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BREASTFEEDING AND SOCIAL, CULTURAL, GEOPOLITICAL EMBODIED BARRIERS

LACTANCIA MATERNA Y LAS BARRERAS SOCIALES, CULTURALES Y GEOPOLÍTICAS

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SUMMARY

This study in medical anthropology was conducted at the National Institute for Health, Migration and Poverty (INMP), in Rome, Italy, and was carried out in 2013-2014 as part of the project "Clinical and social evaluation of medical practices in the treatment of infectious diseases in paediatrics for children of vulnerable populations". At the end of the project, it was possible to ensure diagnostic accuracy, the proper prescription of antibiotic therapy and improve family care of children affected by pharyngotonsillitis. In addition, it was possible to acquire knowledge of the health of children with respect for certain social determinants. The anthropological research targeted mother's of children and adolescents from the age of 3 to the age of 17 immigrated to Rome from Africa: sub-Saharan and North; furthermore from Asia: Indian subcontinent, West Asia, Eurasia, Middle East, Arabian peninsula; South-East Europe; Centre and South America. In this article we'll consider only mother's of 39 children and adolescents from Latin America (Argentina, Brazil, Colombia, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, Peru, Dominican Republic, Uruguay and Venezuela). The study aimed at analysing the formation and the socio-cultural representation, which emerged from interviews of women regarding barriers to breastfeeding; the effects of breastfeeding on the psychological and physical health of infants; the social and domestic consequences, which affect women who did not stop breastfeeding when they feel they should have.

In Italy, as in other destination countries for global migrations, barriers that prevent the access to the healthcare system must be removed, barriers that are accentuated by linguistic and cultural incomprehension, through adequate multidisciplinary healthcare settings such as the one we are presenting, composed of a medical doctor, an anthropologist and a cultural mediator.¹

Key words: medical anthropology, infectivology, transdisciplinary, latin America.

RESUMEN

De 2012 a 2013 se llevó a cabo una investigación de antropología médica en el Instituto Nacional para la Salud, la Migración y la Pobreza (INMP) de Roma, Italia, como parte del proyecto de infectología pediátrica dirigido hacia menores de edad italianos e inmigrados en condiciones socio-económicas frágiles, afectados por faringitis o faringoamigdalitis aguda. Al finalizar el proyecto se pudo garantizar la precisión diagnóstica y la adecuada prescripción de la terapia antibiótica; además, mejorar la atención familiar de los niños afectados por faringoamigdalitis. Además, pudieron adquirir conocimientos sobre el estado de salud de los niños con respeto de ciertos determinantes sociales. El estudio médico antropológico ha involucrado a las madres de niños y adolescentes desde los 3 hasta los 17 años inmigrados de América Latina, Asia, África, hacia Italia; si bien en este texto, se toman en consideración a las madres de 39 niños y adolescentes provenientes exclusivamente de América Latina (Argentina, Brasil, Colombia, Ecuador, El Salvador, Honduras, Nicaragua, Paraguay, Perú, República Dominicana, Uruguay y Venezuela) y se han incorporado algunas enfermedades que las mujeres entrevistadas creyeron transmitir a sus propios hijos a través del amamantamiento. Los resultados de la investigación han evidenciado que las mujeres construyen algunos tipos de enfermedades y sufrimientos que padecen sus hijos a través de factores como el *susto*, el *coraje*, la *muina*, el *enojo* y el *mal de ojo*. En Italia, así como

¹The presence of a cultural mediator, carrier of the language and the culture of the interviewed women, was fundamental not only for translation purposes but also for the interpretation, explanation, and the codification of words, symbols and signs of the culture and social background evoked during the interview.

en otros países destino de corrientes migratorias, existe la necesidad de sobrepasar las barreras de acceso a la salud cuya causa se puede identificar en la incomprensión lingüística y cultural a través de grupos transdisciplinarios de salud, como el que presentamos en este estudio, compuesto por antropólogos, médicos y mediador cultural.

Palabras clave: antropología médica, infectología, transdisciplinario, Latinoamérica.

INTRODUCTION

The necessary milk, memories of an absence

Breastfeeding during the first 6 months postpartum has nutritional, immunological and psychological benefits for the child and the mother (Tenorio, 2014). Breastfeeding is the most cost effective way to decrease child mortality and morbidity in developing countries. In particular, breastfeeding is important for the protection of children against infectious diseases such as diarrhea and acute respiratory infections (Li *et al.*, 2014; Miller, 2005). However, in some cases breastfeeding is not frequent (WHO, 1981).

Early cessation of breastfeeding has adverse health and social implications for women and children. As a result, these produce greater expenditure on the national health care provision, and increase health inequalities.

In Latin America 38% of infants are exclusively breastfed during their first six months of life (PAHO & WHO, 2013); children in Latin America and the Caribbean are breastfed on average for 14 months, though as with other breastfeeding practices, there is great variability in the duration: the average is seven months in the Dominican Republic and Uruguay; 18 months or more in Bolivia, El Salvador, Guatemala, Honduras and Peru; 14 months in Brazil and 10 months in Mexico (PAHO & WHO, 2013).

In fact, numerous studies (Castaldo, 2015; Burkhalter and Marin, 1991; Forman *et al.*, 1992; Labbok, 2013; Patel, 2013) have shown that breastfeeding is interrupted because of specific factors related to a sociocultural system of reference.

The ethno semantic approach to breastfeeding of a specific culture - breastfeeding that may take place, be interrupted or not occur at all- determines the growth and the health of the child's body and thus of this same individual as an adult. The conditions of the mother during pregnancy and maternal milk, but also other fluids such as blood (Castaldo, 2004) in numerous non-western contexts are sometimes seen as causes of transmission of diseases and of psychological distress that appear at birth and that are culturally codified (Barnett, 2005; Castaldo, 2004; Castro *et al.*, 1998; Mendenhall *et al.*, 2012; Mull, 1992). In order to avoid these, mothers must interrupt breastfeeding (Forman *et al.*, 1992), and in their native cultural context, this is not only understood but often recommended.

Women seem to incorporate the moral blame of psychological and physical illnesses, which occur, and represent the signs of these illnesses on the body of their children starting from their birth (Hurtado, 1989). This happens when women who are breastfeeding undergo traumatic experiences, which can affect their milk, in their native context, before emigration. These are: individual or collective violence, torture and abuse; private forms of violence such as psychological and physical abuse and beatings by their partner (Johnson and Johnson, 2013); the death of a family member or of a community member (Malkki, 1995); furthermore these experiences include

persecutory supernatural-magic factors, identified by the hispanophone Latin American women interviewed as *susto* (Castaldo, 2015; 2004; Castaldo *et al.*, 2014, Mysyk, 1998; Rubel *et al.*, 1995; Collado, 1988; Simons & Hughes, 1985; Signorini & Lupo, 1989; Baer & Penzell, 1993), *coraje* (Mendenhall *et al.*, 2012; Donlan & Lee, 2010), *mal de ojo*, *muina* and *enojo*, (Seijas, 1972). Such concepts in hispanophone Latin America and in the Mediterranean region indicate feelings of envy capable of causing illnesses such as *mal de ojo*, anger or resentment like *enojo*, *muina* and *coraje*, and finally of causing feelings of fear and fright as is the case with *susto*. The latter is described in literature also as a culture-bound syndrome², a semantically complex concept in that the same signifier *susto* can indicate both an illness and an etiological factor (Seijas, 1972). Represented as an illness it seems to appear following a strong emotion and a threatening or sudden impression, natural or supernatural, and can especially impact women and children resulting in illness.

Cultural systems and traditional treatments and knowledge are able to provide an interpretation for and signify such childhood illnesses, whereby milk is seen as “bad” because of a series of culturally accepted etiologies such as *susto* (“fright”) (Baer *et al.*, 1993; Castaldo, 2004; 2015; Castro *et al.*, 1998; Mendenhall *et al.*, 2012; Mysyk, 1998; Palma *et al.*, 1974; Seijas, 1972), *coraje* (Collado Ardon, 1988; Castaldo 2004; 2014; 2015) *muina*, *enojo* (“anger”) (Rubel *et al.*, 1995) and *mal de ojo* (“evil eye”).³ In Italy, in a context where the allopathic approach prevails, such interruption of breastfeeding, and especially the effects on the children who are at the center of medical attention requested by the mothers, cannot be fully understood. Biomedicine is not able to recognize factors that differ from the purely biological element of a body and does not see this body as being also historic and cultural; this situation can lead to noncompliance by the nuclear family with a medical examination and consequently with the diagnostic procedure and treatment that might be prescribed (Guerrero *et al.*, 1999; Seijas, 1972; Wikan, 1999; Zuñiga, 2012), an attitude that prevents full access to the National Health System and poses a problem for the health of migrant populations (Palma *et al.*, 1974; Simons, 1985).

The work of transdisciplinarity

This article presents the preliminary results of an ongoing prospective study in medical anthropology carried out in 2013, in the wider context of the project “Clinical and social evaluation of medical practices in the treatment of infectious diseases in pediatrics for children of vulnerable population” carried out at the National Institute for Health, Migration and Poverty (NIHMP) in Rome. The realization of the project required the presence of a multidisciplinary team composed of an infectious disease specialist, a pediatrician, an anthropologist, a pediatric nurse, a developmental psychologist, a social worker, a staff of 32 cultural mediators of the NIHMP, specialists in various medical fields, a pediatric neuropsychiatrist, a cardiologist, an epidemiologist and a pediatric ecographist.

The eligibility criteria for the sampling required the children between the ages of 3 and 17 to be born in Latin America (*Table 1*) and to have immigrated to Italy with their family, with one parent,

²A notion that is substituted by three different concepts in the DSM V: *cultural syndromes*; *cultural idioms of distress* and *cultural explanations of distress or perceived causes*.

³These concepts, frequent in Hispanic America and in the Mediterranean Basin, indicate feelings of envy that can cause illnesses, such as *mal de ojo*, (rage), *enojo*, *muina*, *coraje*, and *susto*, also described as a culture-bound syndrome, associated in literature to a critical state, an illness or an etiological factor that arises as a consequence of an impacting emotion or of a sudden threatening impression, present or past, natural or supernatural, that can occur and cause illness in people of all ages and can transmit diseases and distress especially to children if transmitted through breastfeeding.

or to have joined a relative previously emigrated, and to have been resident in Italy for not more than two years.

The Latin American population was chosen because of the large number of immigrants in Rome from this macro socio-geographical area. These types of displacement are defined as socio-economic by the current European migration policies, which aim to contain and manage migration (see the Frontex Agency) in a more coercive way than before. It must be noted that this type of legislation is built around the dichotomy that is today stronger than ever between forced migrants (refugees) and economic migrants, instrumental in the control of “irregular” migration and in the defense of ephemeral borders and territories, and not so much aimed at the protection of the rights of asylum seekers.

Latin American migration in Europe had a predominantly political nature in the '70s and '80s, and consisted mainly of people exiled from Argentina and Chile, to name only a few contexts. In the '80s and '90s it diversified, the migration flow was now linked to labor patterns of impoverishment and inequality in several countries in Latin America (Yépez del Castillo and Herrera, 2007). This is not the context to dwell on the political, economic and socio-cultural processes that produced and modified the reasons for the displacement of people, especially women (IDOS, 2015), from Latin America to Europe; however it should be noted that in Italy the immigrants of Latin American origin represent one of the twenty citizenships most present, more than half of them being women and minors. It is moreover mainly people from Peru (about 110,000) and Ecuador (about 89,000) (IDOS, 2015).

The children were enlisted by a Brazilian cultural mediator who contacted the Latin American communities in Rome by visiting places of worship, shelter homes for children and their mothers and contacting women and mothers who had been assigned to the day hospital of the NIHMP.⁴ The families that were contacted were directed to the pediatric infectious diseases department where the first examinations took place and where the medical referent for the project explained the protocol so as to begin the medical procedures for the children.

We evaluated every immigrant child by using GLNBI (National Working Group for Immigrant Children) diagnostic protocol (*Figure 1*) (Adami Lami *et al.*, 2007).

GLNBI drew up a diagnostic-aiding protocol for examining children of immigrants at their entry to Italy, in order to assess their health status, often poorly documented, in order to identify infectious diseases, nutritional deficiencies, immunization status, intestinal parasitism or other pathologies.

In agreement with other studies and both Italian and international guidelines, an early and complete sanitary screening is advised at least in children coming from high risk countries and settings with low socio-sanitary conditions (DuPlessis and Cora-Bramble, 2005).

⁴The presence of a cultural mediator in the setting allowed to optimize the identification of the needs of the patients, in that the mediator did not act merely as a translator but played a crucial role in questioning, interpreting, explaining and providing context for the words, symbols and signs of the culture and society of which the family is a carrier.

Anamnesis
Physical Examination
Laboratory tests: glycemia, creatinine, blood count and differential white blood count, alkaline phosphatase, transaminase, blood protein electrophoresis, ferritin, ESR (erythrocyte sedimentation rate), HBV and HCV infection markers, TPHA, HIV 1-2 antibodies, intestinal parasite investigation (on 3 samples), urinalysis, Mantoux intradermal reaction.
According to provenance state:
• Belorussia and Ukraine: TSH and FT4 dosage;
• Latin America, Africa, Asia: antibodies against cysticercus;
• Eastern Europe, Latin America, India: antibodies against toxocara.
Second level examinations:
• Chest X-Ray if positive Mantoux.
• Hb electrophoresis and/or Glucose-6-Phosphate Dehydrogenase dosage: according to blood count results in children coming from high prevalence areas for hemoglobinopathies and/or red blood cells' enzyme deficiency.
Specialists' consultancies: all of the requested as needed.
Vaccine schedule: serological research of vaccine's immunization or boosts if only one dose was performed on the child, according to the Italian vaccine schedule.

Figure 1.- National working group for immigrant children's diagnostic aiding protocol for international adopted and immigrant's children (2007).

A complete physical examination for assessing the overall child health status and the following tests were performed and, when facing potential specific pathologies, a specialist's visit (dermatologist, oculist, otorhinolaryngologist), were prescribed.

All the children were without symptoms or evidence of illness at the time of screening. Surprisingly, 47% had at least one previously unknown health problem if we consider only laboratory tests. If we consider also the specialist's visit (dermatologist, otorhinolaryngologist, oculist) the value rose to 68%.

During the first pediatric infectious diseases examination the anthropologist carried out a semi-structured interview with women, mothers of infants and adolescents, in private to ensure confidentiality, with the aim of analyzing the effects of maternal milk on the psychological and physical health of the children, on the basis of the lines of reasoning provided by mothers in the context of emigration and immigration. The conversation was never forced so as to respect feelings, emotions and provide the time needed by each woman interviewed and by the family member with her, especially children who, during the interview with the mother, waited with the father when present, with the social worker, with the child and adolescent psychologist or with the paediatric neuropsychiatrist. Adolescents instead waited outside the room while their mother was being interviewed. According to the Declaration of Helsinki, written informed consent was

obtained from each participant included in the study, before interview.

The interview was carried out in Spanish, or in Italian in the case of women who preferred to use this language; the Brazilian cultural mediator translated simultaneously into Portuguese. The interview, that consisted in 37 items, open and closed, investigated: breastfeeding; the systems of etiological and therapeutic treatment of reference in emigration and immigration to Italy; specific forms of social distress (linked to the socio-economic conditions of the families living in Italy) and other forms of child illness where the moral and causal connection is believed by the mother to be in specific etiological and socio-economic factors spread in Latin-America, especially in the Hispanic America, such as *mal de ojo*, *susto*, *enojo*, *coraje*, and *muina*. These illnesses were experienced by the mothers and then passed on to their children through breastfeeding, thus leading to a negative alteration in the normal course of gestation and affecting the milk they gave the infants.

The interview was translated simultaneously by the anthropologist; it lasted about 45 minutes-1 hour. The women were interviewed one time for every child, though some aspects not fully dealt with were further discussed with the women on days in which they came to the day hospital for the blood tests of the children, as scheduled by the medical protocol, and on the days they came to pick up the results, for a total of three times. There was no dispersion of the sample of participants; the interview was carried out in 100% of the cases during the first medical examination.

Observations and analysis: migration in children's bodies

Table 1 shows a summary of demographics for the sample of 39 participants. The sample is composed of 39 children of an average age of 12, 4 years, of which 34 (89%) speak Spanish and 4 (11%) Portuguese. The minors arrived in Italy with different typologies of migration, the main types being: on their own, to join their family previously immigrated, came with all the family, came to Italy with the mother, looking for work and in search of social and economic stability; finally came to Italy with the father to join mothers and wives immigrated previously.

The children are mostly from a one parent family, for a total of 30 mothers with children that belong to categories of vulnerable population. Eight of the interviewed women are unemployed, 20 are employed in services and as caretakers, but of these only seven have a contract, while the rest, are paid by the hour and work illegally.

Table 1.- The distribution of the studied population

	Males	Females	Total
Peru	4	7	11
El Salvador	5	4	9
Ecuador	1	3	4
Brazil	3	1	4
Colombia	1	1	2
Venezuela	2	0	2
Honduras	0	2	2
Dominican Republic	1	0	1
Nicaragua	1	0	1
Argentina	1	0	1
Paraguay	1	0	1

	Males	Females	Total
Uruguay	1	0	1

The interviews carried out with the mother's show that 38 out of 39 children were breastfed (*Table 2*) and the period range of breastfeeding varies from one month to two years and a half. Of these 33 were breastfed for a period of time that goes from one month to two years and a half, with no specific duration prevailing. The duration is not known for five children, their mothers did not answer the question because they said they could not remember. It is important to note that the mothers of 19 children reported that they felt forced to stop breastfeeding, and continued feeding with artificial milk, cow's milk or tea. Of these 14 stopped breastfeeding before their child turned two, and said they had done so to avoid passing on through the milk the traumas and suffering they were undergoing, and to avoid compromising the health of their child. This indicates a mother-child relation structured around the inheritance of contagion and on causal connection (Zempléni, 1987). Five women stopped breastfeeding because of work related issues or because of insufficient milk.

The two main reasons given by the mothers for premature cessation of breastfeeding are:

- they suffered traumas, came into contact or were attacked by invisible agents who relate to the socio-cultural system of reference (*susto, mal de ojo, coraje, muina, enojo*);
- they were subjected to violence or psychological and physical abuse by their husbands, such as maternal intimate partner violence (IPV) (James *et al.*, 2014; Wikan, 1999).

Table 3 synthetically reports the reasons given by the women for cessation of breastfeeding.

Table 2.- Infant breastfeeding practice		
Breastfed child ever	Total	%
0	0	0
< 3 meses	10	26
> 3 – 6 mesees	4	11
>6 mes – 1 año	4	11
>1-2 años	7	18
> 2 años	8	21
NR	5	13

Breastfeeding barriers and the embodied fright

Refugees, asylum seekers and victims of torture require an epistemological framework which may allow the convergence of experienced traumatic events during armed conflicts, individual and collective persecution, threats and violence undergone while fleeing, and violence, uncertainty, nostalgia, disappointment experienced in the host countries. It is also necessary to consider the violence in the family, the traumas most intimate that often manifest themselves with heterogeneous expressions of psycho-physical suffering: signs of alienation, rejection of the host context (Fanon, 1959; Beneduce, 2010). With respect to these aspects, the breastfeeding period reveals interesting perspectives.

Mothers in fact imagine and describe themselves as being responsible for illnesses and psychological and physical anomalies manifested by their children since birth (Mabilia, 2000) if

during breastfeeding they are subjected to traumas such as maternal intimate partner violence (IPV), if they come into contact with invisible entities which alter and damage the nutritional values of the milk and if, as a consequence, they do not immediately and definitely stop breastfeeding. These traumas and invisible agents are identified and represented by hispanophone Latin American women with the concepts of *mal de ojo*, *susto*, *enojo*, *coraje*, *muina*, depending on their socio-cultural systems of reference. These are not mentioned during medical examinations, as they are not only concepts expressed in a different language, and have a meaning only in that precise language, but are words that do not have a meaning for western biomedicine which is not able, on its own, to understand types of distress that are alien to allopathic nosology (Hunt and Arar, 2001). It is important to highlight that women immigrated to Italy turn to the SSN expressing needs relating to the health of their children; these children are also immigrants, and have manifested such types of psychological and physical distress from birth, for which the mothers feel they are responsible.

Table 3.- Problems encountered by mothers of 19 Latin-American children <3 month - 1-2 years based on interviews

Breastfeeding period	Problem	No.
< 3 months	<i>Susto</i> : "After having suffered from <i>susto</i> my milk stopped for a week and then came back with medicines, but he didn't want it anymore";	
	"When I was pregnant I suffered a terrible electric shock and the iron caught fire: my milk was watery, this is why I breastfed only for three months"; "Because I had a very strong <i>susto</i> and the milk was bad".	6
	Mother working outside home.	1
	<i>Mal de ojo</i> and mother working outside home.	1
	Domestic violence and mistreatment cause feelings of <i>enojo</i> : "When I was pregnant the father was a drug addict and beat me a lot. I passed the <i>enojo</i> through my milk".	2
3 – 6 months	Domestic violence and mistreatment cause fright as <i>susto</i> ; mother working outside home.	2
	The mother could not wake up at night to breastfeed.	1
> 6 months – 1 year	Domestic violence and mistreatment cause feelings of <i>coraje</i> : "my husband beat me a lot and I was afraid to transmit my <i>susto</i> to my son. He is very afraid, he is afraid because of all the traumas I suffered and because I passed them on to him".	2
	<i>Mal de ojo</i> .	1
	Maternal distress of various kind.	2
> 1-2 years	Maternal milk was insufficient.	1

The medical field is one of the areas in which the exercise of power, bio-power is expressed in a coercive way and exercised on the bodies of migrants by means of rationales and instruments

which search for signs of pathological evidence (Beneduce, 2010). One of these rationales concerns medicalization and scrupulous attention is given to the horrors that migrants and refugees have witnessed: torture, violence, persecutions that have forced the migrants to flee their home towns. The work of Fassin and Rechtman (2007), Fassin and D'Halluin (2005), have shown how exclusive attention is given to the body of migrants requesting international protection; the sick and suffering body emerges as a privileged instrument for exercising the right to citizenship. The body that suffers in an evident way becomes the place where migration policies are inscribed, and is transformed into a battlefield in which one struggles to affirm the present and the future, not only the past of the 'migrant citizen'; this citizen today needs concrete responses to the profound violence and traumas caused by the political, economic and social contradictions experienced in daily life.

Fassin (2006) mention that to legitimize the disease to the point that it is the only justification for the presence of a migrant means condemning many undocumented foreigners to officially exist only as sick people. These statements point to a political strategy that pays attention to the body only when it has suffered persecution in the country of origin, while individual memory becomes less important and does not itself constitute sufficient proof of the suffering experienced. In order to seek international protection it is necessary that the person presents elements that prove the accuracy of his or her story, such as medical certificates. However, these considerations make it necessary to give attention to other rationales of biopolitics, and to consider the present of the immigrant and not only his or her past. In the clinical field, ethnography reveals the violence which arises from misunderstanding the semantics of the suffering brought by migrants and biomedicine unprepared to confront other moral conceptions and policies of health and disease. It is here that the health needs risk not being taken into account.

In order to mediate between the medical doctor and the child's family and convey such message it is crucial to adopt a correct socio-sanitary approach capable of accepting and providing answers to the requests for treatment that the migrant families present. The contribution of anthropology, in a context of daily hospital activity in the department of pediatric infectious diseases, is in fact a fundamental contribution in that it allows for an epistemological reflection on the sanitization of bodies, on the invisible violence generated by the lack of knowledge and comprehension, by the debasement of non-western systems of thought. It also points to the need of an intervention that must be able to work as a container for forms of distress, naming them by using the same language and the same semantics (*susto, enojo, muina, coraje*), allowing us to enter into contact not only with the *immigrant (the person "who is here")* but also with *emigrant, someone who comes from a place that is "full" of objects and ties, from a historic and cultural context (...)* (Beneduce, 2007). On the basis of a retrospective evaluation of our data we were able to establish that only a minority of the children examined resulted negatively to the tests carried out, and this leads us to confirm that a diagnostic survey after the arrival in Italy is useful, and that an early targeted intervention may thus be of primary importance to prevent consequences of neglected problems. In fact the objective of the project, of which we present the first results from an anthropological point of view, is to analyze and negotiate the experience of suffering brought by the families, in the light of socio-cultural processes but also in the light of the historic political and economic forces of migration that produce and reproduce exclusion, marginalization and inequality, in order to form a therapeutic alliance for the psychological and physical well-being of the child.

Limitations of the study

In this research we report the experience of women from diverse cultural backgrounds, it would therefore be inappropriate to attempt to create one picture of migrant breastfeeding practices and barriers.

It was not possible to interview some of the women because they did not return to the hospital. The main reasons are: socio-economic (the cost of transport); they could not miss work; they had to be at school to pick up their children; also the lack of female autonomy, in fact some husbands did not allow their wives to go out on their own and did not consent to them being interviewed by the anthropologist in their absence.

The study also found that some barriers are linked to communication problems due to the absence of the cultural mediator speaks Portuguese.

CONCLUSION

This research is the first stage of the study that we intend to carry out on the barriers to experience by women who for various reasons are immigrants in Italy. We intend to continue research on traumatic events related to intentional violence, structural violence, linked to the invisible world of persecutory magic violence, that women choose as privileged etiological events to signify disease and forms of suffering which them and their children experience. We have seen that such different types of violence endured by women can be transmitted by milk and can become manifest in childhood diseases also many years after breastfeeding, in that they remain active in the memory of the bodies of the children. The families we met with were composed of minors of various ages, also teenagers, and the mother's explanation of the suffering of the children were directly related to the history of breastfeeding (they answered the following questions: Did you suffer injury or trauma, during breastfeeding that may have damaged your milk? Have you ever suffered *susto* during breastfeeding, which may have damaged your milk? Did you have emotions of sadness and *enojo* during breastfeeding, which may have damaged your milk?).

It is possible to say that a past history of breastfeeding emerges from the answers, excessive or absent, which is always actual in the bodies of the children and the lives of their mothers. They, the mothers, make their children sick. This is the maternal imaginary that is shared by the nuclear and extended family.

The first results presented here also convey another aspect related to how we individually and collectively represent disease and underlying etiologies in the migration process: the relationship with other systems, knowledge and therapeutic practices.

The research wants to highlight that the risk of not being able to establish a contact with different cultural frames leads to not being able to deal with, in the context of a western healthcare system, the illnesses and psychological and physical forms of distress of children. If on the other hand, unlike what is being demonstrated by this project, the clinical settings are not able to grasp these aspects, aspects that cannot be related to the body seen solely as a biological body, that replicate the epistemic violence that silences the story and the socio-cultural sense of pain and anguish of the patient, the clinical intervention is bound to fail because this attitude constitutes a barrier that blocks the access to the national, public, healthcare system, intended for the well-being of all citizens.

Finally, the knowledge and the comprehension of different models of parental care also has an important economic effect in this sector: it means a better organization of resources and a reduction of expenses (reduction of the number of admissions to hospital and of the days spent in hospital, reduction of the visits to the emergency rooms, and finally reduction of examinations that are not needed).

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