and a space to better understand and contextually negotiate the role of mediation services in healthcare, and to question an ethnocentric worldview, by developing intercultural sensitivity (Hammer et al., 2003).

To consolidate and further develop mediation services, practitioners consider important to render the basic module mandatory for all healthcare practitioners, as it is for mediators, and add an advanced module for those interested in further intercultural skills.

Several practitioners think that mediators should expand their role, not only regarding interpretation services but offering general information and navigational assistance to immigrant patients, helping them understand procedural issues and supporting them during the transitions from one service to the next. Nurses have a specific job to do, but it relates to other bureaucratic aspects in which they are not experts, as for instance, the official declaration of birth, and some say it would be nice to have someone giving patients assistance about procedures of the kind.

The perspective of practitioners in contact with the public is certainly valuable to determine conditions of quality of care, and it should be taken into consideration. But not all practitioners think that growing the service further would be beneficial. Some nurses felt that what is being done with mediation services has effectively solved the problem, and no more resources are needed. Administrators and ward chiefs have a specific perspective on the costs and complications of growth, particularly when regarding permanent staff. A ward chief perceived the effectiveness of mediation services as they currently are, and the potential complications of further growth:

> Maybe with the exception of some weekend, except in some extraordinary situation, which can always happen, but as it is, as an organization, I don't think we have a problem. Certainly, we could increment, but there we should consider how and how much to increment. Because yes, it is clear that you could call them every day, 24/7, it would be nice, but then you also have to pay these people for them to be on-call 24 hours, in order for them to be called once a week for half an hour. ... These are projects whose importance is to be emphasized, and they have to be further sustained by the healthcare system. And it is not only a healthcare issue, but an issue of importance to the whole Province. (TCD01)

Interviewed administrators called for initiatives not to grow incrementally at a local level, but to invest in sustaining the improvements achieved, and their dissemination throughout the healthcare system, and beyond, in other public services and organizations throughout the territory.

To further contrast linguistic barriers, other measures suggested included the encouragement of diversity and multililingualism among staffers. Fistly, by including workers with a migration background, as the nurses with Pakistani, Arab, Hindi, Polish, and Russian ascent have been found. However, other languages are available among staffers by language studies, before nursing school (NN06, TN02), such as French, Chinese, and more. Multilingual staffers who speak fluently three or more languages have been found very useful in maternity (NN11, TN02), in the MIS Clinic (SN02, SN03), or in the hospital's Public Relations office (OHS04). However, particularly in a province where bilingualism (Italian-German) is not only encouraged but structured within the educational system and mandatory if working in the public sector[25], the English language has lost priority, and those cases are viewed as exceptional. The reality is that multilingual staff is hard to find even regarding mandatory languages, according to a ward chief:

> We struggle to find staff that speaks German and Italian. How can we talk about four languages? Recruit personnel that speaks four languages. We struggle to find doctors speaking two languages, nurses speaking two languages, people that have lived here for years, that struggles to do the bilingual certification. For sure, the idea is nice and useful, Of course, if everyone spoke ten languages, absolutely. But it's something very… Now, [SN02] and [SN03] are for sure two people that stand out, but how many of those are there? Here we have someone who speaks a bit of French, maybe a bit of Spanish… There are those who manage more or less speaking a bit of English, and those who speak English well, while being fluent in Italian and German. But finding people who speak three languages well… In a ward of sixty, you can count them in one hand… maybe one hand is too little but two is too much. It could be maybe ten percent? (TCD01)

Medical and nursing staff have found useful to improve language skills, even taking courses privately (NN08, SN02, TD04). Some frequented language courses at the time of the interview, learning Arab (NCN01) or English (NN02). Interviewees valued foreign language proficiency, feeling it could facilitate their job, particularly English, seen as a *lingua franca*: "to know English could give us an advantage with the patients" (TN08). They were also ready to invest their time and effort on it: "between language courses, the

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[25] Laws and regulations about language teaching in Italian-language schools of South Tyrol can be found here: http://www.provincia.bz.it/formazione-lingue/scuola-italiana/imparare-lingue/normativa-imparare-lingue.asp. Specific guidelines for the English Language are found here: http://www.provincia.bz.it/formazione-lingue/scuola-italiana/sistema-scolastico/linee-guida-scuola.asp

most helpful would be English, I imagine. Moreover, for sure, I would take it immediately, to improve a little" (TN04). Many suggested it would be helpful, however, that the hospital's training platform included foreign language courses. The reasons that were given regard the fact that regular courses were incompatible with rotation schedules (NN09), and because maternity is seen as the first access point of migrant women, the *entrance of the hospital*, thus communication was of paramount importance (NN06).

This proposal, too, encountered some skepticism among administrators, going from organizational investment to individual agency, and sharing doubts on enduring individual investment among practitioners:

> An English course organized by the hospital… yes, well, as they organize courses on Word, Power Point or Excel, they also could have an English course. I have seen people taking these English courses for years and… it depends on the person itself. If one is really interested, one somehow learns it. Because nowadays we have really so many possibilities … These are those kinds of things that two or three people say… "oh, it would be interesting", then other four say… "yes, it would be interesting." Then you go and check how many do sign up, and they are only two. I have seen this on good practices, on those issues regarding quality and patient safety. You propose a measure, and everyone says "nice! super! super!" But afterwards, when they have to take the course and start working on it…. (TCD01)

Following an opposite reasoning, from individual initiative not being supported by organizational structures, a doctor explained:

> I would like to learn Arabic as well, because it is a language that two hundred million people speak. … You have to go in your free time, and I'm disappointed about that. Someone could also say to me: as a doctor, you could also allow it... and this is also true, it's 120... euro that I paid, that's not the problem. The problem is that when they send me to a [medical] congress, they pay a lot of money, instead these [language courses] are not reimbursed, and this means that it is not recognized by my employer as an important thing... instead this is something I should do. (TD04)

Opening to foreign languages as relational capital for patient care, in the view of this doctor, should be valued by the hospital, as much as medical specialization, as they both contribute to patient safety. Opening up to allowing different cultures regarding maternity to be recognized and expressed through customs, practices of newborn care, or rituals of birth and deaths, as well, can thus make a difference in generating trusting and collaborative relations with patients. Compliance is built on that rapport. The flexibilization of rules, procedures, and methods, when compatible with health-related requirements, the reflexive allocation of resources, times and spaces, can contribute to make room for patients to experience inclusion.

Another aspect that becomes apparent, is how healthcare services may serve a connective function, by generating connections among practitioners in hospital wards (micro), organizing system-wide initiatives for intercultural learning and facilitated access (meso) and bridging patients with local clinics, social services and other territorial actors (macro). They can contribute to repair the fragmented welfare system, through strategies of service bricolage (Phillimore et al., 2021) and of social innovation (Moulaert et al., 2017).

6. Conclusion: Towards More Accessible Healthcare Systems

This conclusion contains firstly, an overview of the issue, by recapitulating the premises, the research questions and the approach taken by the study. Secondly, a brief account of the main limitations of this work. Thirdly, an argument in favor of applying the social innovation approach to the problem of accessible services to migrant patients. Then, an overview of the pieces of knowledge that might contribute to the practical discussion on how to improve the accessibility of healthcare services for migrant patients. Lastly, some potentially impactful areas for further research.

Bourdieu taught that "a particular case that is well constructed, ceases to be particular" (Bourdieu & Wacquant, 1992/2008, p. 77). This case study has a potential to be informative for other healthcare organizations, provided this experience is taken as one case, and a list of "best practices" is not automatically transferred to this complex and context-dependent issue. With this in mind, some successful strategies in this case and some conditions of their replicability will be described.

6.1 Premise, Problem and Approach of this Study: An Overview

Available evidence (Petrelli et al., 2017; Cernigliaro, 2024) confirms that migrants in Italy – as elsewhere (Jasso, 2013) – arrive healthier than locals, but the longer they stay, the more this health advantage dissolves. Different explanatory factors have emerged. Firstly, the marginalized and isolated position of migrants in the hosting society, exposing them to greater health risks through precarious living and housing conditions. Secondly, migration itself has been identified as a social determinant of health, beyond socioeconomic conditions (Castañeda et al., 2015; Ingleby & Petrova-Benedict, 2016). Thirdly, the evidence of barriers in the access of healthcare services despite the ample legal entitlements (Decreto legislativo n. 286/1998, Art. 32). Empirical studies (Petrelli et al., 2017; Cernigliaro, 2024) show that access to basic care is not reached by migrants in a timely fashion, generating preventable escalation of conditions which then require hospitalization and emergency access. In the case of migrants with local family members and in the case of healthcare contexts with a higher inclusivity and accessibility in service delivery has been achieved, the disadvantage in the use of services among foreign citizens with respect to Italian citizens reduces significantly. The literature reviewed in the first chapter also shows critical areas of interest, in which low access is related to severely detrimental, durable, and avoidable consequences for migrants' health outcomes. Some of the areas that seem to be constantly referenced across the sector's literature[26] are: a) women's reproductive health and oncological prevention; b) healthcare delivery to migrants in irregular situations, and c) work-related injuries or illnesses.

Following these premises, this work argues that healthcare service accessibility for all groups of patients is paramount to the wellness of patients themselves, to the promotion of public health, and to the efficiency and effectiveness of healthcare organizations. Lack of service accessibility contributes to poor outcomes for individuals and communities, at great cost for healthcare organizations (FRA, 2015; Ingleby & Petrova-Benedict, 2016; Bischoff & Denhaerynck, 2010). Organizations often find themselves having to repeat ineffective interventions, to engage staff in navigational assistance when pathways are not easily understood, to invest resources in response to the acutization, chronicization, or spread of diseases that could have been prevented or more easily resolved at an earlier stage.

The question this book has explored is not *if* but *how* to improve service accessibility, particularly for migrant patients. It has investigated the role that practitioners may play, under certain circumstances, functioning as brokers of social innovation of healthcare service provision, by improving accessibility.

This case study has documented spaces of agency carved by healthcare practitioners to improve service accessibility and quality toward migrant patients. By creating service networks and activating multilevel cooperation processes, obtaining the support of the local healthcare organization and shaping accessible services, by embedding intercultural mediators in healthcare settings, opening space for diverse health-related practices and cultures, and generating joint training and practice initiatives, they have

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[26] For the specific literature about this, too abundant to cite, I encourage readers to consult section 1.3.

contributed to give recognition and response to the often-invisible needs of migrant patients.

This book has also documented the transformative changes in service delivery that have been enacted, which resulted in enhanced use of services among hard-to-reach patients, as well as a greater linguistic and cultural accessibility that has improved medical relations with patients of foreign origin more generally. This study argues that accessibility must be decisively uptaken as a structural task by healthcare organizations, and not left to the individual or collective initiative of practitioners alone. Practitioner networks have crucial expertise, but they can be more effective when motivated, symbolically recognized and materially supported by the organizations and local contexts in which they operate. The center of initiative in this case were networks of medical professionals. The literature has thematized the complexities of their position as "street-level bureaucrats" (Lipsky, 2010), "pragmatic health professionals" (Dauvrin et al., 2012) or "healthcare bricoleurs" (Phillimore et al. 2021, 2019, 2018). Practitioners in this case have built experience in the care of migrant women in maternity as well as undocumented migrants through voluntary work and had been given by the healthcare system the necessary autonomy and resources to shape more accessible healthcare service delivery towards the target group. Surely, such discretionality might be a double-edged sword (Lipsky, 2010) and may lead isolated healthcare practitioners to waver between care and control (Perna, 2018) or let moral judgements interfere with quality or accessibility of care (Hill 2010). However, when connected in advocacy networks, they might give a significant contribution to create inclusive services for marginalized groups.

Going beyond practitioners to the structural and system level, the study underlined the ways in which the effectiveness of practitioners' contribution to organizational change was (or could be) improved and scaled through various forms of support from institutional structures and administrations. Otherwise, when systems leave delivery pathways unmonitored and trace no boundaries when exclusionary or discriminatory discourse and practices emerge, these affect not only patients' well-being and safety but also practitioners' effectiveness, satisfaction, and quality of care, opening the institution itself to resource waste, higher costs, and potential legal liability.

6.2 Limitations of the Present Work

Among the many shortcomings of this research, the following three seem particularly relevant.

Firstly, the limitations of this research regard case study methodology. It reflects only one organization, in one location, so it lacks comparative value, and one prevalent -albeit composite- point of view, as it is focused on the perspective of practitioners, exploring their experiences of medical activism (or otherwise).

Secondly, a limitation of this particular case study, despite containing abundant knowledge on the focus areas, was the impossibility to include the input of migrant patients themselves. It would have given a significant contribution to the understanding of barriers, and to the assessment of practices and services.

Thirdly, the exploratory nature of the study has driven the research to investigate a multiplicity of angles, which has made it versatile and rich in connections, but this also entails a cost in terms of focus. The downside of any exploratory work is also its unpredictability. It grows in directions one does not anticipate or prepare for. In this case, the generosity of participants in sharing information and reflections on practice was so abundant, that carving the boundaries of this work was a permanent challenge, which required iteratively going back to the essential research questions.

A fourth limitation was determined by the pandemic. The book reflects the hospital field as it was between 2017 and 2019, but the situation has drastically changed, and such changes couldn't be portrayed. The original doctoral thesis was written in pre-covid years, and could not anticipate the effects of an event of this magnitude on the services hereby presented. The observation in the field continued, but without systematic data collection they could not offer a complete picture. The collapse of the Italian healthcare system under the first wave's pressures was in plain sight, at a global level. The national landscape of migrant health during the pandemic has been the object of an excellent volume (Cernigliaro, 2024), rich in theory and data, that offers copious data on the unequal and cumulative effects of the so called *sindemic* on marginalized populations. Undoubtedly, in South Tyrol having these networks in place has helped organize low-threshold initiatives for preventive information and vaccine dissemination among marginalized populations, such as undocumented migrants. I was personally witness to that, by being involved in the collection and dissemination of multilingual materials and in facilitating connections with mobile clinics and NGOs on the ground. Since then, the field has deeply changed, including the devastating effects of the pandemic on the healthcare system as a whole, the overload of practitioners, the further marginalization of disadvantaged communities and the inability of systems to effectively protect these groups' disproportionate worse outcomes (partially due to the redirection of attention from marginalized populations, towards other target groups such as the elderly, and other priorities in public health), among others. Significant leading figures in accessibility efforts have left the public sector and have not been replaced, intercultural training programs were halted in an unprecedented hiatus, the clinic serving the undocumented barely survived, with staff cut to a third, and the healthcare system structure overall has not yet recovered. The hope that this study, in analyzing accessibility efforts in their best moment, may offer a roadmap for such recovery, is a driving motivation for this publication.

6.3 The Potential of Social Innovation Research for Accessible Healthcare

Experts on healthcare service delivery (Greenhalgh & Paputsi 2018) have been calling for a paradigm shift for facilitating change in this field. They question evidence-based paradigms in favor of other methodological approaches which can better account for complexity both in healthcare and in society. They explored the relevance of a variety of methods, including narrative methods (Greenhalgh et al., 2005), ethnography (Greenhalgh & Swinglehurst, 2011; Swinglehurst et al., 2011), action research (Swinglehurst et al., 2008) among others (Greenhalgh et al., 2006; Macfarlane et al., 2013; Greenhalgh et al., 2014). This study argues that a social innovation approach might be particularly suited to this task, firstly, for its theoretical and methodological openness. This facilitates to account for social and organizational complexity in a multi-scalar level, and to implement different research strategies on different problems with methodological flexibility. Moreover, it allows to construct solutions to service delivery issues that can effectively contrast implementation resistances through participatory practices. This work has attempted to show that this approach may explain and support processes of transformation in service organizations, especially where the issues involve widening accessibility in healthcare services. In fact, the networks described, aimed to better include marginalized patients, created alliances with other welfare services in the public and private sector, and gained recognition and support from their governing bodies. Thus, these may constitute a showcase of the transformative potential of problem-centered networks aiming to facilitate forms of bottom-linked governance (Moulaert & McCallum, 2019).

Social innovation approaches, because of their collaborative processes of knowledge construction, integrate different positions, forms of expertise, and points of view, which increase significantly the capability of this approach to thematize complexity. Embracing this approach as widely as it was available in the context of a doctoral research, this work has documented multiple agents and relations within the healthcare organization, as well as collaborative relations with agents external to it. In attempting to underline the more collaborative and productive relations, also tensions, resistances, and power struggles have been noticed and reported, showing the complex embeddedness of a healthcare organization in its socio-political context. Being aware of such context and minding the different agents and forms of capital circulating in the healthcare field is crucial for transformative action. No isolated subject can generate change. The creation of alliances and communities of practice with a shared knowledge frame appears to play a key role in transformative action, even if its creation takes time, effort, and compromise. The objectives of social innovation approaches too, are particularly compatible with the work on accessibility of healthcare services, as countering inequalities and fostering redistribution is the origin of most social innovation initiatives:

> SI [social innovation] occurs because socially innovative actions, strategies, practices and processes arise whenever problems of poverty, exclusion, segregation and deprivation or opportunities for improving living conditions cannot find satisfactory solutions in the "institutionalized field" of public or private action. (Moulaert et al., 2014, p. 2)

Countering health inequalities and overcoming barriers in healthcare service delivery is an objective stated by European Policy (European Parliament, 2011). In studying innovative ways to do so, fruitful connections have been found with the research on social determinants of health, which studies the impact of socioeconomic, environmental and other inequalities throughout the life course, documenting their concrete impact in unequal life expectancy, not only between countries but also across the social gradient within the same country and even the same city (Marmot, 2013, 2015). Another fruitful theoretical connection focusing on explaining complex inequality processes is the intersectionality approach, which studies the interplay of gender, class, and race, amongst other factors, in creating new spaces and mechanisms of disadvantage and further stratifying excluded groups (Crenshaw, 1989, 1991 and many others inspired on her work).

When observing the role of practitioners in shaping service delivery in healthcare, and accounting for the various connections and power asymmetries between the actors in the field, a fruitful theoretical connection can be established with the empirically grounded conceptualizations of Lipski's street-level bureaucracy approach. In fact, it has shed light on the position of public service professionals, and the complexity of their relations with the citizenship, with the organization they work for, with the different ethical and juridical frameworks of their mandate, with the productivity indicators by which they are pressured and evaluated and with the chronically scarce resources, spaces and time- frames which are rendered available in the course of their work. Considering social justice and equality in general can be useful to judge the outcomes of healthcare service delivery. Even more useful, however, is to contextualize how equality can be shaped in healthcare services by considering the evolving context, with changing priorities, systemic pressures and insufficient resources, and device strategies to build and readiness (Abel & Frohlich, 2012), for instance, by offering training opportunities that take such elements into account.

As can be seen, social innovation is an approach particularly suited to incorporate theoretical conceptualizations originated in a variety of fields and disciplines, in its embrace of holistic analysis:

> Holistic theory identifies relationships between particular themes across particular subsystems and explains these relationships (or their absence) by use of partial theories fitting a meta-theoretical framework … in holistic knowledge production, the exceptional or the particular matters as much as the structural or the systemic. (Moulaert et al., 2013, p. 445)

Moreover, the multilevel analysis promoted by the social innovation approach can strongly relate to the multi-scalarity promoted by transnational approaches in migration studies. Important voices on this issue, such as Thomas Faist (Faist & Bilecen, 2019), Nina Glick Schiller (2020) and Paolo Boccagni (2017b), in their respective work are very mindful of the interplay of

> larger processes that include all people, migrants and non-migrants, living in a locality and connected to each other and to multiple places and institutions through diverse networks of differential power. … Once multi-scalar processes are understood, scholars, policymakers and all the rest of us can shift our focus from differentiating natives from strangers to creating a politics that speaks to the interconnections among differentially empowered actors (Glick Schiller, 2020, p. 34).

Social innovation, too, invites to transform relations and connections between differently empowered actors, to discuss local policies regarding access to the satisfaction of basic needs. This work has attempted to render explicit the different levels, positions and interests interplaying in the processes of healthcare service delivery to migrant populations.

Social innovation approaches allow problem-centered theorization. They foster the inclusion and connection of other compatible theoretical approaches, systemic or empirical, localized or general, which might help understand complex settings and phenomena. Focusing on connective and conjunct theorizing, it may integrate various approaches, as long as they enable to better make sense of the issues at hand. In this spirit, this work has attempted to offer a coherent, albeit inevitably partial, picture of the problem it studies, not in spite but because of the multiplicity of theoretical conceptualizations it has engaged. Maybe the connective tissue between these theorizations, mobilized to gain a better understanding healthcare accessibility, is even more useful that generating an additional theoretical element. As Thomas Faist, during a lunch at COMCAD in Bielefeld University observed: "we need less theories and more theorizing". Conceptualizing emerging fields, selecting and mobilizing theoretical elements for better problem understanding and transformation, is closer to the tradition of grounded theory than it is to sterile theoretical dogmatism. From the same position, when someone objected that social innovation lacked theoretical and conceptual coherence, Moulaert & McCallum observed:

> We are not convinced that this is a weakness as we believe that plurality in concepts and theories enriches the practical value of theoretical discussions for addressing action and policy questions. The strongest embryos often have hybrid antecedents (2019, pp. 93–94).

Multiplicity in theorization does not only juxtapose indiscriminately different approaches. It can be connective if it integrates a multiplicity of perspectives in a conjunt theorizing. The conceptual plurality of social innovation connects with what Tsoukas calls conjunctive theorizing:

> Complex theorizing is conjuntive: it seeks to make connections between elements of human experience through making those analytical distinctions that will enable the joining up of concepts normally used in a compartmentalized manner. (Tsoukas, 2017, p. 132)

Social innovation processes in hospital organizations (as much as elsewhere) entail collective and reciprocal learning, and it is not a priori closed to other theoretical inputs, as long as they serve to explain and advance the comprehension of the complex problems at hand. This entails both holism and pragmatism, brought together in a joint problematization approach (Moulaert & MacCallum, 2019, pp. 103–105).

When those included in such joint problematization go beyond a single discipline, and moreover, beyond the entirety of academia, to include relevant persons and organizations not only as objects or users of research but as research partners, who contribute to shape the research questions, methods, results and utilization, the research efforts can be considered transdisciplinary.

This may particularly facilitate sustainable change in organizations, and particularly public services. In fact, professionals and users involved in processes of change of which they can claim ownership are more likely to be uptaken, incorporated in existing systems, invested into, collaborated with, and sustained in time. Changes that are shaped within the fields of application (Nowotny et al., 2001; 2003) may produce socially robust knowledge, whose credibility depends not only on the internal validation of academia but on the negotiated validation with concerned parties in the field of practice, in a democratization of expertise (Nowotny, 2003; Moulaert & Van Dyck, 2013). Judging by the interest of interlocutors in the field and by the researcher's progressive embeddedness in it (participation in numerous events and membership in the local SIMM group) as the continued interest of members of the hospital in the research results, the field has spoken, on the effectiveness of social innovation approaches. That said, academic validation through peer-reviewed publications has also been acquired (Zadra, 2021a, 2021b).

The notion of bottom-linked governance developed by social innovation research is another useful conceptualization in seeking organizational change in healthcare. It is defined as "new forms of democratic governance collaboratively built between SI initiatives and activists, their scalarly dynamic networks and state institutions and agencies" (Moulaert & MacCallum, 2019, p. 117). It involves contextualized forms of governance partnership between actors with different scales of influence, thus having the potential to transform social relations and political practices across these different scales. In the healthcare context, accessible service delivery cannot be brought to a system-wide scale starting from the bottom level only, nor can they be mandated top down, as they would be less accurately targeted and technical considerations, cultural resistances, and sheer habit might get in the way of their uptake. Multiscalar collaboration platforms – such as the ones organized by the Società Italiana di Medicina delle Migrazioni (SIMM) at the regional level – may include the wider logics of policymaking and resource allocation in systemic levels, as well as the technical middle gears, and actors on the front lines with a granular understanding of what works. This articulated national network of advocacy has had a significant impact on healthcare service delivery to migrants by systematically mapping of issues emerging from the frontlines in each region, with the assistance of a variety of private and public actors in this field, and bringing data and concrete policy proposals at the national level, through technical, administrative, and legislative steering tables. Knowingly or implicitly, the network's advocacy system is multiscalar knowledge circulation for a bottom-linked governance, at its best. A similar approach, on occasion conceptualized in different terms, has been present in the theorizations of scholars in the healthcare and welfare sectors, such as Ferrari and Accorinti in welfare systems research, as well as Elsen and Lorenz, which champion social innovation approaches in various realms of the social field (see also Marceca et al., 2013; Ferrari, 2010; Accorinti, 2013; Elsen & Lorenz, 2014). Accorinti has noted – in the analysis of information systems for the governance of welfare services – the need of a transition

> from a closed system of hierarchical and centralized government … [to a] organizational model of network-oriented governance", which would only be possible if public authorities through bilateral processes "reorient their cognitive universe and their actions according to the interpretation of the needs of their target users. (Accorinti, 2013, p. 32)

This work argues that social innovation research offers the frameworks and methods to accomplish such goal.

All the aspects above bring me to the conclusive argument that social innovation is a very promising approach to create a social change in public services, to make them more inclusive and responsive to the new needs of their increasingly diverse public.

6.4 Contributions to the Study of Inclusive Healthcare Delivery

This has been exploratory research on an understudied area through a case study, whose main contribution has been to signal spaces, processes, and mechanisms of social innovation for the accessibility of healthcare services to migrant patients. In this section, I will briefly offer a synthesis of some of the most potentially useful sets of knowledge that have been acquired, both with respect to the academic field and the field of practice. That is, both in the study of healthcare service delivery to migrant populations and in the processes of social innovation within healthcare organizations for more accessible services.

6.4.1 Mapping barriers

The study has documented practitioners' perception of barriers in access, presenting exploratory data on juridical, organizational and socioeconomic barriers, and going deeper in the analysis of linguistic and cultural barriers, which seemed to be at the forefront in the perception of practitioners. Beside the value of their contextualized descriptions, the case study has shown an emerging awareness of their own participation -alongside their administrative bodies, regulations, organizational processes and technologies- in shaping barriers or contributing to accessible services. This work has intended to examine the complex and dynamic field of interactions in which barriers arise. Therefore, also barriers experienced by practitioners in treating migrant patients are documented. In fact, barriers, conceived as failed interactions among those involved and the structuring contexts in which they are embedded, should be further explored in the healthcare context and in other contexts of public services. Practitioners' perceptions do not substitute the most informative perspective, that of patients themselves, but they do contribute with a narrative that help explain decision-making with regards to accessibility. Moreover, comparing patients' and practitioners' views of barriers can shed light on organizational blind spots, and strategically target data collection. This work has also produced arguments to show that overcoming patients' barriers is in the best interest of all involved, as barriers have high costs not only for patients, but for practitioners themselves and for the healthcare system in its entirety.

6.4.2 First, do no harm

Primum non nocere is a part of the hippocratic oath. This study documented instances in which practitioners themselves recounted all the ways in which migrant patients' right to health has been compromised. The efforts of practitioners in this work often responded to blatant injustices, omissions, or mistreatments operated at the harm of migrants. Without going into details, it is necessary to say that current reporting mechanisms for complaints, namely, the Public Relations Office (URP), is rarely accessed by foreigners. Better and more accessible mechanisms should be put in place. Practitioners have also reported the harm that ignorance can do, particularly with regards to the widespread ignorance on migrant entitlements. It has brought practitioners to treat service delivery to migrants in irregular situations as a favor instead of a right, and it has affected the quality of care. A particularly dangerous piece of legislation that it would be harmful to ignore is the prohibition to report migrants in irregular situations to the authorities, and the anonymity under which health services must treat them, through an STP code. Moreover, severe omissions can cause harm as well. When basic healthcare through general practitioners is not delivered in ways that are accessible to migrants, including linguistically accessible, an increase in preventable negative outcomes, and their long-lasting consequences is predictable. Harm to the healthcare services comes as well, as the cost of preventable acute and chronic conditions escalates, and emergency services become a bottleneck.

6.4.3 Diversifying entry points and offering navigational assistance

In this case study, contact with patients that find it difficult to reach health services is facilitated in the clinic for migrants in irregular situations. However, it is not restricted to migrants, also some marginalized groups of locals are supported. Access is facilitated by predisposing multiple, differentiated and low-threshold entry points. That means, that services, provided in anonymity, through the special STP code, could be reached through multiple avenues with minimal red tape: through emergency services, through rounds in migrant reception centers, by showing up at the clinic, which functions as a drop-in point, by referral by other practitioners or patients, through NGOs or outreach social workers, through a mobile clinic that reaches out to the homeless and other marginal settings, among others. Moreover, navigational assistance is offered to patients facing barriers, because the workings of the healthcare system are hard to grasp for persons living in marginality. Thus, connections are curated with other services, to lower the thesholds to access testing, medicines, or specialized care, when needed. When barriers are repeatedly observed, facilitated pathways to assistance are created to lower the thresholds of access, for instance, by structuring referral procedures or identifying point-persons within a ward which can facilitate transitions.

6.4.4 Mapping unmet needs and fostering prevention

When preventive and risk-containing information does not effectively reach marginalized persons, a harm to public health is done to the community. For instance, in the case of screening opportunities, safety measures during a pandemic, as well as infectious or sexually transmitted diseases, such as HIV. That is why a comprehensive screening is available, for all those who cannot access healthcare through the general practitioner. It entails a pneumological visit, as well as blood tests: complete blood count, HBV markers (hepatitis), AC tetanus. For adults and children that need them, X-rays and HIV testing are added. When a new need emerges, facilitation of access entails on occasion a widening of the offered services, as when widespread dental problems were noticed among asylum seekers hosted in reception centers, and a window of assistance was scheduled to address them.

Prevention is fostered through multilingual information initiatives, through targeted screenings, low-threshold vaccination campaigns, and by training NGO's and reception centers' staff in early identification of specific needs, particularly regarding mental health, to facilitate access to testing and specialized services.

6.4.5 Improving training programs

The documentation on practitioners' perception (or lack thereof) regarding barriers in access could also illuminate training programs. In fact, this section will probably be used on a training program for the practitioners of the hospital, in order to present them with the collective picture that composes in a collective voice the individual elements of perceived barriers they have offered throughout the interview process. It could raise their collective awareness of the difficulties experienced by patients.

The training-mediation combination that was documented in the hospital has also shed light on how professionally life-changing it can be for practitioners to have mediators working with them when needed, and also what can the pitfalls and conditions of such effectiveness be. For instance, the ambiguity in the role of the mediator, the different priorities that his work acquires in the different wards and how the skills which become more important vary significantly from maternity to the STP clinic, from emergency services to psychiatry. The data collected here could contribute to the ongoing reflection on the professional training of intercultural mediators in the healthcare sector and argue for the convenience of the joint training of mediators with healthcare practitioners, to foster synergy, cooperation, as well as reciprocal learning and trust. It also hints at the downsides of not having a systematic evaluation of such programs and their effects on practice.

6.4.6 Implementing and deploying mediation services

The process of implementation of mediation services in San Maurizio Hospital has shown several aspects that I deem relevant for the study of such processes in other contexts. Firstly, the importance of structural conditions, in particular continuity, quality controls and organizational simplification, as well as the positive impact of reinforcing even small forms of structural embeddedness of mediators in the context of their practice. Secondly, the positive impact of the contextual implementation of mediation services with joint training programs where practitioners and mediators together can create a common knowledge base and negotiate expectations about the role of mediators, their skills and quality indicators. Thirdly, the different priorities, preferences and needs that specific healthcare contexts have regarding the mediators' performance. For instance, in the emergency service the priority is the immediate intervention of the mediator, in its conduit role as an interpreter with a specialized understanding of medical language, while in the psychiatric ward the relational aspects, the knowledge of the symbolic and cultural worldview of the patient are a great help, as well as a desirable continuity, elements which benefit the therapeutic alliance. This study documented the preference of female mediators in the maternity ward, who can put mothers at ease in discussing intimate gendered issues, like breastfeeding or post-partum conditions, and about the context of undocumented migrants, with which confidentiality breaches might entail severe additional legal consequences, both for patients and for practitioners. An adequate preparation of mediators for such negotiated and contextualized performances would highly aid the collaborative work with practitioners.

In the studied case, new forms of embeddedness of mediators in the healthcare system have contributed to its more differentiated activation.

For instance, the stabilization of female mediators in the maternity context, which not only has contributed to a greater synergy between mediators and healthcare practitioners but has produced diversified instances of involvement of mediators in the ward efforts to respond to migrants' needs. For instance, translation of informative documents in the more represented nationalities, debriefing of nurses on cultural customs, case-analysis group discussions, amongst others. The introduction of Remote Simultaneous Interpreting (RSI) in Emergency services through audio and video conference calls has also solved significant linguistic access issues in that context. With a greater synergy a negotiated arrangement to simplify bureaucratic processes in calling for a mediator have been negotiated for the benefit of the hospital, the agency and the patients. The aforementioned developments have shown to contribute to a higher stability and expertise of mediators, as well as diminishing their cost in terms of time expenditure and organizational work for practitioners, and greater opportunities for reciprocal trust, synergy and effective collaboration.

6.4.7 Resources for linguistic and cultural accessibility

Other resources practitioners, particularly in the maternity area, have deployed to facilitate linguistic and cultural accessibility include:

- Facilitating verbal communication, by avoiding complex structures, uncommon and technical terms, paying attention to speed and clarity of pronounciation, including pauses to give patients the chance to pose questions or doubts, repeating key messages, and confirming understanding by using the teach-back technique.
- Producing and distributing multilingual written material, or translating relevant parts of written documents and communications.
- Using technological tools, such as videos, translation apps, posting multilingual information documents online or sharing them upon need through messaging, using remote forms of follow up to answer questions from discharged mothers and babies.
- Using non-verbal communication, deploying gestures and facial expressions, teaching by doing (for instance, showing how to change a diaper using babydolls), using pictures, cards, illustrated books, etc.

- Training on diverse cultural views on motherhood, health and illness, and deploying respectful interactions on those regards, as well as progressively adapting gendered expectations to a variety of cultural contexts (for instance, applying non-judgement, respecting the right of mothers not to breastfeed)
- Applying flexibility in regulations to accommodate diverse birth and death rituals, and offering privacy spaces whenever possible in the context of infant death, for kangaroo therapy, or breastfeeding.

6.4.8 The role of networks of knowledge circulation and inclusive practice

In complex systems, quality does not entail a permanent state but keeps evolving, being constantly recreated in changing conditions. Therefore, gaps in service are to be expected, detected, and repaired regularly. Interventions must have an adaptive quality to them that allows a navigational discretion, to detect emerging contextual obstacles and apply discretionality in the adaptation of practices. Discretionality is a double-edged sword, but in this case study it has allowed practitioners a collaborative steering of initiatives to improve healthcare accessibility for migrant patients.

The problems arising in services can be more efficiently spotted and solved when systems are open to connections that enable access to expertise coming from other professional areas. Forms of knowledge brokerage, collaborative knowledge creation, and circulation, as well as formal and informal networking platforms, have been documented in this work, combining different pools of knowledge in an environment of respectful collaboration, which helped significantly improve the quality of services.

An important suggestion in this regard is that more and better resources need to be invested in professional problem-oriented connections. For instance, services for asylum seekers have been for years based mainly on informal platforms of professional cooperation, but when support and resources were invested by the healthcare system, which did not depend on the goodwill and professional generosity of employees, services were allowed to grow exponentially. Such investments in supporting connective platforms and knowledge sharing for more accessible service delivery can find fruitful applications in other healthcare services (or public services in general).

The documentation of processes of networking for inclusive services and knowledge circulation might shed light on the spaces of agency of practitioners for social innovation of service delivery when they act collaboratively. Nurses are often collaborative, but seldom innovative and reaching other wards. Doctors might individually come up with ideas for reengineering the system for better inclusion, however, they seldom think of themselves in collective terms, propose collaborations with different specialties, or attempt big and uncertain experiments. However, it has been documented during fieldwork that healthcare practitioners interact among themselves, with administrators and social workers, with NGO employees, with knowledge brokers from different social sciences, with representatives of migrants' associations, and with international networks. Those connections contributed to producing accessibility outcomes, making practitioners brokers of knowledge circulation and social innovation in healthcare service delivery.

Practitioners innovated services collectively, creating connections one step at a time: e.g. creating situated alliances for concrete purposes or training themselves on an effective trialogue with patients and mediators or establishing reciprocally beneficial interactions or structuring stable knowledge circulation platforms, or opening new low-threshold entry points to healthcare services. In this and other ways that have been documented, they made significant steps towards contrasting barriers in access for a variety of migrant populations. When they were presented the collective result of their work throughout the last few years, they realized that while the contribution of each could be small and unique, the cumulated weight of the cultural and practical changes they have created and continue to create in the hospital is important and empowering. The practitioners' feedback in the collective meetings in which this work has been discussed have shown that much.

6.5 Open Questions and Future Research Agendas

This research has indeed raised more questions that the ones it has answered. That might be a positive feature. This section offers some ideas for future research that have been given visibility by this exploratory work.

This study has discussed Italian healthcare policies arguing that the law entitles migrants to receive healthcare services, including migrants in irregular situations or asylum seekers. However, governance issues as the contrast between national and local provisions, insufficient funding, absence of control mechanisms, etc. do not always establish accessible pathways for disadvantaged populations (migrants or otherwise) to get the services they are entitled to by law. This seems an important area of study for medical sociology, migration studies and social policy research to address, by projects as Footprints[27] which are extremely important and urgent.

A multifaceted approach to the topic of service delivery is for sure a limitation in obtaining focused information about one intervention, but it may also constitute an occasion of highlighting the linking areas between different problems, which are usually studied separately. In this research, for example, the connection between different types of barriers in accessing services, or the connection between the practitioners' and the mediators' perspective on their professional roles while training and working together, or the impact that a greater access of undocumented migrants to low-threshold screening pathways has on their use of other more specialized services. Or the connection between the social and the health sectors in the reception of asylum seekers.

This study attempted to show that the social innovation approach can positively contribute to this multilevel analysis. In a case study, the approach of social innovation my foster a multiscalar systemic view offering different advantages than, for instance, the "impact measurement" approach on one intervention. To start, social innovation paradigms enable participative processes to create a shared view of problems and strategies of solution among researchers, stakeholders and field actors. Impact studies of individual interventions in favor of inclusive services (like training initiatives or prevention initiatives) are of course very useful, however they seldom go very deep in analyzing the structural conditions in which such interventions are embedded, and which might greatly influence results. Moreover, such impact studies often document only recipients' perspectives, while it would be perhaps illuminating to include those who identified the need, those who organized and financed the intervention, those who then performed the delivery itself, those who did not participate or criticized the initiative, those who received

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[27] https://www.simmweb.it/progetti/928-footprints

an indirect impact, and so forth. That is why it seems to be time to overcome the "measurement" approach to innovation and research in terms of complex systems and networks. The perspective of social innovation has proved to be very fruitful in that regard.

Some of the accessibility interventions operated by health professionals at this hospital have shown results that should be analyzed more closely. Some of the issues that have emerged during this research, which would merit further exploration are hereby summarized:

- How can preventive services in general (and screening for breast and cervical cancer in particular, as data reports it as a critical issue in causing preventable deaths) further diminish the documented gap in access between local and migrant patients?
- How could a systematic monitoring of accessibility in services, particularly linguistic accessibility, be implemented? Which control mechanisms could ensure that patients that need linguistic mediation can have it in all relevant medical exchanges? How can digital technologies, beyond the remote interpretation by video conference, facilitate healthcare service accessibility, without compromising quality and continuity of care?
- To what extent and how do practitioners within healthcare networks bridge their differences to collaborate: ideological differences, professional or positional biases, religious or cultural backgrounds, etc.?
- Where could migrants find a comprehensive and updated source of information to the use of local healthcare and welfare services at least in English, if not in the most represented languages? Why is there no visible investment in creating and rendering available such information? Moreover, what does the network comprising social and health services need to ensure coverage of essential needs for the homeless, local or foreign? In South Tyrol, scarce resources don't seem to be the problem.
- How can mediators' roles be better negotiated and adapted to the specific wards' needs given the precarious position of on-call mediators and mediation provider organizations? Furthermore, how to ensure the quality of mediators' training and performance, in such precarious circumstances? A common training base should be ensured, as well as quality controls.

- To that purpose, how to structurally embed mediators in healthcare organizations, or at least give them employment stability and an effective reward systems?
- How to systematically operationalize practitioners' feedback to organization leadership, and back, to enable a joint problematization approach to innovation?
- How to operationalize a socio-linguistic analysis of mediated medical encounters into more specialized training programs for mediators and medics?
- How to contrast the widespread disinformation and misinformation of practitioners about undocumented migrants' entitlements, and how to document the reported difficulties of general practitioners in providing care for residents of migrant origin?
- How to focus qualitative research on migrant patients, mapping their healthcare experiences, needs and barriers? It would greatly help the processes of creating inclusive healthcare to include the voices of those targeted by the measures, in the attempt to improve service provision. Although service sectors tend to give user satisfaction a great importance, public healthcare seems to be resistant to implement consistently participative feedback channels in quality improvement efforts.
- Moreover, how to do research on barriers in access that reach non-patients, or those who are not able to adequately receive the healthcare services they need?

Research on the impact of linguistic barriers is surely important and has received international attention. Accessibility of STP services in Italy for undocumented migrants and asylum seekers is a huge topic in urgent need of study, and also issues of management and organizational barriers seem to merit more attention than they get, not only with regards to migrant patients but also to facilitate access from disadvantaged groups of the local population.

Another suggestion for future research in the area regards quantitative studies. The scarcity and inaccessibility of local data on patients of foreign origin is a great limitation in painting a quantitative picture of the topic of migration and health at the provincial level. The undeniable complexities of defining the target population should not bring healthcare systems to avoid the issue. An additive approach could help this issue by considering more than one indicator of migration-related diversities (e.g. foreign citizenship status OR country of birth OR mother tongue) in shaping the very blurry “migrant” group of patients. National data documents a wide difference in use of services by migrant and local populations, signaling areas in which a significant improvement of service delivery is greatly needed (e.g. breast and cervical cancer prevention). It would be essential to acquire better local quantitative data on healthcare service use of migrant populations.

With these challenges for future research, this case study closes, in hope that readers will have found useful information and motivation to contrast barriers and social determinants of health, by implementing accessible healthcare services for all.

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With a background in philosophy and a sociological research practice, Franca Zadra has obtained a PhD at the Free University of Bozen-Bolzano focusing on migration studies. Methodologically, she is inclined to social innovation approaches through systems analysis, implementation of transdisciplinary methodologies, and participatory action research among others. Past work focuses on migration policy, intercultural relations, immigrant women, and the social innovation of public services, especially in the areas of education and healthcare, oriented to the consolidation of inclusive communities of practice. In the last years she has focused on multiagency programs to prevent and redress labor exploitation of migrant workers in situations of complex vulnerability, and on digitalization of outreach social work in the areas of trafficking in persons and gender violence.