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Being a migrant woman during disasters: A phenomenological study to unveil experiences during the COVID-19 pandemic in Milan, Italy

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ABSTRACT

Migrants and women were among the groups most severely affected by the COVID-19 pandemic disaster. By adopting an intersectional lens, it can be inferred that migrant women (MW) were particularly vulnerable to its impacts. This study aims to explore the multifaceted impact of the COVID-19 pandemic on MW living in Milan, Italy, investigating a broad spectrum of experiences. We conducted a phenomenological study using semi-structured interviews from September 2023 to January 2024. Interviews were transcribed and inductively analyzed. We interviewed 19 cisgender MW coming from 10 different countries, with a median age of 43 years. At the pandemic's onset, 12 were undocumented migrants, four were documented, while three had obtained Italian citizenship. Most held informal job positions, primarily as domestic workers, and were impacted by the economic crisis triggered by the pandemic. Both before and during the pandemic, non-governmental organizations were the preferred entry point to the healthcare systems. Their psychological well-being was compromised by distance from family members and the extensive COVID-19 media coverage. Despite skepticism, most MW adhered to the vaccination campaign due to its de-facto mandatory nature. Social isolation was not considered a major impact. Overall, MW did not perceive themselves as a particularly vulnerable group. Systemic interventions to address inequalities faced by MW should be incorporated throughout the entire disaster risk management cycle and an intersectional approach should be integrated into all stages of public policy development. As distrust emerged as a particularly significant issue building trust before disasters is crucial for an effective response.

1. Introduction

Italy is one of the countries most affected by the COVID-19 pandemic, with its national healthcare system being put under severe strain, especially in the hardest-hit regions such as *Lombardia*, whose capital is Milan (Armocida et al., 2020). Italy is also one of the European countries hosting the highest number of migrants. In 2023, over 5 million migrants accounted for almost 9% of the total population (Ministero del Lavoro e delle Politiche Sociali). No official data are available for undocumented migrants, but they are estimated to account for 500,000. *Lombardia*, with its capital Milan, is the most attractive region for migrants, accounting for 23.1% of the whole foreign population in Italy (XXXII Rapporto Immigrazione 2023). In this region, female and male migrants account respectively for 48.7% and 51.3% of the migrant population (CGIL e UIL Milano e Lombardia, 2021).

In the context of disasters, migrants and women are among the groups more likely to experience negative consequences due to differences in conditions of vulnerability, exposure, and capacity compared to the general population (UNDRR). They were also among the groups most negatively impacted by the COVID-19 pandemic globally (Migration Data Portal, 2023; Orcutt et al., 2020; Hayward et al., 2021;

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Abbreviations

MW	Migrant Women
GBV	Gender-Based Violence
KIs	Key Informants
COREQ	Consolidated Criteria for Reporting Qualitative Research
NGOs	Non-Governmental Organizations
ED	Emergency Department
GP	General Practitioner

Vang & Ng, 2023; Hargreaves et al., 2020; Ryan & El Ayadi, 2020; Buvinic et al., 2020; Policy Brief, 2020). By adopting an intersectional lens that considers the challenges arising both from being a migrant and being a woman, as well as the multiplying effects of diverse systems of oppression (e.g., racism, sexism) (Bauer, 2014; Crenshaw, 1989; Nixon, 2019), it is possible to emphasize how migrant women (MW) faced specific challenges and impacts (Laster Pirtle & Wright, 2021; Nhengu, 2022; Trentin et al., 2023; Yong & Germain, 2022). On one hand, their migrant status may limit their access to care, expose them to discrimination, and confine them to unstable jobs. On the other hand, as women, they are often confined to a limited range of gendered jobs, frequently burdened with childcare and domestic responsibilities, and are at higher risk of gender-based violence (GBV) (Trentin et al., 2024; Gillespie et al., 2022; UNICEF, 2022).

In the Italian and Milanese context, studies investigating the impact of the COVID-19 pandemic on MW are limited in number, and while highly relevant, the few available often focus on specific subgroups such as sex workers (Cabras & Ingrascì, 2022), caregivers (Dotsey et al., 2023), or particular issues like GBV (Gillespie et al., 2022; UNICEF, 2022). Nonetheless, existing evidence indicates that MW were a particularly vulnerable group during the COVID-19 pandemic in Italy and in Milan. They were more severely affected by the pandemic-induced decrease in employment compared to both migrant men and Italian women (UNAR, 2021). Episodes of discrimination, including sexism, racism, and xenophobia, were exacerbated for migrant and refugee women. Furthermore, timely referral of survivors living in reception centers to GBV services was hampered and MW's freedom of movement was hindered by their precarious socioeconomic status, sometimes leaving cohabitation with abusive partners as their only available option (Gillespie et al., 2022; UNICEF, 2022).

In health research, it is common practice to engage both key informants (KIs), such as healthcare workers, non-governmental organizations (NGOs) personnels, or policy-makers, and the population under investigation to capture diverse perspectives (Gillespie et al., 2022; Hahn, Steinhäuser, & Goetz, 2020; Kietzmann, Hannig, & Schmidt, 2015; Knights et al., 2021; Lotito et al., 2023; Peprah, Lloyd, & Harris, 2023). While in a previous study our research team investigated the impact of the COVID-19 pandemic on MW by interviewing a group of KIs (Trentin et al., 2024), in this one we employed a phenomenological approach to engage MW directly, aiming at exploring their lived experiences and uncover the subjective meanings they attribute to these experiences. Specifically, we explored the multifaceted impact of the COVID-19 pandemic on MW living in Milan, investigating a broad spectrum of experiences and challenges, spanning from economic hardship to social isolation, from GBV to childcare burden, and from mental to physical health issues. In particular, we investigated MW's access to healthcare during the pandemic to understand whether and how pre-existing hurdles typically affecting migrants (Giovannini et al., 2023) and MW (Di Napoli et al., 2022; Di Napoli & Cacciani, 2021; Di Napoli et al., 2020; Giovannini et al., 2023; Lauria et al., 2013) have been exacerbated by the COVID-19 pandemic disaster. Considering the relevance of the vaccination in the context of the COVID-19 pandemic, we also explored whether MW faced barriers to vaccination and whether vaccine hesitancy, which has been observed among migrants in other settings (Crawshaw et al., 2022; Hajissa et al., 2023; Lin, 2022; Page et al., 2022), was also present among MW in Milan.

Conducting this study in Milan is particularly relevant for several reasons. Milan was one of the Italian cities most severely affected by the COVID-19 pandemic and hosts the largest migrant population in the country (Ministero del Lavoro e delle Politiche Sociali, 2023). Moreover, the third sector plays a key role in the city, facilitating engagement with hard-to-reach populations. Barriers to access to care are especially pronounced in *Lombardia* region, making it an ideal setting to examine the challenges faced by MW during the pandemic.

The research questions that guided our study were: "How did MW experience and perceive the COVID-19 pandemic?", and specifically, "What challenges and positive experiences characterized their pandemic experience, particularly regarding access to healthcare?".

The findings of such an investigation will enable to inform policies and interventions aimed at strengthening MW's disaster and pandemic preparedness, as well as to reducing inequalities affecting them in ordinary times.

2. Material and methods

2.1. Study design

This study is part of a larger project titled "*Being a migrant woman during disasters: a mixed-methods study exploring multidimensional inequalities during the COVID-19 pandemic in Northern Italy*". We conducted a phenomenological study using semi-structured interviews to explore the pandemic-related lived experiences of MW living in Milan. The methods section relies on the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

In this study, a migrant woman is intended as an individual above the age of 18 self-identifying as a woman and that moved away from her place of usual residence across an international border, either temporarily or permanently and for a variety of reasons, and arrived in Italy (International Organization for Migration).

2.2. Research team and reflexivity

Interviews were conducted by two researchers who are cisgender, white, non-migrant women with experience in global health, disaster medicine, migration studies, and qualitative research (MT, MV). One interview was conducted with the support of a third global health researcher who is a Yemeni migrant cisgender woman with experience in qualitative research (AB). Mindful of their positionality and the power dynamics with participants, the interviewers concentrated on fostering trusting relationships and maintaining cultural sensitivity throughout their investigation. Recognizing the influence of the researchers' identities on data collection and reporting (Darwin Holmes, 2020), efforts were made to emphasize the firsthand experiences of MW as articulated by the participants throughout the manuscript, in order to minimize potential biases.

2.3. Participants' recruitment

We relied on purposive and snowball sampling. Our sample was not fixed in advance, as we intended to include a broad range of experiences to enable a "richly textured understanding" of the phenomenon under study (Sandelowski, 1995; Vasileiou et al., 2018). The final sample size was largely determined by respondents' willingness and availability in participating in the study (Vasileiou et al., 2018). Although we recognize that data collection is not an exhaustive process (Dey, 1999) and that involving more participants, including MW from diverse backgrounds, could have revealed additional nuances, we believe the study reached data saturation. As the interviews progressed, they increasingly

revisited themes that had already been discussed, rather than generating new insights or perspectives. Therefore, the decision to conclude the data collection phase was based on the recurrence of the main themes from the interview guide, which began to produce repetitive responses.

KIs working in third sector organizations (i.e., EMERGENCY, Dare.ngo, Caritas Ambrosiana) were asked to act as a contact point, offering some of their patients the possibility to participate in the study, thereby facilitating culturally appropriate communication regarding the study. Appointments with the participants were taken either by KIs or by researchers *via* an instant messaging app (i.e., WhatsApp) or through phone call. Of the 21 migrant women who initially agreed to participate, 19 completed the interview, while two did not proceed with the meeting request. No incentives were used to encourage participation. To be eligible for inclusion, participants were required to have at least a basic proficiency in one language among Italian, French, Arabic, or Spanish, which were the languages spoken by the research team. While no exclusion criteria was applied based on MW's legal status and length of stay, only those who spent the two years of the COVID-19 pandemic (i.e., February 21, 2020–December 31, 2022) in Italy on a permanent basis were eligible for inclusion.

2.4. Data collection

Data was collected through semi-structured interviews from September 2023 to January 2024. The main sections of the interview guide followed the thematic areas identified in a review previously conducted by the research team (Trentin et al., 2023) and additional questions were added to cover the objective of the study. The interview guide was piloted with a pool of migrant fellow researchers and adjusted accordingly. The final interview guide (Supplementary material 1) was divided in three sections: i) introduction, ice-breaking questions and lockdown experience, ii) negative impact of the pandemic, iii) positive experiences during the pandemic. Even though no direct reference was made to sensitive issues (e.g., GBV), participants were allowed to openly discuss these themes thanks to the nature of the questions (Pinto et al., 2022; Rosala, 2024). A storytelling and exploratory approach was employed to allow them to narrate their experiences. Iterative analysis of interview transcripts enabled to improve the interview guide in the data collection phase (Kvale & Brinkmann, 2014). Interviews lasted from 30 min to 2.45 h and were audio recorded upon consent. Participants could skip any question that made them uncomfortable. Interviews were conducted in Italian (n = 18) or Arabic (n = 1), in person (n = 17) or online (n = 2) using Zoom [version: 5.16.10 (26,186)] depending on the participants' availability. When in person, interviews took place in NGOs offices (n = 10), at the participants' home (n = 1), or in a public venue (n = 6), isolating as much as possible from other individuals to ensure privacy. After de-identification, interviews were transcribed verbatim using Word [version 2311] or Sonix [2023, Sonix, Inc] and manually checked to assess completeness.

2.5. Data analysis

After developing a codebook based on the study objective and on emerging themes based on a sample of transcripts (Supplementary material 2), inductive analysis was performed by two researchers (MT, MV). A third researcher supported the data analysis for the interview conducted in Arabic (AB). Data coding was performed using Atlas.ti software [version 23.4.0.29360] from November 2023 to February 2024. Afterwards, findings were thematically analyzed. Translated quotes were added to enrich the understanding of the study findings.

2.6. Ethical considerations

This study was conducted in compliance with the 1964 Declaration of Helsinki and its later amendments, and received ethical approval from the Ethics Committee of the A.O.U. "Maggiore della Carità" di Novara (protocol number 966/CE, July 21, 2023). All participants were required to give written or oral informed consent prior to data collection. Before starting the interview, the participants were reminded of the study's aim and the interview process and made aware of the implications of giving informed consent. Collected data was anonymized, with access restricted to the research team.

3. Results

We conducted 19 interviews with cisgender MW coming from 10 countries: Colombia (n = 1), Costa Rica (n = 1), Ecuador (n = 1), Georgia (n = 2), Morocco (n = 3), Peru (n = 4), Philippines (n = 1), Romania (n = 3), Ukraine (n = 2), Uruguay (n = 1). Their age ranged from 27 to 80 years old, with a mean age of 43 years, while their length of stay in the country varied from 4 to 35 years (mean: 12.61 years; SD = 9.61). At the pandemic's onset, 12 of them were undocumented migrants, four were documented migrants, while three had obtained Italian citizenship. The majority of MW held informal positions, primarily working as domestic workers. A more comprehensive overview of participants' demographic characteristics can be found in Table 1.

Study findings will be divided into two main sections: the first will focus on the onset of the COVID-19 pandemic and access to information about the virus and regulations, while the second will explore the impact of the pandemic on MW. A summary of the study's key findings is provided in Table 2.

3.1. The onset of the COVID-19 pandemic

3.1.1. Information about the pandemic

Most interviewees reported discovering about the outbreak through Italian television news programs, even in presence of language barriers, while they were less frequently informed by their partners or through telephone conversations with friends. As the pandemic progressed, some MW perceived the Italian media as overly sensationalist, leading them to disengage from television news consumption altogether. This decision was influenced by skepticism towards the severity of COVID-19 as portrayed by the media, compounded by conflicting information from these sources. A participant also reported that some acquaintances advised her against watching television, claiming that "*It only spreads lies*", while she expressed complete trust in the Italian media. Some MW said they only started to believe what was being reported in Italy when they realized the situation had also worsened in their home country.

Almost all MW expressed at least some doubts regarding the origin of the virus and the crisis management approach. Some reported believing that the virus had accidently escaped from a laboratory in China, while others discussed it as a deliberate social experiment aimed at counteracting global overpopulation. One MW reported her belief in a theory encountered on YouTube, suggesting that COVID-19 would be transmitted through a microchip implanted in the skin by mosquitoes. One prevalent theory that emerged posits that physicians overstated COVID-19 deaths to ensure hospitals received additional fundings. Other beliefs included accusations that medical personnel intentionally hid oxygen to avoid assisting patients, and that individuals who died from COVID-19 were disposed of in mass graves.

3.1.2. Information about regulations and public health measures

MW learned about the regulations in force during the pandemic (e.g., the lockdown, the curfew, the need to fill out a self-declaration form to leave the house), through television programs, their employers, posters hung in the building where they lived, or via word of mouth among their networks. Not all MW consistently followed COVID-19 regulations, while others wanted to always be up to date on them to avoid incurring sanctions that could compromise their stay in Italy.

> "*After hearing that if you left the house you could be fined or even taken to prison, I got a bit scared, especially since I didn't have documents*." (P8)

Table 1
Demographic characteristics of participants.

Participants	Age[a]	Legal status[b]	Length of stay in Italy (in years)[a]	Children	Professional background		People they were cohabiting with	Reason for migration
					Milan[b]	Home country		
P1	80	Undocumented	22	Yes	Caregiver	Restaurateur; nurse	Partner	Family reunification
P2	43	Undocumented	7	No	Waitress	Journalism, communication and marketing	None	Violence and insecurity in the home country
P3	45	Undocumented	4	Yes	Caregiver	n/a	Employer	Work
P4	27	Undocumented	4	No	Caregiver; baby-sitter	Pharmacist	None	Work
P5	53	Citizen	26	No	Unemployed	Restaurateur	Husband	Family reunification
P6	60	Undocumented	35	No	Caregiver	n/a	Husband	Poverty
P7	34	Regular	11	No	Baby-sitter	n/a	None	n/a
P8	36	Undocumented	5	Yes	Caregiver	n/a	At the beginning none; later on sister and cousin	Work
P9	31	Undocumented	4.5	Yes	Babysitter; housekeeper	Mining engineer	Flatmates; most of the time at employer's house	Gender-based violence in home country
P10	48	Regular	10	Yes	Caregiver	n/a	Daughter	Poverty
P11	52	Undocumented	4	Yes	Cleanings	Hairdresser	Partner	n/a
P12	43	Regular	16	Yes	Caregiver	Degree in literature	Children	n/a
P13	43	Undocumented	8	No	Unemployed	n/a	Friends' house	Work
P14	31	Undocumented	6	Yes	Housewife	n/a	Partner, child; flatmates	n/a
P15	51	Citizen	26	Yes	Caregiver	n/a	Child	Work
P16	26	Undocumented	4	Yes	Unemployed	n/a	Husband, child born during the pandemic	n/a
P17	43	Regular	15	Yes	Caregiver, cleanings	n/a	Employer's house with husband	Work
P18	43	Citizen	27	Yes	Street vendor	n/a	Extended family	n/a
P19	34	Undocumented	5	Yes	Unemployed; worker	n/a	Flatmates; later only partner	n/a

[a] At the time of data collection.
[b] At the onset of the pandemic.

3.2. The impact of the COVID-19 pandemic on MW

3.2.1. Access to care

While exploring the impact of the COVID-19 pandemic on MW's access to healthcare, challenges and considerations pertaining to both the pre- and post-pandemic period were mentioned.

3.2.1.1. Access to care before the COVID-19 pandemic. In general, most interviewees access public hospitals through NGOs referrals, which are more accessible due to their proximity to neighborhoods with a high concentration of migrants and the support they provide in helping them navigating the public health system. Except for one participant who had trouble because of issues with her tax code, MW did not encounter difficulties accessing hospitals. MW's experiences in public hospitals in Milan vary depending on the hospital they access and the health professional providing care. Some interviewees reported being treated poorly and shared a sense of distrust in the diagnoses of doctors, with some expressing that migrants' health conditions are underestimated. For this reason, some of the interviewees prefer to seek treatment in their country of origin, when possible. This is also linked to the fear associated with being alone in case of complications when they undergo invasive surgical procedures. Among the main challenges encountered in accessing public hospitals are difficulties navigating the health system due to service dispersion and fragmented information, and not being assigned to a single healthcare provider but having to deal with different professionals in their care journey. A criticism shared by several MW concerns excessively long waiting times in the emergency department (ED). On the other hand, several MW recounted positive experiences with doctors who were understanding and kind.

The majority of MW were entitled to access to primary care through a general practitioner (GP) and had diverse experiences when accessing this service, with some encountering challenges due to the need to periodically renew their provisional health card. A sense of distrust characterizes the relationship between MW and their GP, especially regarding drug prescriptions:

> "If you tell me to take paracetamol, I can't trust you. Today you can't trust anyone. You can't even trust the general practitioner, because a doctor gives you this [medicine], but when you go to the hospital they give you another one." (P17)

Nevertheless, many MW reported that they have been entitled to a GP with whom they feel comfortable, although some interact with GPs sporadically and refer to NGOs for most of their health needs.

3.2.2. Access to care during the COVID-19 pandemic

Five MW reported that their elective visits were canceled during the COVID-19 pandemic, but then rescheduled, while urgent visits were maintained. On one hand, the infection prevention and control measures implemented by hospitals (e.g., wearing gowns, shoe covers, temperature checks), deterred some MW from seeking care; on the other, these precautions reassured women, making them feel protected against COVID-19. One MW complained that her children could not visit her in the hospital if she were to be admitted during the pandemic.

Access to the ED for sudden health issues not related to coronavirus infection was hindered by the COVID-19 pandemic:

> "That day [my partner] fell four times. I was shocked, so I called the doctor who told me: 'If you take him to the hospital now, I doubt you'll bring him home' and he told me: 'There are too many people in the hospital, they can't look after him if it's not COVID. They need to focus on the people who are seriously ill'." (P5)

Another barrier to accessing the ED was fear fueled by circulating conspiracy theories claiming that doctors would intentionally cause deaths or falsely attribute deaths due to other causes to COVID-19.

For basic care needs, many MW reported relying on friends or relatives who work in the Italian health and social care systems to avoid accessing hospitals or primary care clinics during the pandemic. One MW deliberately chose not to contact her GP to avoid overburdening

Table 2
Overview of study findings.

Thematic area	Summary of findings
The onset of the COVID-19 pandemic	
Information about the pandemic, regulations, and public health measures	The main source of information about the pandemic and restrictions was Italian news, which was later deemed overly sensationalist. The news about the pandemic was believed by some migrant women (MW) only when the situation worsened in their home country too. Skepticism and conspiracy theories were common, and COVID-19 regulations were not always followed.
The impact of the COVID-19 pandemic on migrant women	
Access to care	
Access to care	MW preferred non-governmental organizations (NGOs) as their entry point to the healthcare system, both before and during the pandemic. Hospital experiences varied by facility and staff, and most were entitled to a general practitioner (GP). Conspiracy theories about hospital practices hindered access to emergency departments. The pandemic limited care for non-COVID health issues; elective visits were canceled but rescheduled later, while urgent visits continued. Many MW relied on friends or relatives in healthcare to avoid hospitals and clinics, and GPs were sometimes difficult to contact.
COVID-19 infection and self-protection mechanism	Most MW opposed masks or used only cloth ones. About one-third relied on do-it-yourself remedies for self-protection against the virus. Practices such as using sanitizers were mentioned, while swabs as a monitoring tool were rarely used.
Access to vaccination	17 of 19 MW were vaccinated: seven voluntarily, and the rest due to the de-facto mandatory nature of vaccination. Some MW had difficulty registering online for the vaccination and sought help from NGOs. Side effects and skepticism about the vaccine were mentioned.
Job and economics	Economic constraints were faced by most MW. Several domestic workers lost jobs due to employer fearing exposure to the virus. Social and economic assistance was commonly sought from NGOs. Support was also received from partners, friends, or relatives, sometimes causing feelings of shame.
Mental health	Concerns about COVID-19, separation from family, news coverage, and issues related to the regularization process affected MW's mental health. A minority reported no distress and faced the situation with serenity.
Social isolation	Overall, social isolation was considered a minor impact. Some MW felt trapped during the lockdown, though some experienced only slight discomfort. Some violated lockdown rules to meet friends and relatives.
Childcare	Homeschooling presented challenges, including connection issues and lack of tools. MW also struggled with their children's inability to go outside.
Interruption of educational, recreational, and religious activities	Italian courses attended by some participants shifted online, though in-person lectures were preferred. Others stopped attending places of worship but continued their religious practices individually.
Intragroup differences and differences with migrant men and Italian women	Regarding intragroup differences, those with permits, Italian proficiency, and children in Milan were seen as having a better pandemic experience. No differences were perceived by some between MW and migrant men, while others believed men found it harder to stay home and secure jobs post-pandemic. Women, often in contact-heavy jobs, were reported to be more affected by preventive measures. Compared to MW, Italian women were considered to have advantages like healthcare access, family support, and welfare, though they appeared more emotionally distressed.

him during a period of high stress; in other cases, women reported having troubles contacting their GP by phone or in case they offered online consultations. A MW who worked as a caregiver for an elderly patient described undergoing check-ups by the elderly person's GP during the pandemic.

NGOs were the preferred point of entrance into the health system also during the COVID-19 pandemic, especially to get refill of medications, and to register for the vaccination campaign.

Regarding pharmacies, some MW experienced difficulties finding affordable masks and hand sanitizers. At times, MW working as caregivers were economically supported by their employer to undergo swab tests.

3.2.3. COVID-19 infection and self-protection mechanisms

Most interviewees stated they were against the use of masks or used them only if they were made of cloth, as they reportedly caused allergic reactions or irritation. One participant slept wearing a mask while she was positive for coronavirus because she was afraid of infecting her adolescent daughter, who slept in the same room. Another one disclosed that she wore masks out of fear of contracting the virus, but also because she feared being fined.

> Interviewee: "When I wore the mask, my whole face would get irritated […]. I would put a scarf underneath and then I would put the mask on top. Because these masks are not really good, they're not even cotton, so … "
>
> Interviewer: "Which ones did you use?".
>
> Interviewee: "Like the ones used in hospitals, the blue ones. But since my husband was in Pakistan, he brought me some masks made of cotton." (P17)
>
> "I was allergic to masks, the blue and white ones. […]. I couldn't keep wearing them, so I holed up at home and learned how to make one with fabric by watching a YouTube tutorial." (P5)

Nearly one-third of the study participants adopted do-it-yourself remedies during the pandemic as a self-protection mechanism towards the virus. These included preventive herbal remedies, or consuming soups (e.g., containing garlic and olive oil) or beverages (e.g., milk and turmeric tea, vinegar tea) to recover from the disease, at times in substitution of medical consultations.

Other preventive measures included purchasing the equipment for aerosol treatments, using sanitizing products, and leaving the clothes they wore outdoors. Swab use for monitoring of asymptomatic COVID-19 was rarely mentioned.

One interviewee, living with her partner and two-year-old in a shared apartment with four others, worried that her roommates might '*bring the virus home*' by going out without masks but avoided confrontation to prevent conflict. Most MW reported contracting COVID-19 at least once, with all but three experiencing only mild symptoms. In three instances, MW spent their isolation period at their employer's house. Two of them had their own apartment, yet they chose to stay there as it meant having someone to rely on. In another case, a caregiver decided to return to her own home to spend her quarantine.

> "When they found me with COVID and [me and my employers' family] were all infected, I couldn't go back to the shared apartment where I lived, because I said, 'What do I do over there? Infect everyone? No, I'll stay here. If they care about me, they also have to take care of the medicine I need, they have to buy it'. I thought: "I'm here with them, if something happens to me I'll be with them." The first week was tough because everyone was confined in their room. The Mr. in his room, the Ms. in her room, I stayed in the living room, in the kitchen, and in a small room with the children. I lived with them for 20 days. I was the only one who cooked, even though I had

COVID, I cooked for everyone, I did everything in their house because I was locked in with them." (P9)

3.2.4. Access to vaccination

Among the interviewees, 17 out of 19 were vaccinated, but only seven of them wished to. In most cases, doubts about vaccination led them to delay their decision. To register for vaccination, at times MW reported that they had called a toll-free number advertised on television dedicated to undocumented individuals; by dialing this number, they were assigned a code that enabled them to access vaccination services. In some cases, MW encountered difficulties in registering for the vaccination through the online platform and they relied on third sector organizations for assistance.

MW who worked as caregivers received information about vaccines from the GP who visited the elderly patients they cared for. Others were discouraged or convinced to get vaccinated by friends and relatives. Most MW only received the necessary doses of the vaccine to get the COVID-19 Certificate (i.e., "Green Pass").

"It's not that I was scared, but to take a vaccine I know nothing about … I wasn't keen. Anyway, I have a cousin and an aunt who are doctors, and they said that the vaccine works like antibodies fighting inside you, meaning they protect you […] so I decided to go ahead. Also, for work reasons, because I was working with two children and couldn't enter the nursery, so that was another reason I did it." (P7).

Five of the vaccinated MW reported health issues related to the vaccine; they mentioned feeling more fatigued to the point of not being able to go to work, having become allergic to some food, having dizziness, and suffering from arm pain following the injection. Those who did not get vaccinated were afraid of the vaccine's negative consequences and believed it to be unsafe, at times recounting stories of individuals who had become paralyzed or died following vaccination. An interviewee reported having undergone a gynecological check-up following vaccination to verify her ability to still have children, as she feared the side effects of the vaccine.

"They need to do autopsies because I think they're giving us poison, because [a man] died. The doctor said: 'The man died because of the vaccine, look what's in his arm' and there was a white spot. Before, the man was healthy, he walked and everything, even by himself … he died just because of the vaccine." (P1)

On the contrary, a participant expressed frustration with vaccination skepticism, emphasizing that researchers dedicate their entire lives to such achievements.

3.3. Job and economics

Most interviewees (n = 13) reported facing economic challenges during the pandemic. Public health regulations allowed individuals to work in sectors categorized as essential, however, despite caregiving being included in this classification, MW lacking formal employment contracts or not living in their employers' households were unable to continue working due to the potential risk of being required to self-declare an illegal job at police checkpoints.

Economic issues were caused by job loss or reduced income as a result of anti-contagion measures, while in other cases the pandemic made it practically impossible for those seeking employment to start working. In two cases, interviewees were not working before COVID-19, and difficulties arose because their partners' income was reduced during the pandemic. One participant explained that she did not face economic problems because she kept her main job as a domestic worker. However, losing her second job left her unable to cover personal expenses, as she had to use all of her income from the first job to pay for rent in Milan and to support her children in her home country. The interviewee further elaborated that while workload heightened amid the pandemic, her income remained unchanged.

Single mothers reported that the situation was particularly challenging because they had to support their children by themselves.

The economic difficulties experienced during the pandemic led to various consequences, such as difficulties in affording food or paying the rent, depletion of their savings, inability to send remittances to their family, or difficulty in paying for healthcare services (e.g., physiotherapy). This situation led to feelings of worry, anxiety, and distress.

"We usually make bread because we don't always have money to buy it, and it's cheaper for us to buy flour and make it ourselves. [During the lockdown] it was a problem for us because with 1€ or 1.5€, you could buy two sacks of flour, and we made bread, so we all ate, friends and all. But there was that period when we couldn't even find flour. […]. Today we ate a little, tomorrow a little, and that's how it went. We would eat just a piece of bread, rice - just rice, without meat -, and then pasta. I can't tell you, we ate pasta for ten days, pasta, pasta, pasta, pasta. Because for a week, we couldn't find flour anywhere, not even oil. […] My sister had four young children: I wanted to ask for charity because I saw the children crying from hunger". (P16)

Several caregivers and maids revealed that they lost their jobs because their employers fired them fearing they might "*bring the virus home*".

For one woman, despite facing economic challenges to make ends meet, losing her job as a waitress at the onset of the pandemic was an opportunity for change.

"For me, [the pandemic] was also a change. I was tired of working at that restaurant … I was just surviving, doing everything to survive, but I had this unhappiness … And then, for some time, my soul or my intuition were telling me, like, "Okay, now what do you want to do? What are you doing?'" Until I was forced by the pandemic to make choices I hadn't made yet." (P2)

In numerous instances, MW sought financial and material assistance, while a minority of interviewees were unaware of the existence of services that could support them.

With few exceptions, where MW described receiving home-delivered food parcels or grocery vouchers from initiatives promoted by the Municipality of Milan, institutional support was lacking. In many cases, this happened due to their undocumented migrant status, which rendered them ineligible for benefits, or because they lacked residency in Milan, and thus were not entitled to municipal welfare measures, despite being regular migrants. Often, support was provided by third sector organizations, primarily through canteen services or food parcels. In some cases, interviewees were directed to these organizations by compatriots (e.g. through Facebook groups). However, a South American participant shared experiencing hostility from fellow nationals, driven by a sense of unfairness towards newcomers receiving assistance while others faced challenges alone.

"In the package, they included some things that are not needed, they only give biscuits, and some things that are not really the ones you need the most […]. There are always things that are needed more, like oil, which they don't give. […] They give you biscuits, but what do you do with biscuits or pasta? One does not only eat biscuits and pasta." (P18)

"[In that place] they give you lunch, and they also give you dinner. You go there, eat, then go home, and come back for dinner, right? When the COVID situation was a bit better, my sister and I would take a train and go eat there, and to avoid buying two tickets, we would eat, take a walk in Milan to pass the time until dinner […] Sometimes we were forced to do this because if we didn't have the money, what could we do?" (P8)

In other cases, assistance came from partners, friends, or relatives,

sometimes causing feelings of shame. One interviewee voiced discontent with the absence of support from social workers, while another revealed her reluctance to seek assistance, expressing a preference for securing employment to achieve financial independence.

With the easing of social distancing rules, some interviewees resumed their work, sometimes having to take on multiple jobs simultaneously to make ends meet. In some cases, returning to work was possible thanks to their network of acquaintances. One participant reported that "*the real crisis began after the pandemic*", as she could no longer rely on her friends' support and had to restart her job search being aware that it would have been extremely hard to find one due to her undocumented status.

3.4. Mental health

Overall, MW's psychological well-being was impacted by concerns about contracting COVID-19, separation from family members, their relationship with the COVID-related news, and hindrances in their regularization process. In a minority of cases, MW reported not experiencing distress during the pandemic. At times, they mentioned that they could do nothing but acknowledge the situation and face it with serenity.

One of the topics mostly discussed was the distance from their family members in their home country, particularly from their children and parents. In two cases, MW expressed fear of dying themselves. More consistently (n = 12), their concerns revolved around the potential infection and death of family members, particularly elderly parents or those with chronic conditions. This worry was compounded by the realization that, due to travel restrictions, it would have been impossible to reach them. Moreover, some shared that relatives in their home country passed away from COVID-19, and they were unable to be present for grief rituals. Due to Italy being severely impacted by COVID-19, family members in the home country expressed concerns and frequently contacted MW to monitor their health.

> "I imagined many things … like getting infected with the virus and dying, and never seeing my daughter again. For me, it was very tough because my daughter wasn't here, I didn't have anyone, I was alone in Italy". (P3)

> "You don't know how many funerals my family had … We lived a horrible year and I couldn't take it anymore. I remember praying and saying, "Enough for us" […]. That year was devastating, it was like … "*¿Quén sigue?* Who's next?". I was here and they were there … just dying." (P2)

A number of MW expressed concerns about being alone in Milan and feared not receiving support from anyone in case of illness, while others were concerned about their partners, children, or other relatives in Milan. At times, fear was linked to the prospect of going to the hospital, as they believed they "*would never come out from there*" and were worried about facing consequences because undocumented. In one case, the fear of contracting the virus and being unable to go to work was mentioned.

Less frequently, participants were not concerned about getting infected but rather shared fatalistic views about the virus, considering it as an unavoidable event where one's behavior makes no difference in the course of events. Alternatively, some disclosed that if they contracted it they would simply deal with it.

When it comes to their interaction with the media and COVID-19-related news, MW were obsessed with seeking information and kept the television on 24/7, while on the other they avoided it, feeling overwhelmed by the negative and distressful news.

> "The television was on day and night. All day long. All-day-long! If one program ended, I would start another because I wanted to see what they were doing with people, because they treated people differently from one to another … I wanted to see how people were doing." (P19)

At times, the pandemic led to anxiety because it impeded their regularization process or caused complications in renewing their permits to stay due to the closure of public offices and postponed appointments. This situation also impacted their ability to return to their home countries once the pandemic ended, as they would not be allowed to re-enter Italy if they left. The transition of many bureaucratic services to online platforms also caused distress for some interviewees.

> "I used to leave [from public offices] with tears because they didn't want to talk, they didn't want … Everything was online, everything, but I'm not capable of doing everything online." (P11)

During the pandemic, when experiencing distress, MW utilized various coping mechanisms, including meditation, focusing on positive thoughts, having phone conversations, studying, cooking, doing indoor physical activities, singing or listening to music, and performing household tasks.

3.5. Social isolation

Overall, social isolation was identified as one of the least significant impacts. Half of them reported having suffered from being locked down and feeling trapped, although some were only slightly discomforted. One participant mentioned adopting a dog as a pretext to go outside, since walking the dog was one of the few permitted reasons for leaving home during the lockdown. Two caregivers spent months at their employer's house, with one of them not leaving the house even once for over a year.

In other cases, MW violated social distancing measures and gathered with partners or friends during the lockdown. When MW expressed not feeling alone during the pandemic, it was for several reasons: some spent hours each day on phone calls with family and friends, others were locked down with family members, and in some cases, they felt loved and supported by others, such as through food deliveries.

Another participant observed that her concern grew when vaccination became a requirement for accessing public spaces, as she decided against getting vaccinated.

3.6. Childcare

MW emphasized the challenges of homeschooling and their children's inability to go out. Concerning homeschooling, some children faced internet connection issues, lacked the necessary tools, and had to attend lectures using their mothers' phones. In certain instances, schools and NGOs lent them computers, tablets, and internet access cards. Limited space within the household posed challenges for the entire family, particularly when children did not have their own room, requiring other family members to keep quiet during lectures. One participant shared that when she went out, her son would frequently leave his online class, forcing her to contact the teacher to ensure he was supervised. In one case, attending the daughter's classes was both a chance to learn and unwind.

Numerous participants discussed the difficulty of keeping their children at home during the pandemic, noting frequent tantrums when they were told they could not go out, especially when young and unable to understand what was happening. A participant who was living with her elderly and sick parents, emphasized the stress caused to them by the constant presence of numerous children at home. Another participant who had a two-year-old baby felt relieved that her husband could not work during the first three months of the pandemic, so that he could also take care of the baby. Having children at home caused problems for single MW, who had to leave their children with a neighbor or friend, sometimes breaking social distancing rules, or leaving them home alone to go to work or grocery shopping.

> "[Being locked down] was a bit boring because [my son] was still two years old, nearly three. So he wanted to go to the park, and we

couldn't even go outside the courtyard. We were moving between the living room and the bedroom. The other roommates would be watching TV, so we had to stay inside the living room". (P14)

3.7. Interruption of educational, recreational, and religious activities

Five interviewees mentioned that Italian language courses they were attending shifted online. In one case, the interviewee opted not to continue attending, finding it uncomfortable to follow lectures on her phone. Another interviewee began taking Italian lessons online during the pandemic. Overall, MW favored in-person classes, with one noting that online provision diminished the quality of the learning experience. Still, they appreciated the chance to continue their courses.

In some cases, MW reported discontinuing recreational activities like sport classes, occasionally due to their unvaccinated status.

When it comes to the religious sphere, some interviewees mentioned missing going to church or mosque. Reading the Bible on their phone or watching streamed Mass still facilitated their prayer time, together with the belief that faith is not confined to a worship place but resides within oneself.

3.8. Intragroup differences and differences with migrant men and Italian women

When prompted about intra-group differences as well as differences between MW and migrant men and Italian women, various contrasting viewpoints emerged.

Regarding intragroup differences, MW believed that those possessing a permit to stay, proficiency in the Italian language, an established network of contacts, and those living with their children in Milan were more likely to have a more positive pandemic experience.

When it comes to perceived differences between them and migrant men, some of them disclosed that they perceived none. In other cases, women stated that, in their opinion, men found the pandemic more challenging due to their lesser familiarity with staying at home compared to women, who often take on the role of housewives. Additionally, some believed that for migrant men it would be more challenging to find employment while undocumented compared to their female counterparts, making it harder for men to re-enter the job market after the pandemic. When it was stated that women would be more penalized, this was because they more frequently have jobs involving contacts with people, and therefore had to take more preventive measures during the pandemic.

When discussing differences between MW and Italian women, it was observed that Italians had a more favorable experience during the pandemic due to their access to the national healthcare system, presence of family members in the same country, and eligibility for welfare benefits. Conversely, MW noted that Italian women seemed to experience more emotional distress compared to them during the pandemic.

4. Discussion

In this qualitative phenomenological study, we explored the experiences of 19 cisgender MW during the COVID-19 pandemic in Milan.

Overall, despite facing several challenges, MW did not perceive themselves as a particularly vulnerable group, in general and compared to migrant men or Italian women. For most, the primary impact of the pandemic was economic. Their psychological well-being was compromised by distance from their family and COVID-19 media coverage. Most had a GP, and, while there was some distrust, others had positive relationships with them. NGOs were still the preferred entry point to the healthcare system. At times, circulating conspiracy theories or fear discouraged MW from seeking care at the ED. Vaccination skepticism, the use of do-it-yourself remedies, as well as complaints about masks were common. Social isolation was identified as one of the least significant impacts.

In this study, we adopted an intersectional approach (Bauer, 2014; Crenshaw, 1989; Nixon, 2019) to explore the convergence of migrant and female identities. Because of their legal status, interviewees often hold informal and unstable jobs, and sometimes cover lower-skilled positions than in their home countries. As MW they were frequently confined to a limited range of sectors, namely caregiving, which were particularly impacted by the COVID-19 pandemic, leading low socio-economic status to act as an additional driving factor for inequalities (Silas, 2020). It follows that, for the study participants, COVID-19 was primarily a financial crisis rather than a health emergency, and while the latter eventually concluded, the former persisted long after the pandemic was officially declared over, perpetuating a cycle of poverty. Moreover, while participants generally felt comfortable accepting support during the pandemic, since the crisis made it more justifiable for them, this support diminished after the pandemic ended due to concerns about potential dependent relationships.

Most of the findings of our study revolved around the concepts of trust and distrust, both in ordinary times and during the pandemic. Many MW expressed doubts about the very existence of the coronavirus, the management of the health crisis, the COVID-19 vaccination, and the national healthcare system. In some cases, feelings of mistrust were directed towards the media, while in others, full trust was placed in the media and in the government. Feelings of trust and distrust could coexist simultaneously for MW: some participants disclosed that they were worried about the ongoing health emergency, that they had complete trust in their GPs, but that they distrusted vaccines they "*did not know anything about*". Others expressed complete trust in vaccines and scientists, but raised concerns about the quality of personal protective equipment, choosing homemade masks instead.

Higher levels of trust were instead directed towards NGOs because of their sympathetic and welcoming nature. As a result, the interviewees preferred seeking health and social support from NGOs rather than from the national healthcare system, even after residing in the country for decades. This is notable since NGOs are intended to only serve as a bridge to support patients in accessing the healthcare system. However, the findings suggest that migrant women are not generally hostile towards Italian healthcare professionals. Rather, the national healthcare system often fails to establish a trusting relationship with them, urging the system to consider how to better include and address the needs of migrants, especially women (Savas et al., 2024).

Another significant finding from our study concerns how MW engaged with the media, particularly Italian television's coverage of the pandemic. Understanding the effects of media exposure on MW is crucial, as it can influence both adaptive behaviors (e.g., practicing social distancing) and maladaptive behaviors (e.g., panic buying) (Hita et al., 2023). In our study, television appeared inadequate in its role as an information source. On one hand, it caused distress and led MW to avoid news updates. On the other hand, it fostered an unhealthy obsession with pandemic-related information, not only to be updated on the trend of infections and the number of deaths, but also to monitor "*what happened to people in hospitals*". In addition, the presence of contradictory information characterizing the COVID-19 infodemic posed serious issues, especially when participants were unable to assess the degree of reliability of different information sources. As found also by the study of Czakpa et al. in Norway (Czapka et al., 2023), further confusion arose for MW when they compared the information available in their host country with those coming from their country of origin. This highlights the heightened vulnerability of migrants during disasters, as disaster communication efforts often overlook their language and cultural backgrounds, thus increasing their exposure to misinformation and misunderstandings, which in turn reinforces cycles of mistrust.

Trust was particularly influential in the acceptance of the COVID-19 vaccination. In our sample, 17 out of 19 MW received the vaccination, although only seven did so willingly. Several frameworks have been

proposed to explore the social and psychological factors influencing individuals' health behaviors (Ajzen, 2020), including vaccination uptake (Betsch et al., 2018), especially in the context of the COVID-19 pandemic (Barattucci et al., 2022; World Health Organization, 2022). The Health Belief Model shows that key drivers for vaccination uptake are the individual perceived likelihood of getting infected and of developing severe symptoms of COVID-19, together with benefits of preventive measures (i.e., vaccination). However, other factors need to be considered, including the trust in government, health authorities, and science, the belief in conspiracy theories (Barattucci et al., 2022; Han et al., 2023; Liddell et al., 2021; Wong et al., 2021), and the psychological reactance, which posits that strongly persuasive messaging and social pressure can be perceived as a threat to freedom (Huang et al., 2024; Verpaalen et al., 2023). In our study, for many participants, fear of COVID-19 alone was not a significant driver for vaccination, as it was strongly moderated by beliefs in conspiracy theories, which were prevalent during the pandemic, in line with other study findings (Czapka et al., 2023; Gordon, A.C.T, & Mamluk, L, 2023; Sallam et al., 2021; Vandrevala, Hendy, Hanson, Alidu, & Ala, 2023). Despite hostility towards vaccination, most of the times the *de-facto* requirement for immunization to participate in social activities such as work, use public transportation, and travel within and outside the country was the key driver for vaccination uptake. In this context, the influence of strong familial pressure to avoid vaccination (e.g., subjective norms) (Winter, Pummerer, Hornsey, & Sassenberg, 2022) that many MW experienced, weakened once vaccination became necessary. Therefore, it would be incorrect to assume that people's commitment to the vaccination campaign solely reflects their trust and willingness to get vaccinated, or to consider it the sole measure of the campaign's success.

Although vaccine hesitancy towards COVID-19 has been observed in other populations, in the case of the interviewed MW it was amplified by feelings of distrust towards the national healthcare system. Vaccination campaigns adopting a "one size fits all" approach did not facilitate vaccine uptake among MW. It is worth considering the implications that vaccine refusal may have had on MW, including potential visa-related issues and exacerbation of social stigmatization and discrimination. It is essential for the media, healthcare system, and scientists to reflect on how communication around COVID-19 vaccination has been disseminated.

Interestingly, according to MW's accounts, vulnerability associated with their female identity did not emerge prominently and they often indicated that, for various reasons, migrant men probably faced greater challenges. These accounts are in contrast with those of KIs engaged in a study previously conducted by our research team (Trentin et al., 2024), who described MW as a deeply vulnerable group and further marginalized by the pandemic, in line with other study findings (Trentin et al., 2023; Lebni et al., 2022). MW often mentioned that, despite the challenges, they did not perceive the pandemic as a major issue overall and did not suffer from social isolation. The divergent perspectives may be due to KIs' emphasis on highlighting challenges, believing that underscoring these issues within the context of this research could promote meaningful change. Additionally, MW may lack complete awareness of the structural barriers affecting them or may not fully understand how services are supposed to work in a host country. They might also not view the COVID-19 pandemic as the most significant issue they have faced, or they may downplay their experiences as a form of self-protection. MW may be also already accustomed to such long-distance relationships with their family and friends, which may have lessened the impact of pandemic-related social isolation.

Additionally, although KIs noted or perceived a rise in GBV cases among their MW patients, as widely observed worldwide during the pandemic (Mittal & Singh, 2020; UN Women, 2020; UN Women, 2021; United Nations Population Fund, 2020; UN Women, 2020; UN Women b, 2020; Dlamini, 2021), our interviewees did not discuss this issue. It remains unclear whether this was due to a lack of GBV or because it is a sensitive topic they chose not to disclose. Some MW were also living alone during the pandemic, which may have affected their exposure to intimate partner violence or domestic abuse. Again, the experiences reported by MW we interviewed may differ from those of the MW KIs were referring to.

Similarly, despite extensive literature on the pandemic's impact on women, including migrants, often emphasizes issues such as childcare responsibilities and household burdens (Crawford et al., 2023; Haney & Barber, 2022; UN Women c., 2020), these did not emerge as prominent in our study. Rather, MW expressed concerns about homeschooling and government-imposed social measures.

Finally, our study shed light on the positive experiences of MW during COVID-19, such as instances where participants used the pandemic as an opportunity for personal and professional change. Despite facing vulnerabilities and challenges, MW demonstrated resilience and effective coping mechanisms and future research should also acknowledge these strengths (Molenaar & Van Praag, 2022; Trentin et al., 2023).

4.1. Recommendations

Although the COVID-19 pandemic has unique characteristics that may not be generalizable to other disasters (e.g., its global scale), the experiences of migrant women during the pandemic in Milan provide valuable insights that can inform not only policy recommendations but also strategies for managing future pandemics and other disasters in Milan, Italy, or similar countries.

Firstly, this study further highlights that COVID-19 exhibits a syndemic nature, indicating that solutions focused solely on biological factors and neglecting social and economic disparities will be ineffective in combating a pandemic (Bambra et al., 2020; Caron & Adegboye, 2021; Da Mosto et al., 2021; Horton, 2020). Systemic interventions aimed at addressing inequalities affecting migrant women should be implemented consistently throughout the whole disaster risk management (DRM) cycle (United Nations Office for Disaster Risk Reduction) with a long-term vision, rather than relying on emergency measures during the response phase. Extending legal protection, expanding access to healthcare and to education, ensuring housing security, and facilitating regular access to the job market are essential measures for enhancing migrant women's social protection, which, in turn, helps to promote resilience and mitigate the adverse effects of disasters (Barron et al., 2022). An intersectional approach must be integrated into all stages of public policy development, from agenda setting and problem identification to formulation, implementation, and assessment (Hankivsky & Cormier, 2011). Currently, policies often fail to address the complexities of multiple identities, leaving migrant women–who should benefit from both gender-specific and migrant-specific policies–frequently overlooked. Policymakers must embrace intersectionality to create more effective, responsive, and equitable policies, ultimately reducing inter-group and intra-group disparities. For example, an intersectional disaster-related policy could ensure not only that emergency hotlines for GBV operate 24/7, providing critical support for all women, but also that they are staffed around the clock with cultural mediators and interpreters trained in GBV. Better efforts should also be made to make MW aware of the services available in the city of Milan, as current strategies heavily rely on word-of-mouth communication among fellow citizens.

Vaccination campaigns should be tailored to the needs of different groups (Kumar et al., 2021), possibly engaging communities and relying on NGOs as entry points to facilitate vaccine uptake considering the high level of trust often placed towards them.

Pandemic preparedness and DRM strategies should be both gender-responsive (Women in Global Health, 2023), inclusive towards migrants, and follow an intersectional lens (Jean et al., 2023). As trust is crucial for the effectiveness of disaster response strategies, trusting relationships need to be built before a disaster occurs.

Governments and the national healthcare system should leverage the

expertise of NGOs to identify best practices in supporting migrants and in particular MW in times of a disaster. This can be done by engaging them when designing health policies or DRM strategies addressing migrants.

Lastly, it is crucial that disaster response strategies consider people's risk perceptions and cultural attitudes without dismissing them as "irrational", as may be the case of MW expressing fatalistic considerations. In this regard, it is important to note that DRM adopts an interdisciplinary approach including social sciences. We also emphasize the importance of engaging communities such as MW in the development and implementation of disaster risk reduction strategies.

4.2. Strengths and limitations

This study has some important strengths. Firstly, despite the interviewees' diversity in terms of country of origin, legal status, age, and length of stay in Italy, we were able to show how certain obstacles and experiences are common among MW. This confirms that understanding a phenomenon by also considering the perspectives of long-term residents remains highly valid. Secondly, our interview guide, based on the findings of a scoping review previously conducted by our research team (Trentin et al., 2023), enhances the generalizability of our findings. Thirdly, our study advances the scientific literature on the experiences of migrant women during disasters, addressing a gap in both Italian and global contexts.

This study also has some limitations. The time gap occurring between the start of the pandemic and when interviews were conducted may have created some bias. Such a time gap may have also resulted in an underestimation of the challenges they have experienced. Secondly, MW were recruited through three third-sector organizations, so their experiences may differ significantly from those not accessing these services or the national healthcare system. Thirdly, in some cases, the lack of full command of the Italian language may have made it difficult to address certain topics. Lastly, although we did not intend to generalize our findings to the entirety of MW around the world, the interviewees represent only some regions of the world, limiting the understanding of a broader range of experiences and cultural approaches. The same issue applies to the generalizability of these findings to MW living in Milan. In this regard, it is worth mentioning that our study falls short of reaching all nationalities of MW in Milan.

5. Conclusion

This qualitative phenomenological study, adopting an intersectional approach, explored the experiences of 19 cisgender MW from 10 countries, most of whom held informal positions, primarily as domestic workers, and were significantly impacted by the economic crisis triggered by the COVID-19 pandemic. Their psychological well-being was compromised by distance from family and Italian COVID-19 media coverage. Both before and during the pandemic, NGOs were the preferred entry point to the healthcare systems. Despite vaccine skepticism, most MW adhered to the vaccination campaign due to its *de-facto* mandatory nature. Social isolation was not considered a major impact and overall, despite facing several challenges, MW did not perceive themselves as a particularly vulnerable group.

This study presents policy recommendations and strategies, particularly in light of the increasing frequency of such events and the rise in migrant populations. Systemic interventions to address the inequalities faced by MW should be integrated across the entire DRM cycle, with a long-term approach, rather than relying solely on emergency measures during the response phase. An intersectional approach must be integrated into all stages of public policy development. Governments and the national healthcare system should leverage the expertise of NGOs to identify best practices in supporting MW in times of a disaster. As distrust emerged as a key finding, establishing trust prior to disasters is essential for an effective response.

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CRediT authorship contribution statement

Monica Trentin: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Martina Valente:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Conceptualization. **Emanuele Longo:** Writing – review & editing, Writing – original draft, Methodology. **Elena Rubini:** Writing – review & editing, Writing – original draft. **Awsan Bahattab:** Writing – review & editing, Investigation, Formal analysis. **Giulia Facci:** Writing – review & editing. **Giorgia Ziliani:** Writing – review & editing, Methodology. **Loredana Carpentieri:** Writing – review & editing, Methodology. **Francesco Della Corte:** Writing – review & editing, Supervision. **Luca Ragazzoni:** Writing – review & editing, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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