Pregnancy in immigrant women

R. Corosu, A. Fedeli, A. Rossetti, P. Mancino

Department of Gynaecological Science, Perinatology and Child Welfare
University of Rome "La Sapienza", General Hospital "Umberto I", Rome (Italy)

Summary

Objective: We wanted to study how foreign women face pregnancy and childbirth in a society quite different from their own. *Methods:* In 2004 we studied 328 pregnant women at the Department of Gynaecology at the "General Hospital Umberto I" in Rome. Information on patients' personal lives and experiences was collected. Results: Women were classified into six (6) groups based on nationality, race, religion and culture. *Conclusions:* Arabian women had the most natural childbirths. African women had a longer duration of gestation. Women from Eastern Europe underwent frequent tests and examinations, but had the highest chance of having preterm births. Chinese women did not usually undergo many examinations and were able to tolerate pain during childbirth quite well.

Key words: Immigration, Pregnancy, Maternal complications.

Introduction

Today, the presence of foreign women in Italy, in particular those who come from poor areas of the world, is increasing more and more. The rise in population together with requests for obstetrics and gynaecological care is causing a constant increased demand for assistance and also better services [1-13].

Immigrant women are usually young and in good health but, because of their pregnancies, they are also exposed to risks which have two good allies in poverty and marginalisation. Every year 590,000 women die all over the world because of complications during pregnancy while about 7,000,000 are exposed to health risks. Maternal deaths are higher in poor countries (developing ountries). Among those women who die due to pregnancy or birth complications, 24% die during pregnancy, 16% die during childbirth and 61% die from after-birth haemorrhage and sepsis.

The most difficult time for these women living in our society is, therefore, during pregnancy and childbirth. The majority of women coming from undeveloped or developing countries who have not experienced "emancipation" believe, indeed, that "being a woman" essentially and obviously means "becoming" a mother. Thus the essence of "womanhood" corresponds to the essence of "motherhood" [14-30].

After analyzing different aspects linked to immigrant maternity, it is possible to see the negative aspects. Above all, the difficulty for women to obtain assistence or the possibility to benefit from healthcare services becomes clear. This difficulty is due to both an insufficient and an unsuitable solution to the increasing demands coming from this immigrant population of women and in contrast, cultural and social reactions coming from women in general. Immigrant women's cultural and physiological heritage should not be disregarded by healthcare workers in our hospitals and medical centers that take care of maternity patients. Although progress is being made and services are becoming more efficient (e.g., the establishment of "cultural mediators" to help in developing services), the path is still very long. The purpose of this study was to give a complete overview of the situation [31-45].

Methods

In 2004 we studied a group of 328 foreign pregnant women at the University of Roma "La Sapienza", Department of Gynaecology, Perinatology and Child Welfare of the General Hospital "Umberto I" in Rome. We considered some elements of collecting information such as patients' personal data and experiences, the number of examinations each pregnant patient underwent, different types of childbirth and each newborn's state of health after birth.

We also divided all the information into different groups according to each woman's nationality and country of origin. The research was carried out by analysing data in files containing personal information and medical history, thus giving us the possibility to make notable observations.

Results

After considering the woman's nationality, patients were divided into six groups selected according to these criteria: nationality, race, religion and culture.

The following groups were formed:

1) Eastern European countries and Russia (Poland, Ukraine, Bulgaria, Yugoslavia, Romania, the Czech Republic, the Moldavian Republic, Albania, Latvia, Slovenia, Macedonia, Croatia);

2) Central and South America (Cuba, Columbia, Ecuador, Peru, Honduras, Brazil, Jamaica, Argentina, Dominican Republic, Venezuela, Uruguay);

3) Arabic countries, the Middle East and North Africa and all those with a predominance of Muslim religion (Marocco, Algeria, Tunisia, Libya, Egypt, Iran, Yemen, Armenia);

Revised manuscript accepted for publication January 7, 2006

4) Africa (Nigeria, Sudan, Ethiopia, Senegal, Somalia, "Mauritius" Islands, the Ivory Coast, Madagascar, Cameroon, Cape Green);

5) Asia (The Philippines, China, South Korea, Bangladesh);

6) India (India, Sri Lanka).

The number of women admitted to our hospital according to these groups resulted as: Eastern European countries and Russia: 153; Central and South America: 58; Arabic countries, the Middle East and North Africa: 20; Africa: 20, Asia: 66, India: 11.

Taking the different nationalities into consideration, it is clear that the majority of women came mostly from Eastern Europe (46.6%), then from Asia (20.12%) and finally from Central and South America (17.6%). As for African, Indian and Arabian women, the percentages are extremely lower. Thus, it was hard to examine pathologies using only these statistical data. It has been demonstrated that only 7.3% of women obtain Italian citizenship, of which 5.1% have it because they marry an Italian man and 2.1% because they work.

If the average age of pregnant women is considered aside from nationality, it comes out that the majority are between 24 and 31 years old. The minimum age was 15 for Romanian women and the maximum age was 44 for Columbian women.

Although the percentage of married Asiatic, Indian and Arabian women was high, there was a large difference.for the rest. It is possible to see how it is important to be married and have a family, especially for Indian and Arabian women. It is known that according to Muslim religion women are not allowed to have children without being married. In fact, it is impossible for Arabian and Indian women to face a pregnancy without a husband. After meeting Arabian and Indian patients, we also understood that they would feel ashamed if the the baby did not have a legitmate father. On the contrary, for women from Eastern countries and South America, being alone did not mean they were bad or incompetent mothers. Thus an unmarried woman is not considered "shameful" by the family. Moreover, we observed that the level of education is getting higher. With reference to nationality, the majority of women had a high school diploma (60% was represented by Indian women). In contrast, Arabian and African women had the highest percentage of illiteracy (10%).

Although we found a high rate of education, the present work conditions in Italy make job prospects uncertain if compared to the country of origin because many degrees and qualifications are not recognised by European countries. Another interesting fact is that 90% of the Arabian women were housewives. Consequently, we could deduce that, according to Muslim religion and habits, women are obliged to stay at home, to take care of their family and not to go to work, because it is considered a male activity.

There is also the problem that women coming from Eastern Europe are often unemployed. They would like to find work but it is very difficult for them to have this opportunity. As for Asian women, in particular Chinese, it came out that most work for private businesses which, are becoming more and more powerful in commercial and economic fields. This also explains why the number of private companies owned by Chinese people is rising so quickly in Italy.

We then turned our attention to medical examinations performed during each woman's pregnancy in order to identify the risks. It came out that the percentage of patients who do not have examinations was low while, the percentage of women who undergo accurate examinations and tests such as amniocentesis, foetal echocardiogram and flowmetry was quite high. For example, all Indian women responding had had at least one examination, indicating that they understood the importance of examinations during pregnancy.

On the contrary, among Arabian women there was a high percentage of patients who did not undergo examinations, probably due to their "Arabic" culture which makes it difficult for a woman to be examined by a doctor. Asian women, in particular Chinese, and Eastern European women also did not have many examinations. In this instance the reason was due to a high percentage of "young mothers" who are often faced with a difficult financial situation. Finally, we can say that in each group there were different reasons why examinations are not undertaken: difficulty in communicating, lack of information. disinterest (especially in Romanian women), difficulty to be examined in medical centres, and difficult financial situation.

As for the "period of gestation", at the time of each childbirth we noted that it was more than 37 weeks for all women, independent of nationality. Of African women, 95% had a pregnancy at term whereas the rest had a premature and or risky pregnancy. This was also the case for women from Eastern European countries (25.53%) and South America (22.41%).

We also focused some attention on the most frequent problems occurring during pregnancy (Table 1).

The percentage given for each problem was calculated without taking into consideration patients who had vaginal births. We observed that the majority of women examined suffered from illness or minor annoyances during pregnancy: 90% responded that they felt somewhat sick during the first three months (e.g., nausea or vomiting). One of the most common problems was the premature breakage of membranes.Very few cases occurred in women of African origin. On the contrary, the maximum percentage was represented by Eastern European (34.88%), and Indian and Asian women (25%). Regarding premature labour, data revealed an incidence of 7%. This problem can usually be resolved if the patient stays in bed and undergoes medical therapy. Diabetes primarily occurred among Indian (25%) and Asian women (12.82%). In the latter, there were two cases of intrauterine deaths due to lack of insulin therapy.

Another problem is "hypertension" during gestation. This involved mostly women from Eastern Europe (9.30%) and South America (11.43%) although they were

following specific therapy. Contagious diseases such as HIV, HCV, tuberculosis and toxoplasmosis were found in patients from Africa (2.33%), Eastern Europe (2.86%) and South America (8.35%). Diseases that affect amniotic fluid such as "oligohydramnios" and "anhydramnios" did not occur very often. It was the same for thyroid and heart diseases, and flowmetry changes. The last important element considered in discovering diseases was "the trace" (tracer graph). It showed a percentage of 10% for each group of women and thus most of them underwent caesarean section. There are also other diseases to consider but we included only those most relevant to our population groups.

Table 1. — *Diseases occurring during pregnancy.*

	Eastern Europe & Russia	South & Central America	Africa	Arabian countries & Middle-East	Asia (The Philippines & Baengladesh)	India & Sri-Lanka
Foetal diseases	1.16%	2.86%	8.33%	6.67%	5.13%	
Tuberculosis toxoplasmosis	1.16%	2.86%	16.67%	6.67%		
Hypertension (with therapy)	9.30%	11.43%				
Hypertension (no therapy)	4.65%				2.65%	
Diabetes		5.71%	8.33%		12.82%	25%
Intrauterine deaths					5.13%	
Thyroid illnesses		2.86%	8.33%		2.56%	
Heart diseases		2.86%				
Drug addiction	2.33%					
Anihydramnios	2.33%					
Oligohydramnios	2.33%	2.86%	16.67%		7.69%	
Blood loss	5.81%				2.56%	25%
HIV & HCV	2.33%	2.86%	8.33%			
Flowmetry changes					2.56%	
Risk of abortion	9.30%	14.29%		20%	5.13%	
Varix, edema, vascular diseases	3.48%	5.71%	8.33%	13.33%	5.13%	
IUGR (uterine infections)		11.43%	8.33%	13.33%	5.13%	25%
PROM	34.88%	17.14%		20%	25.64%	25%
Risk of premature labor	8.14%	2.86%	16.67%	6.67%	7.69%	
Cardiotocography	8.14%	11.43%		13.33%	7.69%	
Precocious contractions	3.48%	2.86%			2.56%	

After analysing the diseases concerning pregnancy, we focused our attention on the different types of childbirth and on why it was necessary to employ caesarean section or any kind of surgical procedure.

The percentage of women who had a spontaneous labour was low. The result was 57.52% for Eastern European countries and Russia, 46.55% for Central and South America, 45% for Arabian countries, the Middle East and North Africa, 51.52% for Asia and 36.36% for India. After interviewing some patients, we found out that they preferred facing pregnancy and childbirth in Italy rather than having a baby in their countries of origin. It should also be noted that tricotomy was applied to all the patients whereas clyster was given only to some patients (as usually is the case for Italian patients). Caesarean sections were performed on women coming from Eastern European countries and Russia (28.10%), from Centrral and South America (29.31%), from Arabian countries, the Middle East and North Africa (10%), from Asia (25.76%) and from India (36.36%).

Table 2. — *Cause of emergency caesarean section.*

	Eastern countries and the Russian federation	Central-Southern America	Africa	Arab countries, the Middle East and North Africa	India and Sri-Lanka
Central foetal placenta previa	1	1	1		1
Foetal distress	5		1	2	
Cardiotocography (CTG) not reassuring	7	3	3	6	
Detachment of the placenta	4				
CTG not responsive	1	3			
Uterine infections	2	4	1	4	
Caesarean section in progress (menace rupture of the womb)	4	1		2	2
Gestosis (preeclampsia)	1	1		1	
Hypertension	5	1	1	1	1
Blood-flow problems		2		2	
Oligohydramnios	3	3	1	2	
PROM	5	1			
Distention arrest		1		4	
Unfulfilled commitment of the part involved	10	2		23	
Dystocia	2	1		1	
Sacral rotation	3	1		2	
Soiled amniotic fluid	5	2	2	1	
Other	3			1	

For most of the patients, emergency caesarean section was justified for many reasons (Table 2). What can at once be observed is the high number of diseases identified in women from Eastern countries; they had more cases of foetal suffering, above all during advanced labour.

The "unfulfilled committment of the part involved" (or the unfulfilled newborn's expected position), together with dystocia of the movable body, e.g., sacral rotation, implies a more frequent resort to caesarean section for women from Eastern countries, followed by Asian and South American women.

Moreover, data relative to cases of hypertension and gestosis, which, as already seen, were more frequent in women from Eastern countries. These women were the only ones that had serious problems, such as detachment of the placenta.

Pathologies of the amniotic fluid, such as oligohydramnios and soiled amniotic fluid, substantially affected the typology of birth for all the groups. Percentages of caesarean sections carried out:

– 13.73% for women from Eastern countries and Russia;

– 24.14% for women from Central/South America;

– 40% for women from Africa;

– 45% for women from Arabian countries, the Middle East and North Africa;

– 13.64% for women from Asia;
– 27.27% for women from India.

As for caesarean sections we noted that the main reason for the procedure was advanced rupture of the womb, which in Arabian women was equal to 100%. In contrast, twin pregnancies and podalic births were mostly evident in women from Eastern countries (respectively, 14.29%; 14.29%) and from South America (respectively, 7.14%; 14.29%). As already mentioned, we noted HIV infection in Eastern women (9.52%) and African women (12.50%). In Table 2 "other" refers to cases relating to haematological diseases, such as allo-immune neonatal thrombocytopenia, sickle-cell anaemia, vulvar infections, foetal macrosomia and uterine malformations. There were six operational births involving only Asian women in which there was a higher application of the vacuum extractor due to unsuccessful exitis of the baby, probably caused by the type of pelvis, foetal macrosomia, sacral rotation and other reasons. The use of episiotomy involved 86.52% cases of parturients from Eastern Europe and Russia, 85.19% from Central/South America, 66.67% from Arabian countries, 55.56% from the Middle East and North Africa, 77.50% from Asia and 75% from India.

Today, the practise of episiotomy in Italy and in many clinical environments is considered "routine": it is wrongly supposed that this practise is effective against vaginal laceration and compression of the foetal head during the expulsive stage. Episiotomy was not implemented in cases in which the patient showed higher tissue elasticity, in multiparous women or in those urgently admitted whose foetal head was already at the perianal level (lack of space and time to implement an episiotomy). Amniorrhexis was applied to parturients from Eastern countries and Russia (15.03%), on pregnant women comimg from Central/South America (12.07%), from Africa and Arabian countries, the Middle East and North Africa (10%) and eventually to Asian women (12.12 %). It should be noted that amniorrhexis was not frequently implemented: the high percentage of 15% involved only women from Eastern countries, whereas was completely absent in those coming from India.

Conclusions

Data collected in this work along with the results and of previous research, present a plurality of opinions, situations and attitudes which are difficult to classify. Histories of women from countries culturally different from Italy are difficult to explain, especially those histories concerning such a special period in a woman's life, such as pregnancy and postpartum. If we want to sum up this study, we can note that most immigrants that come to Italy are from Eastern Europe, followed by Asia and South America. Moreover, we can observe how different religions, traditions, habits and customs are significant in how a pregnancy is coped with. In fact, Muslim women have problems being attended by male physicians during pregnancy and birth, and consequently echographies and medical examinations were not made very often. In spite of the few medical examinations carried out on Arabian women, it can be seen that the Arabians had natural childbirth, except for a few cases of caesarean section carried out because of risk of womb rupture.

In African women we noted a longer gestation period than the other groups of women and, that only one-third of them had a natural childbith. Very significant is the fact that in their country pregnancy is controlled and carried on by "the mother and the chief of the tribe". In Italy it is completely different because foreign women undergo medical examinations and clinical tests with trust and self-assurance.

Women from Eastern European countries also controlled their pregnancies, except for Romanian women who did not undergo medical examinations or clinical tests. More than half had natural childbirths, whereas in the rest urgent caesarean sections were performed. Among these we noted the highest percentage of cases of preterm labour (9.80%), with only 32 weeks of gestation. From a psychological point of view, these women are more likely to ask for help during labour and childbirth because many are unmarried mothers. On the contrary, the Chinese and Asians in general showed a more passive attitude. They were able to accept and tolerete the pain of labour and childbirth, but they were not able to tolerate pain caused by surgery, such as episotomy, caesarean section and mere injections. Chinese women less frequently underwent medical examinations because of work schedules (the entire day) but also because they were more confident in Chinese medicine. In addition, they did not undergo haematological tests done during pregnancy because they considered them unnecessary. (In fact, according to their culture, "to draw blood" means "to take away energy"). For Indian and the South American women a very similar percentage was seen for birth and development. In fact, for both caesarean section was implemented in two-thirds of the cases.

Almost all the women examined had children who were in good health with an average body weight between 2,900 g and 3,400 g, and with an Apgar score between 8 and 9. Only for a few newborns, above all premature babies, this score at birth was equal to 6 and, in most cases, improved at the 5th minute of life.

In conclusion, we observed that a foreign woman who begins a pregnancy in Italy has her own standard of rules to follow, which is very different from the Italian standard of strict medical care with many examinations, tests, echography, etc. In fact, in Italy we are used to applying techniques that have proven to be efficient in protecting and supervising pregnancy. This is because, first of all, Italian women are inclined to reproduce less and less and, above all, because Italian women experience pregnancy and childbirth without the serenity which should "naturally" characterise the period of pregnancy.

References

[1] Istat: "La presenza straniera in Italia negli anni '90. Informazioni 61". Roma, Istituto Nazionale di Statistica, 1998.

[2] Agenzia Romana per la Preparazione del Giubileo, Convegno Internazionale: "Dossier di ricerca: Migrazioni: scenari per il XXI secolo", 2000.
[3] ISTAT: "La popolazione straniera residente in Italia al 1° gennaio 2005". Rapporto 2005.
[4] Caritas di Roma, Immigrazione: "Dossier Statistico 2001. XI Rapporto sull'immigrazione". Edizioni Nuova Anterem 2001.
[5] Pittau F.: "La nuova realtà socio-demografica dell'immigrazione femminile". Roma, Percorsi Editoriali, 2001.
[6] Caritas: "Dossier Statistico Immigrazione, 2002". Roma, 2003, 2004.
[7] Basso P., Perocco F.: "Immigrazione e trasformazione della Società". Franco Angeli Editore, Milano 2000.
[8] Di Cristofaro Longo G., Morrone A.: "Cultura, salute e immigrazione". Roma, Armando, 1995.
[9] Mernissi F.: "L'harem e l'occidente". Giunti, Firenze 2000.
[10] Geraci S., Colasanti R.: "Aspetti socio-sanitari dell'immigrazione e.c. in Italia (medicina e migrazioni)". Quaderni di Azione Sociale, anno XXXVIII, 1993, 91.
[11] Melotti U.: "L'immigrazione: una sfida per l'Europa". Ed. Associate, Roma, 1992.
[12] Morrone A.: "Salute e società multiculturale". Milano, Raffaello Cortina, 1995.
[13] Caritas di Roma: "Forum per l'Intercultura, Migrazioni. Paesi e culture: esperienze europee a confronto". Roma, Sinnos Editrice, 1998.
[14] Geraci S., Marceca M.: "Donne e bambini immigrati". In: Geddes M., Berlinguer G. (eds.) La salute in Italia, Roma, Ediesse, 1998, 43.
[15] Annali Istituto Superiore di Sanità: "La salute riproduttiva delle cittadine straniere del Lazio". 2002.
[16] Geraci S., Colasanti R.: "Aspetti socio-sanitari dell'immigrazione e.c. in Italia (medicina e migrazioni)". Quaderni di Azione Sociale, anno XXXVIII, 1993, 91.
[17] Favaro G., Tognetti Bordogna M.: "Donne dal mondo, strategie migratorie al femminile". Milano, Guerini, 1992.
[18] Melchiori P. (a cura di): "Donne del Mediterraneo: identità, convivenze, mediazioni". Al – Milano, COS, 2000.
[19] Kouider S.: "Donne immigrate musulmane: realtà e stereotipi, in "Donne, migrazioni, diversità". Presidenza del Consiglio dei Ministri, Commissione Nazionale per la Parità e le Pari Opportunità tra Uomo e Donna, Istituto poligrafico e Zecca dello stato, Roma, 2002.
[20] Saint-Blancat C.: "L'immigrazione femminile magrebina: nuove identità di genere e mediazione tra culture". In: Basso P., Perocco F. (a cura di): Immigrazione e trasformazione della Società, Milano, Franco Angeli Editore, 2000.
[21] Kitzinger S.: "Donne come madri". Milano, Bompiani, 1980.
[22] Miceli M., Di Lallo D.: "La salute riproduttiva delle donne immigrate: uno studio nella città di Roma negli anni 1982-1992". *Epidemiologia e Prevenzione*, 1996, *20*, 80.
[23] Bona G., Zafferani M. e Gruppo di Lavoro Bambino Immigrato: "Stato di salute dei neonati figli di immigrati". *Rivista Italiana di Pediatria*, 1998, *24*, 713.
[24] Spinelli A., Baglio G., Donati S., Grandolfo M.E., Andreozzi S., Geraci S. *et. al.*: "Gravidanza, parto, puerperio: una ricerca su donne immigrate". Atti del Convegno "Immigrati e salute sessuale riproduttiva: le risposte dei servizi". 26-27 Novembre 1998, Milano, 35.
[25] Donati S., Spinelli A., Grandolfo M.E., Baglio G., Andreozzi S., Pediconi M., Salinetti S.: "L'assistenza in gravidanza, al parto e durante il puerperio in Italia". *Annuali dell'Istituto Superiore di Sanità*, 1999, *35*, 289.
[26] Baglio S., Spinelli A. *et. al.*: "La gravidanza in Italia tra le donne immigrate". In: Atti del Convegno "Nascere stranieri a Milano", 1998.
[27] Dal Verme S., Parolari L., Sacchetti G.: "La biologia non è esterna alla cultura: La formazione nell'area sanitaria". In: Crinali, Professione Mediatrice Culturale. Un'esperienza di formazione nel settore materno infantile, Milano, Editore Franco Angeli, 2001.
[28] Dall'Ara P.: "L'assistenza ostetrica alla luce delle modificazioni etniche e sociali della fine del secondo millennio". In: Atti del Convegno U.I.C.E.M.P.: Immigrati e salute sessuale e riproduttiva: le risposte dei servizi, 1998.
[29] Donati S., Grandolfo M. *et. al.*: "Analisi epidemiologica dell'evento nascita e valutazione dell'assistenza a gravidanza, parto e puerperio". In: Todros T., Vasara F., Nascere nel 2000, Bologna, Il Mulino, 2001.
[30] Favaro G., Giacobini M., Tognetti M.: "Identità cangianti, nascite, luoghi femminili e legami familiari nella migrazione". In: "Marginalità e Società", 1994, 28.
[31] Crinali-Associazione di Ricerca, cooperazione e formazione interculturale tra donne, Professione mediatrice culturale. Un'esperienza nel settore materno infantile, Milano, Franco Angeli editore, 2001.
[32] Castiglioni M.: "La mediazione linguistico culturale". Milano, Franco Angeli Editore, 1997.
[33] "Crinali"-Bestetti G. (a cura di): "Sguardi a confronto. Mediatrici culturali, operatrici dell'area materno infantile, donne immigrate". Milano, Franco Angeli Editore, 2000.
[34] Nathan T., Stengers I.: "Medici e stregoni". Torino, Bollati Boringhieri, 2000.
[35] Bruno P.: "Introduzione alla medicina tradizionale cinese". Roma, Mediterranee, 1986.
[36] Morrone A., Mereu F.: "La nuova realtà dell'immigrazione: dal singolo alla famiglia dinamiche famigliari e aspetti sociosanitari. La mediazione culturale tra l'estraneo e il familiare" (a cura) Andolfi M., Milano, Franco Angeli, 2003.
[37] Diasio N., Geraci S.: "L'angelo triste: operatori socio-sanitari e percezione dello straniero". In: Delle Donne M. (ed.). Relazioni etniche. Stereotipi e pregiudizi, Roma, EdUp, 1998.
[38] LABOS: "Osservatorio sui bisogni sociali: famiglie immigrate bisogni e servizi sociali". (Collana nuovi bisogni e nuove politiche sociali). Direzione Generale dei Servizi Civili del Ministero dell'Interno. TER, Roma, 1993, 17.
[39] Mazzetti M.: "Il bambino straniero in Italia: crescita psicologica ed igiene mentale". In: Geraci S. (a cura di) Argomenti di Medicina delle Migrazioni. Parma, Peri Tecnes, 1994.
[40] Morrone A.: "Cure mediche appropriate. Per tutelare la salute della donna immigrata". *Famiglia Oggi*, 1998, *21*, 6.
[41] Morrone A.: "Medicina interculturale: un'esperienza di dieci anni a Roma". In: Di Cristofaro Longo G., Morrone A. (eds.) Cultura, salute, immigrazione. Roma, Armando, 1995.
[42] Geraci S.: "Immigrazione femminile: quale assistenza sanitaria?". Roma, Percorsi Editoriali, 2001.
[43] Morrone A., Mazzali M.: "Le stelle e la rana. La salute dei migranti: diritti e ingiustizie". Milano, Franco Angeli, 2000.
[44] Morrone A.: "Problematiche sanitarie in una società multiculturale". In: DeMicco, V. (ed.), Le Culture della Salute, Liguori Editore.
[45] Buonomini I., Valeri M., Morrone A.: "Aspettare un figlio in un paese straniero". In: Morrone A., ...? Salute e società multiculturale. Raffaello Cortina, Milano 1995.

Address reprint requests to:
C. FEDELI, M.D.
Department of Gynaecological Science
Perinatology and Child Welfare
General Hospital "Umberto I"
Viale del Policlinico, 155
00161 Rome (Italy)