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TABLE OF CONTENTS

Lucina: from Pathway to Horizon	3
<i>Silvia Vaccari</i>	
Updating the European Directive on Midwives: an Opportunity to Align with Global Standards	5
<i>Lia Brigante, Elsa Del Bo, Silvia Vaccari</i>	
Telephone Triage in Italian Midwifery Care: a Quantitative and Qualitative Study	7
<i>Sofia Colaceci, Mannela Mariotti, Chiara Della Valle, Chiara Grandi, Angelo Pio Morese, Silvia Giovinale</i>	
Work-Related Wellbeing, Organizational Support and Professional Recognition among Italian Midwives: Results from a National FNOPO Survey	21
<i>Caterina Masè, Maria Panzeri, Nadia Rovelli, Simona Fumagalli, Silvia Vaccari</i>	

Lucina: from Pathway to Horizon

Silvia Vaccari

President of the National Federation of the Councils of Midwifery Profession (FNOPO), Rome, Italy

Corresponding author: Silvia Vaccari; e-mail: s.vaccari@fnopo.it

Keywords: *Midwifery profession; Public health; Open access journal; Indexing.*

Since 1935, *Lucina* has been a leading reference for the midwifery profession in Italy and serves as the official journal of the National Federation of the Councils of the Midwifery Profession (FNOPO). A journal with nearly ninety years of history, accompanying the evolution of midwifery, documenting its changes, and preserving its professional memory.

Over time, *Lucina* has adapted to profound editorial and cultural transformations while preserving its identity. Even in the face of the challenges posed by digitalization and the evolving language of scientific communication, the journal has maintained its paper publication, thanks to the commitment of the Presidents of the Colleges, and later of the Councils, who have recognized *Lucina* as an essential space for professional development, dialogue, and a sense of professional community.

It is within this continuity that the journal's new phase takes place. The aim of achieving indexing, which *Lucina* is now resolutely pursuing, was not a sudden turning point, but rather the natural culmination of a journey begun in the previous term and pursued with consistency and vision. This is a patient effort, built over time, which finds the conditions for its implementation in this new edition.

From the beginning of this journey, we believed that *Lucina* could be more than an information tool. We envisioned a journal able to express the scientific thinking of the midwifery profession, enhancing its contribution to research, and offering an authoritative platform for cultural development. Over the years, attention to content quality, methodological rigor, and editorial responsibility has been a conscious and strategic choice.

The challenge of indexing today represents recognition of midwives' ability to produce scientific knowledge. The midwifery profession is not just healthcare practice, but also research, study, critical reflection, and a contribution to the scientific debate on sexual and reproductive health, childbirth, prevention, and health education. These are key areas for public health, requiring solid evidence and constant engagement with national and inter-national scientific literature.

Through *Lucina*, we intend to strengthen this awareness by offering a structured and credible space for those who produce research, experimenting with innovative care models, and contributing to the development of evidence-based practices. Being an indexed journal means giving visibility and dignity to this wealth of knowledge, making it recognizable within the scientific community.

Research and quality of care are inextricably linked. Investing in a scientific journal means investing in the health of women, newborns, and families, promoting appropriate, safe, and respectful care. Science is not distant from the daily lives of midwives: it is their foundation and a guide for their choices.

The journal *Lucina*, as it takes shape in this new edition, is an open access journal, capable of engaging with the academic world, other healthcare professions, and public health. It is a journal that looks to new generations of midwives, supporting their scientific and professional growth, and aiming to be a place for rigorous and diverse debate.

This new mandate begins with a strong sense of responsibility and continuity: a commitment to consolidating what has been achieved while looking ahead to the future, strengthening the scientific identity of the midwifery profession and its role within the healthcare system. *Lucina* will be one of the key tools in this journey.

With this new edition, we renew a commitment rooted in history and looking with determination to the horizon that awaits us.

Silvia Vaccari
President FNOPO

Updating the European Directive on Midwives: an Opportunity to Align with Global Standards

Lia Brigante^{1,2}, Elsa Del Bo³, Silvia Vaccari⁴

¹ Professional Policy Advisor, Royal College of Midwives, London, UK

² Board Member (Europe), International Confederation of Midwives (ICM), The Hague, the Netherlands

³ Secretary, National Federation of the Councils of Midwifery Profession (FNOPO), Rome, Italy

⁴ President of the National Federation of the Councils of Midwifery Profession (FNOPO), Rome, Italy

Corresponding author: Lia Brigante, RM, MSc, BSc (Hons); e-mail: lia.brigante@rcm.org.uk

Keywords: Midwifery education; Global standards; Maternal and newborn health.

The European Commission is currently considering revisions to the Directive on minimum professional qualifications for midwives (Directive 2005/36/EC). This could be the first substantial revision in over twenty years and therefore represents an important opportunity to update the regulation of the profession in light of the latest scientific evidence and changes in healthcare systems¹.

Although the directive formally applies to EU and European Economic Area Member States, its impact extends far beyond the region. European regulatory frameworks are often used as a reference in other national and regional contexts when defining educational and professional standards. For this reason, updating the directive also has implications for the global governance of maternal and newborn health.

In recent years, international organisations such as the World Health Organization (WHO) and the International Confederation of Midwives (ICM) have developed and updated global standards for midwifery education, regulation, and professional competencies. These include the ICM Global Standards for Midwifery Education² and the Essential Competencies for Midwifery Practice³, which are regularly updated to reflect international scientific and professional consensus.

Aligning European legislation with these standards is essential to ensure quality and safety of care. Evidence shows that health systems where midwives are well educated and enabled to practise to the full scope of their professional competencies achieve better outcomes for women and newborns⁴. Furthermore, greater consistency in educational standards facilitates mutual recognition of qualifications and professional mobility within Europe. The latter is particularly relevant in contexts such as Italy, where strengthening alignment with international standards could support the ongoing development of midwifery education, professional autonomy, and implementation of midwifery led models of care.

Midwives are able to provide up to 90% of essential sexual, reproductive, maternal, and newborn health interventions, particularly within primary care-based models⁵. Strengthening midwifery education and the professional role of midwives is, therefore, an effective strategy to improve access to care, reduce inequalities, and enhance the resilience of health systems.

The revision of the European directive, therefore, offers a concrete opportunity to modernise the regulation of the midwifery profession, strengthen alignment between European policies and international standards, and contribute to improving the quality of maternal and newborn care. Aligning European legislation with global standards is not only a bureaucratic process, but an investment in the health of women, newborns, and families.

Declarations

Author Contributions

All authors contributed to the conception and drafting of the manuscript and approved the final version.

Conflict of Interest

The authors declare no conflicts of interest. All authors hold professional roles within national and international midwifery organizations; however, the views expressed in this article are those of the authors and do not necessarily reflect the official positions of their affiliated institutions.

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Telephone Triage in Italian Midwifery Care: a Quantitative and Qualitative Study

Sofia Colaceci¹, Manuela Mariotti², Chiara Della Valle³, Chiara Grandi⁴, Angelo Pio Morese⁵, Silvia Giovinale⁵

¹ *Departmental Faculty of Medicine and Surgery, Saint Camillus International University of Rome and Medical Sciences (UniCamillus), Rome, Italy*

² *Independent Research Midwife, Rome, Italy*

³ *Independent Research Midwife, Parma, Italy*

⁴ *Independent Research Midwife, Rimini, Italy*

⁵ *Independent Research Midwife, Florence, Italy*

Corresponding author: Sofia Colaceci, MSC, PhD; sofia.colaceci@unicamillus.org

Abstract

Background: While telephone triage (TT) is common in other clinical disciplines, its use in midwifery is limited. It has significant potential for managing low-risk cases and reducing unnecessary visits, although logistical and medico-legal barriers remain. The aim of this study was to investigate midwives' experiences and practices in TT management in Italy.

Participants and Methods: A quantitative and qualitative descriptive study involving midwives employed in Italian maternity hospitals was conducted. For the quantitative phase, an online questionnaire was administered via social networks, and for the qualitative phase, midwives were invited to join online focus groups.

Results: The quantitative phase included 224 respondents, 50.9% of whom worked in advanced care maternity hospitals. Approximately 98% received calls from pregnant women, with 59.7% requesting specific information. Training in TT was lacking for 76.8%, while 92.4% lacked tools for managing TT. Key concerns included medico-legal issues and the inability to assess women face-to-face. Key aspects of effective TT management were considered an adequate training and a dedicated service.

For the qualitative phase, 16 midwives participated in two focus groups. Three themes emerged: 1) current TT use and organisation, 2) competencies and resources, and 3) strengths and weaknesses. Despite recognising the numerous strengths of TT in improving clinical practice, midwives do not feel confident in providing telephone consultations, especially for medico-legal reasons, if the TT service is not official and structured.

Conclusions: Standardised systems, training, and dedicated services are crucial to enhancing midwives' confidence and safety regarding TT, ensuring clear documentation, and addressing medico-legal concerns to improve clinical practice.

Keywords: *Telephone triage; Telemedicine; Midwifery.*

Introduction

Italy has been significantly impacted by the COVID-19 pandemic, and the related restrictive measures to prevent contagion have led to a substantial reduction in emergency room visits^{1,2}. This scenario has represented a necessary opportunity to implement certain practices, such as the use of telemedicine and telephone consultations, especially in emergency and triage settings³.

Triage is the initial assessment phase in which patients are evaluated for their relative risk level and subsequently assigned an appropriate priority code based on their clinical condition⁴. This practice is of paramount importance, as it guides patient prioritisation and ensures appropriate care planning⁵. While triage is a well-established and regulated practice in clinical settings, particularly in nursing⁶, its application in obstetric and midwifery settings requires specific consideration owing to the particular characteristics of these disciplines⁷. Many clinic disciplines already experimented with the practice of telephone triage (TT) or telephone consultations before the COVID-19 pandemic. Contrastingly, the international literature regarding their use in midwifery care is limited⁸, and there are no national data on TT provided by midwives nor on their opinions and experiences regarding this practice.

The potential of TT in midwifery care is significant, especially in managing low-risk women to assess whether they need an in-person visit or another service/specialist or, in the case of the latent phase of labour, to provide information that is useful for a wait-and-see attitude at home until active labour develops. The literature shows that the practice of TT has numerous benefits, such as reducing unnecessary access, decreasing healthcare costs, and improving staff satisfaction⁹. However, persistent barriers that hinder midwives' widespread adoption of TT include logistical challenges and apprehension about potential medico-legal implications¹⁰.

Therefore, the aim of this study was to investigate midwives' experiences and practices in TT management in Italy.

Participants and Methods

A quantitative and qualitative descriptive study that included midwives who were employed at an Italian maternity hospital was conducted. Approval by the Ethics Committee was not required by Italian regulations for this type of study (GU n. 76 of 2008). The participants were informed about and agreed to the use of anonymous data in line with Italian data protection legislation. All participants provided written informed consent prior to inclusion in the study.

Quantitative phase

For the quantitative phase, an anonymous questionnaire was developed based on a preliminary literature review on telephone triage in obstetric and emergency settings, as well as on the main organisational and training aspects described in previous studies^{8,10}. Particular attention was given to variables related to professional background, training in telephone triage, availability of protocols and tools, perceived confidence, and organisational characteristics of the workplace.

The items were formulated to explore the factors that may influence the use of telephone triage in clinical practice, in line with the literature highlighting the importance of structured interviews, documentation tools, adequate training, and organisational support for safe telephone assessment⁸⁻¹⁰. Between October and November 2022, the final 14-item questionnaire was pre-tested and then administered online to Italian midwives using professional social media platforms to facilitate voluntary participation.

Statistical Analysis

The collected data were analysed using Epi Info statistical software version 7.2 (Centers for Di-

sease Control and Prevention, Atlanta, Georgia, USA). We conducted a descriptive analysis using absolute and relative frequencies, average, and range. The results of the quantitative phase of the study were reported following the STROBE checklist¹¹.

Qualitative phase

Upon analysing and discussing the quantitative data, the working group opted to delve deeper into the study to gain a more comprehensive understanding of the topic. Given the limited prevalence of TT, a qualitative approach was chosen, as this methodology is recommended for exploring individuals' experiences and opinions.

The descriptive phenomenological phase of the study was conducted from March to April 2024. Midwives who were practising in Italy were recruited through convenience sampling involving colleagues who expressed interest in the project.

Participants were invited to join an online focus group and provided written informed consent via email. The focus groups were facilitated by a research midwife experienced in qualitative data collection, and the sessions were digitally audio-recorded and transcribed in full.

The focus group questions were developed through a brainstorming session among the authors, aligning with the specific objectives derived from the scientific literature^{8,10} and the results of the quantitative phase of the study. These objectives were formulated into four open-ended questions and summarised into a semi-structured interview form (Table 1). An anonymous form was created to collect key sociodemographic data. The duration of each focus group was guided by the participants' input.

The focus group discussions were fully transcribed and manually coded using the long table analysis method¹². Data saturation was achieved when no new information emerged from the focus groups¹³. Three authors analysed the data to mitigate subjective biases, adhering to Creswell's methodological framework¹⁴. The themes that emerged, as well as their interpretations, were discussed among the three authors, while the remaining authors provided oversight to ensure the rigour of the qualitative analysis. The identified themes were shared with the participants via email for their feedback, which was unanimously positive.

The qualitative phase of the study was reported in accordance with the COREQ checklist¹⁵.

Table 1. List of questions for the focus groups.

How is Telephone Triage currently managed in your professional setting?
How was Telephone Triage handled during the Covid pandemic?
In your opinion, what are the strengths of Telephone Triage? And what are the challenges or key aspects to pay attention to?
In your view, what are the most important skills and aspects in managing Telephone Triage?
How could healthcare organizations improve the Telephone Triage in the Midwifery Care?

Results

Quantitative phase

The quantitative part of the study entails a descriptive-observational investigation aimed at assessing the organisation of TT in Italian maternity hospitals and midwives' opinions and experiences on this practice.

The sample consisted of 224 respondents, whose sociodemographic characteristics are reported in Table 2. Specifically, regarding the geographical working area, 72.8% of the sample were from Northern Italy. Subsequently, the work setting was investigated, and 50.9% of the sample were employed in an advanced care maternity hospital. Regarding the age and work experience of the study participants, 53.6% belonged to the 25–34-year age group, with a minimum percentage of respondents > 44 years (5.8%), and 45.5% of the sample were found to have 1–5 years of work experience.

Regarding workplace characteristics (Table 3), a substantial number (71.4%) of respondents confirmed the presence of differentiated clinical-care pathways based on obstetric risk (low risk/modified risk). Additionally, 98.2% reported receiving phone calls from pregnant women during their shifts, with 59.7% of these calls entailing requests for specific guidance. Regarding training, 76.8% of the respondents lacked TT training, and among those who received training, undergraduate education (42.3%) and shadowing experienced colleagues (42.3%) were the predominant methods.

Regarding the characteristics of TT service (Table 4), the majority of the sample (92.4%) indicated

Table 2. Participant characteristics (N=224)

Characteristics	N	%
Geographical working area		
Northern Italy	163	72.8
Central Italy	41	18.3
Southern Italy	20	8.9
Setting		
Hub hospital	114	50.9
Spoke hospital	88	39.3
Community	22	9.8
Age of participants (years)		
< 25	45	20.1
25-34	120	53.6
35-44	46	20.5
> 44	13	5.8
Working experience (years)		
< 1	33	14.7
1-5	102	45.5
6-10	37	16.5
11-20	42	18.8
> 20	10	4.5

Table 3. Workplace characteristics (N=224)

Characteristics	N	%
Differentiated clinical and care pathways (low-risk /modified-risk)		
Yes	160	71.4
No	64	28.6
Calls from pregnant women during work activity		
Yes	220	98.2
No	4	1.8
Theme of the questions to be answered (multiple answer)		
Specific behaviour directions	132	58.9
General information	128	57.1
Labour and delivery information	110	49.1
Training in telephone triage (multiple answer)		
Yes	52	23.2
No	172	76.8
Type of training (multiple answer)		
Training with job shadowing	22	9.8
Undergraduate education	22	9.8
Training with refresher courses	12	5.4

Table 4. Characteristics of telephone triage service (N=224).

Characteristics	N	%
Availability of tools for managing telephone triage		
Yes	17	7.6
No	207	92.4
Type of tools present (multiple answer)		
Specific protocols	7	3.1
Specific checklist	7	3.1
Systems for calls recording (paper sheets, software applications, other)	6	2.7
Confidence in managing calls		
Yes, enough	121	54.0
No	68	30.4
Yes, almost all the time	30	13.4
Yes, always	5	2.2
Major concerns (multiple answer)		
Difficulty in not being able to assess face to face	153	68.3
Fear of underestimation of the situation	129	57.6
Medical-legal aspects	117	52.2
Incomplete understanding of the real problem manifested	74	33.0
Inadequate preparation for managing the call	50	22.3
Telephone triage management environment		
Ward's room	122	54.5
Obstetrical emergency room outpatient	40	17.9
Obstetric ward	38	17.0
Dedicated spaces	24	10.7
Presence of dedicated midwifery staff		
Yes	10	4.5
No	214	95.5
Skills and most important aspects in the management of telephone triage (multiple answer)		
Possibility of devoting sufficient time to the call	196	87.5
Appropriate training	137	61.2
Presence of a dedicated service that does not burden other midwifery activities	135	60.3
Presence of quiet environment	114	50.9
Ability to prioritize correctly	113	50.4
Decision-making skills	105	46.9
Active listening skills	100	44.6
Strong communication skills	58	25.9

that they lacked the tools to manage TT in their workplace. Among the minority with such tools, specific protocols (41.2%), checklists (41.2%), and call recording systems (35.3%) were equally represented. Moreover, 13.4% of the participants almost always felt confident, while 2.2% reported that they always felt confident when handling phone calls. Primary concerns included the inability to assess women face-to-face (68.3%), underestimation of clinical situations (57.6%), and medico-legal considerations (52.2%). Additionally, a mere 10.7% reported having dedicated spaces for handling phone calls, and only 4.5% had dedicated midwifery staff in their workplaces.

Finally, the questionnaire probed midwives on crucial skills and aspects of TT management. Notably, among the respondents, dedicating sufficient time to phone calls (87.5%), receiving adequate training (61.2%), and having a dedicated service (60.3%) emerged as highly important.

Qualitative phase

Between March and April 2024, we conducted two online focus groups involving 16 midwives. Most of the participants were aged between 29 and 36 ($n = 8$) and had been working as midwives for less than 10 years ($n = 12$). Most of them worked in central Italy ($n = 9$)—and, to a lesser extent, in the north ($n = 4$) and south of Italy ($n = 3$)—mainly in advanced care maternity hospitals ($n = 11$). The following three themes emerged: 1) current TT use and organisation, 2) competencies and resources, and 3) strengths and weaknesses. The related main representative verbatim quotes are reported in the text.

Theme 1. Current TT use and organisation

All the participants, except one, declared that in their work settings, there is no structured TT system; therefore, calls are managed in a “confusing” way. Women phone the hospital switchboard, and the calls are forwarded to the obstetric emergency room or obstetrics department based on how the hospital is organised. Sometimes, when precise instructions are not given, the switchboard operator can randomly pass the call to the obstetrics department, obstetric emergency room, or delivery room, and this creates further confusion for both women and staff:

Telephone triage is very confusing. It also depends on the number given to women. Some call the ward; others call the obstetric emergency room. When we receive the call, if it is urgent, we have them come to the emergency room immediately. If it is not urgent, we evaluate what to do. It is not easy because it is not structured. (P1)

Only one participant stated that at her hospital, they recently started a TT project dedicated to low-risk women that is especially for the management of prodromes. The system is well structured and includes call recording and a specific protocol that guides midwives during the phone call, as evidenced by the following quote:

Women can have telephone access to triage services without going to the emergency room. So you do a short anamnesis. We have set it up on an obstetric anamnesis. We have a paper medical record of TT in which you fill in all the fields. Our protocol provides for three calls for the same symptoms of the same woman, after which it is recommended to come to the hospital for observation. (P2)

Most midwives reported that because TT is not structured and is not an official service, they feel the burden of responsibility in making an assessment only by telephone; therefore, this leads them to always end the phone call with the recommendation to go to the emergency room. P5,

the only participant who deals with structured TT, stated that before the start of the project, the midwives “could not tell women not to go to the emergency room” given that the call was not recorded and there was no predefined protocol for assessment. If, however, a structured TT is established, a legal and official connotation is given to this activity:

TT is not structured; it is not defined by any protocol ... so most of the time, we do not want to take the responsibility on the phone to leave the woman at home. We almost always tell her that it would be better to come to the emergency room anyway. So in the end, the phone call is of no use. (P5)

In both focus groups, some midwives clarified to those participants who were more reluctant towards TT that the aim of this tool is not to make a diagnosis but, rather, to assess whether the woman needs an in-person visit or to be referred to another service. Once this aspect was explored, the importance of working in hospitals in which a clear differentiation between low- and high-risk care pathways has been implemented emerged in both focus groups. The midwives repeatedly reiterated the need to reserve TT exclusively for low-risk women at term. In fact, in facilities in which the division between low- and high-risk pathways is implemented, low-risk pregnant women are taken care of by midwives and receive a designated telephone number for requests. In hospitals in which the division of care pathways is not present, the midwife’s care of the woman becomes more complex as multi-professional and team management takes over, rendering the organisation of TT complex in terms of roles and responsibilities:

TT is not intended to make a diagnosis, which in any case would be the responsibility of the obstetrician and not the midwife, but it is used to understand if the woman should come in person because her condition and symptoms require it. On the contrary, if a woman with a physiological pregnancy at term calls [and] reports contractions that we still assess as prodromes, then we should support her with all the necessary information. (P2)

The COVID-19 pandemic is a subtheme addressed by the research group to explore its impact on TT practice. The participants stated that during the pandemic, they witnessed a drastic decrease in emergency room visits but, conversely, a notable increase in the number of telephone calls. All the midwives agreed that the investment required was, above all, emotional; in fact, the fear and uncertainties induced by the pandemic, as well as the isolation and restrictions that became necessary, increased the state of anxiety and fragility of pregnant women and new mothers. Calls during the pandemic therefore mainly took on the role of reassurance, an “open door” to which women could refer, even for sometimes very “trivial” reasons. One participant stated that during the pandemic, the hospital equipped midwives with a phone with which they could make video calls and chat with women. Furthermore, home visits increased. This also made it possible to reach a subpopulation of women and couples who, faced with some doubts and having no economic or transportation means, would not have physically reached the obstetric emergency room or, to do so, would have called the emergency number to request an ambulance. Being able to chat with the midwife, send her photos, or video-call her guaranteed to the user that they would be taken care of.

During the lockdown, there was a drastic drop in emergency room visits, there was an increase in home births, and the phone was ringing like crazy continuously for anything. The anxiety of the women was skyrocketing. (P14)

It almost became a psychological consultation. It was difficult to manage the phone calls because they were much less practical and much more emotional. (P8)

None of the participants stated that the number of telephone consultations managed during the COVID-19 pandemic encouraged health departments to improve the service of TT to use it in a more effective and organised way even after the pandemic.

Theme 2. Competencies and resources

According to the participants, TT requires, on the one hand, some specific selection criteria for the personnel who answer calls and, on the other, specific human and organisational resources.

When it comes to staffing, the two key elements are work experience and communication skills. Working in the obstetric emergency room for some time offers midwives greater confidence in managing cases over the telephone and therefore greater promptness in recognising the symptoms reported by the women. In any case, it is important that the midwives who deal with TT have good communication skills, in addition to specific clinical skills, as lacking direct observation of the woman, her tone of voice, her silences, and the speed with which she communicates are relevant clues. Regarding the organisation, all the participants agreed on the need to have a structured and official TT system with a dedicated midwife. This system should offer a predefined set of questions and ensure the traceability of the information collected:

It takes the right words; it takes the right way to talk to that person, knowing how to manage words, tone of voice, [and] speed. You have to do the impossible to be as clear as possible. (P12)

We need a midwife dedicated only to telephone triage. It takes work experience in the emergency room, and it takes a standardised protocol that also includes a checklist and a list of questions to follow to properly frame the clinical and emotional situation of the woman. (P16)

The only participant who deals with structured TT states that there are no dedicated staff in her hospital, as the service is offered solely to low-risk women who are assisted by the hospital midwives. If the service were advertised and the calls increased in number, it would be essential to have dedicated midwives.

Theme 3. Strengths and weaknesses

Among the strengths, the participants indicated that TT is an effective method of reducing inappropriate access to the emergency room and the improper use of ambulances. Furthermore, TT guarantees women 24-hour access to secure information provided by healthcare personnel. A further advantage of TT is that when the telephone consultation ends with the invitation to come to the emergency room in person, the healthcare staff can already plan the activities and prepare the necessary devices while waiting for the arrival of the woman. One study participant stated:

For me, the strength is the continuity because it is reassuring for the woman to have a point of reference. And it is also reassuring for me to know who is coming because we spoke on the phone, and I already have an idea of the reason why I advised the woman to come. (P11)

Regarding the critical issues, the midwives raise the problem of the language barrier which, in addition to causing difficulties when the consultation is in person, is amplified in TT. In an in-person situation, the woman's triage can be facilitated by paraverbal language, observation of symp-

toms, and the possible use of digital tools that allow women to quickly translate information into Italian using their smartphones. For these reasons, the participants hypothesise the possibility of using a TT system that allows for the rapid availability of linguistic mediators online or via telecall or the use of artificial intelligence so that translations can be obtained in real time, although they are less precise and reliable than those carried out by cultural mediators. Another critical issue mentioned concerns the weight of medico-legal responsibility. Some midwives believe that the TT system should be able to guarantee midwives the same level of medico-legal risk as in-person triage. If the level of risk of TT use were higher, they would probably not feel protected. For this reason, the participants suggest focusing on training triage staff in terms of clinical skills and decision-making as well as effective communication. One participant stated:

There are many foreigners who struggle to explain what is happening. Maybe you underestimate a situation that could potentially be serious. (P4)

Discussion

The findings indicate that the practice of TT is mainly characterised by telephone consultations, which do not have an official connotation. This is consistent with the literature; in fact, Bailey et al.⁸ state that TT in midwifery care is often an informal service that is managed by midwives who are already occupied with other clinical activities on the wards. Our study has revealed that calls received at the maternity hospital are frequently dealt with hastily or even interrupted owing to the lack of spaces and/or personnel dedicated for this purpose. This exacerbates the workload of midwives, who, if already busy with other clinical duties, tend to provide standardised and impersonalised advice, often opting to recommend in-person visits to the facility.

The integration of quantitative and qualitative findings allowed a more comprehensive interpretation of telephone triage practice in Italian midwifery care. While the survey provided an overview of the organisational characteristics, training background, and perceived confidence of midwives, the qualitative phase helped to explain the reasons underlying these results.

In particular, the quantitative data highlighted the limited availability of training, protocols, and dedicated resources, whereas the focus groups clarified how the absence of structured systems leads to uncertainty, increased perceived responsibility, and defensive clinical behaviours. The qualitative findings also helped to interpret the high importance attributed by respondents to training, dedicated staff, and organisational support, showing that these elements are considered essential to ensure safety and professional accountability in telephone triage.

Overall, the combination of quantitative and qualitative data suggests that the main barriers to the implementation of telephone triage are not related to its perceived usefulness, but rather to organisational, educational, and medico-legal factors. This methodological integration strengthens the interpretation of the results and provides a more complete understanding of the current situation in Italy. Bailey et al.⁸ report that the calls are frequently undocumented and that midwives' attributes in TT are not evaluated. In this regard, the lack of guidelines, protocols, and standardised documentation systems emerged as a key organisational issue. This informal and unofficial approach to TT translates into significant medico-legal apprehensions for midwives who are involved in the process. As noted by many authors^{10,16}, the main legal concerns that

staff encounter in TT include failure to identify the nature and urgency of the problem, inadequate responses, indirect communication with the patient, insufficient or absent documentation of telephone calls, and breaches of patient privacy.

In terms of the skills and attributes required, according to Bailey et al.¹⁰, the profile of a midwife performing an effective TT includes being experienced and confident, possessing effective communication and counselling skills, and having strong clinical knowledge and advanced decision-making abilities.

One of the most common fears among the midwives included in our study is the inability to accurately assess the nature and urgency of a situation over the phone. Some midwives worry that they lack the appropriate experience to make informed decisions by phone. Therefore, training focused on enhancing skills and confidence in this practice is crucial⁸.

Presumably, the insecurity felt by midwives is also due to the intrinsic remote nature of the TT practice itself. First, evaluations rely solely on auditory information. Consequently, some clinical details, which are sometimes crucial in midwifery for determining the priority level of a situation, may be missed. Second, the midwife seldom personally knows the woman with whom they are speaking on the phone, and the clinical documentation may not be immediately available during the call.

Another issue relates to the ability to speak directly with the woman, instead of having to communicate through a third party, such as her partner. It is well known that when messages are relayed through a third party, there is a risk that not all information is conveyed accurately owing to this mediation¹⁰. Another scenario in which an in-person assessment is necessary, as a telephone assessment may not be adequate, is when the woman's first language is different from the primary language spoken in the country in which the maternity hospital is located. In such cases, it is essential to use the services of an in-person cultural mediator⁸.

Moreover, the process of listening becomes more difficult when the woman is experiencing heightened anxiety or fear, as these emotions can hinder her ability to articulate her concerns or relay crucial clinical information accurately. This can lead to misjudgements regarding the urgency and nature of the situation. Therefore, if the woman exhibits signs of anxiety or makes multiple calls, it is advisable to encourage her to visit the healthcare facility in person⁸. All these factors can negatively impact the clinical assessment and decision-making process.

Consistent with the literature, despite the fears and uncertainties attributed to the practice of TT, the participants in our study also recognise its numerous strengths and advantages. First, this tool would enable more appropriate management of patient flow to hospitals, thereby reducing the number of unnecessary visits. As a result, a more efficient use of staff and resources would be achieved, enhancing the quality of care for already admitted patients in terms of time and concentration^{8,17}.

Moreover, TT reduces unnecessary trips to the hospital for pregnant women⁸. Women at full term, especially first-time mothers, often visit their chosen maternity hospital two or three times in the hours leading up to active labour. With access to a TT service staffed by dedicated midwives who are skilled in communication and equipped to offer pain management strategies during the

prodromal phase at home, unnecessary hospital visits could be minimised. Once any conditions requiring in-person assessment have been ruled out, the number of women accessing obstetric emergency rooms would decrease. Consequently, for low-risk women, arriving at the maternity hospital during only the active phase of the first stage of labour would also reduce their likelihood of receiving unnecessary treatments. This is an important aspect to take into consideration given that national data show a medium-high level of medicalisation and overtreatment during pregnancy, childbirth, and puerperium¹⁸.

It is interesting that the COVID-19 pandemic has apparently been unable to give an impetus to the diffusion of official and well-structured TT services in midwifery care in Italy. However, we hypothesise that this is partly owing to the limited national implementation of the differentiation of obstetric risk levels, as also emerged in the focus groups. Having a care pathway dedicated to low-risk women would allow the selection of a specific target group of women whose care is provided exclusively by midwives. This would make the midwifery personnel dedicated to TT more confident in answering calls and managing telephone consultations. This aspect is probably an expression of the current status of the midwifery profession in Italy. In fact, the latter is influenced by the partial application of both the guidelines of the Italian Ministry of Health¹⁹ on the adoption of the midwifery-led care model for low-risk cases and the legislation on midwives' autonomy²⁰.

Limitations

Considering the voluntary participation and the convenience sampling, this study may have been affected by self-selection response bias²¹, with midwives who are interested in the topic being more inclined to participate. In addition, the geographical distribution of respondents was not homogeneous, with a clear overrepresentation of Northern Italy, which may reflect differences in organisation of maternity services across the country. This imbalance may limit the generalisability of the findings to the entire Italian context, as organisational models, availability of resources, and implementation of midwifery-led care pathways may vary between regions. Moreover, with specific regard to the qualitative part of the study, some nuances and meanings from the respondents' original language (Italian) may have been lost in translation. However, despite these limitations and to the best of our knowledge, this is the first study conducted in Italy specifically examining midwives' opinions, attitudes, and practices related to TT. Further research should investigate this area to assess its efficacy, particularly in contexts in which TT is an established practice.

Conclusions

This study provides a significant contribution to our understanding of midwifery TT practices and experiences in Italy. Although midwives generally consider TT to be useful, they feel constrained in their roles, particularly owing to medico-legal concerns. There is an urgent need to implement appropriate logistical and organisational strategies. For example, the development and adoption of standardised systems are essential to ensuring the existence of clear and precise documentation that guides the TT process, making it safer for both midwives and women. Tools such as call-recording forms and specific training are effective and cost-efficient in enhancing midwives' confidence in TT, aiding in the standardisation of call management processes. Im-

proving TT practices could help midwives tailor the service to better meet both their workplace requirements and women's needs.

Declarations

Artificial Intelligence (AI) – Assisted Technology Statement

No AI-assisted technologies were used in the preparation of this manuscript.

Authors' Contributions

All authors meet the 4 authorship criteria as defined by the International Committee of Medical Journal Editors (ICMJE). Each author has contributed substantially to the conception and design of the study, the analysis and interpretation of data, and the drafting / critical revision of the manuscript, as follows: SC, SG - Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing-original draft, Writing-review & editing; CDV, CG - Data curation, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing-original draft, Writing-review & editing; MM, APM - Data curation, Investigation, Project administration, Supervision, Validation, Writing-original draft.

All authors have approved the final version of this manuscript.

Conflict of Interest

No conflict of interest to declare.

Data Availability Statement

The data used and/or analyzed during the current study are available upon reasonable request from the corresponding author.

Ethics Approval

Approval by the Ethics Committee was not required by Italian regulations for this type of study (GU n. 76 of 2008).

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Informed Consent

All participants provided written informed consent prior to inclusion in the study.

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Work-Related Wellbeing, Organizational Support and Professional Recognition among Italian Midwives: Results from a National FNOPO Survey

Caterina Masè¹, Maria Panzeri², Nadia Rovelli³, Simona Fumagalli², Silvia Vaccari⁴

¹ *Independent Midwife, Trento, Italy*

² *School of Medicine and Surgery, University of Milano-Bicocca, Milan, Italy*

³ *Vice President of the National Federation of the Councils of Midwifery Profession (FNOPO), Rome, Italy*

⁴ *President of the National Federation of the Councils of Midwifery Profession (FNOPO), Rome, Italy*

Corresponding author: Maria Panzeri, PhD student; e-mail: maria.panzeri@unimib.it

Abstract

Background: Work-related wellbeing, organizational support, and professional recognition are key determinants of job satisfaction, workforce sustainability, and quality of care in midwifery. In Italy, midwives work across heterogeneous organizational settings and often face challenges related to resource availability, professional autonomy, and recognition within multidisciplinary teams. However, national-level evidence exploring these dimensions of midwives' professional wellbeing remains limited. This study aimed to investigate Italian midwives' perceptions of work-related and organizational wellbeing, focusing on three core dimensions: availability of resources, team support and professional recognition, and workplace safety.

Materials and Methods: A national cross-sectional survey promoted by the National Federation of the Councils of Midwifery Profession (FNOPO) was conducted among registered midwives in Italy. Data were collected through an anonymous online questionnaire consisting of 178 items. For the purpose of this study, analyses focused on a specific section comprising 20 items assessing work-related and organizational wellbeing, measured using a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Descriptive and inferential analyses were performed using Stata/MP 18.0.

Results: A total of 2330 midwives participated in the survey, representing 11.99% of all midwives currently practicing in Italy. Among the respondents, "Team support and professional recognition" was generally rated positively, while "Availability of resources" and "Workplace safety" showed more mixed perceptions. Midwives in Level I maternity units reported higher work sustainability and perceived quality of care, whereas those in Research Hospitals reported lower perceptions across multiple dimensions despite higher satisfaction with professional development. Self-employed midwives reported adequate work sustainability but limited access to resources, psychological support, and team recognition. Post-bachelor education was associated with higher perceived exposure to workplace aggression and lower freedom of expression, while years of experience and geographical area were significantly associated with most items.

Conclusions: This study highlights variability in Italian midwives' perceptions of work-related and organizational wellbeing, largely shaped by organizational and contextual factors. Care setting characteristics, professional experience, and geographical context play a central role across multiple dimensions, while educational level shows a more limited association. The large national online survey, with broad participation and good representativeness, strengthens the robustness and relevance of these findings. Targeted organizational strategies to improve resources, leader support, and workplace safety are needed to promote midwives' wellbeing and workforce sustainability.

Keywords: *Midwifery; Work-related wellbeing; Organizational support; Workplace safety; National survey; Italy.*

Introduction

Work-related wellbeing is a multidimensional construct that extends beyond the mere absence of occupational illness or stress. It encompasses overall quality of working life, including physical, mental, and social health¹. According to the Job Demands–Resources (JD-R) theory, organizational wellbeing across occupational context is shaped by the balance between job demands and job resources. Job resources are defined as those physical, psychological, social, or organizational aspects of work that support goal achievement, reduce job demands, and foster personal and professional growth. These resources include, among others, the availability of adequate staffing and material resources, team support, professional recognition, and workplace safety².

This theoretical framework is particularly relevant in healthcare settings, where unfavourable organizational conditions are associated with a heightened risk of emotional exhaustion and burnout among professionals^{3,4}. Such adverse psychological outcomes affect not only individual practitioners but also healthcare organizations as a whole, contributing to increased staff turnover, chronic understaffing, and reduced system efficiency. Importantly, a substantial body of literature has established a strong association between healthcare workers' distress and patient safety outcomes: lower levels of staff wellbeing are linked to a higher incidence of clinical errors and a deterioration in the overall quality of care⁴. Consequently, healthcare professionals' wellbeing has been formally recognized as a core component of the “Quadruple Aim”, which identifies care for the provider as a prerequisite for achieving high-quality care, improved population health, cost containment, and system sustainability⁵.

Within the specific context of midwifery, work-related wellbeing acquires distinctive characteristics due to the intense emotional demands and the profound responsibility inherent in maternity care, which simultaneously involves at least two individuals—the mother and the newborn. Midwives may be exposed to traumatic clinical events, moral distress, and complex ethical dilemmas; when these experiences are not adequately buffered by organizational support, they can lead to significant emotional strain⁶. Evidence suggests that when midwives perceive insufficient professional recognition or limited team support, the quality of woman-centered care may be compromised, potentially resulting in more fragmented or defensive clinical practices⁷. Recent studies further highlight that the capacity to offer personalized, woman-centered care is not solely an individual competency but is strongly influenced by the organizational climate. Supportive work environments enable midwives to sustain their professional identity, resilience, and commitment to care^{7,8}.

Within midwifery practice, organizational conditions also shape midwives' perception of professional empowerment, defined as the perceived ability to exercise autonomy, professional judgement, and woman-centered care. Evidence suggests that perceived empowerment represents a crucial psychosocial resource, mediating the relationship between organizational support, professional recognition, and work-related wellbeing⁹.

Despite growing international interest in organizational wellbeing in midwifery, empirical evidence focusing on Italian midwives remains limited. Available studies indicate that midwives' professional experiences in Italy are strongly shaped by organizational factors, including support from colleagues and managers and levels of professional recognition, all of which contribute to

perceived workplace safety, stress, burnout, and overall professional quality of life^{10–13}. However, existing research is often context-specific^{12,13}, qualitative¹¹, or conducted during the acute phases of the COVID-19 pandemic^{10,11}. As a result, there is a paucity of systematic evidence exploring Italian midwives' perceptions of key dimensions of organizational wellbeing under routine, non-emergency working conditions.

An additional layer of complexity arises from the marked heterogeneity of the Italian midwifery professional context. Working conditions, role autonomy, and organizational models vary considerably across regions and healthcare settings. Compared with countries where midwifery roles are more clearly defined and standardized—such as the United Kingdom—Italian midwives often report lower levels of professional recognition and job satisfaction¹⁴. This dissatisfaction has been identified as a contributing factor to professional migration, with a growing number of Italian midwives seeking improved employment opportunities and working conditions abroad¹⁵. Such variability has important implications for organizational wellbeing, workforce retention, and the quality and continuity of maternity care.

In response to these gaps, the present study aims to investigate Italian midwives' perceptions of work-related and organizational wellbeing, with a specific focus on three core dimensions: availability of resources, team support and professional recognition, and workplace safety.

Materials and Methods

Study design

A cross-sectional study was conducted using an online questionnaire to address the aim of the study. Data were collected between June and September 2022. The reporting of this study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for observational studies¹⁶.

Setting

The study was conducted in Italy and targeted midwives working across different regions of the country, reflecting the national heterogeneity of maternity care organizations. In 2024, approximately 19,500 midwives were employed in Italy, and a total of 369,944 births were recorded nationwide.

Within the Italian healthcare system, midwives are responsible for providing public health and maternity care to women and families across the reproductive continuum. However, their professional role and level of autonomy vary considerably depending on regional policies and organizational models. The majority of Italian midwives are employed within the National Health System and primarily work in hospital-based maternity and gynaecology services, while a smaller proportion are involved in community-based care. Only a limited number of midwives practice in midwifery-led units or as independent professionals.

The Italian maternity care context is largely characterized by a mixed-care model, in which midwives and nurses jointly provide care within obstetric and gynaecological services, rather than a predominantly midwife-led model¹⁵.

Participants

Given the exploratory and descriptive nature of this national cross-sectional survey, no a priori sample size calculation was performed, in line with established guidance for observational and survey-based research^{16,17}. Instead, the study aimed to achieve the widest possible participation of practicing midwives across Italy. The final sample size was considered adequate to provide stable descriptive estimates and to support multivariable analyses, consistent with methodological recommendations for applied health and organizational research¹⁸.

A purposive sampling strategy was adopted to recruit midwives practicing across Italy through the National Federation of the Councils of Midwifery Profession, which act as regulatory bodies and gatekeepers for professional registration. An invitation email containing a participant information sheet and a link to access the informed consent form and the online questionnaire was distributed to potential participants. In addition, the study was promoted via the official website of the Italian Councils of Midwives. A member of the research team was available to respond to enquiries, provide further details about the study, and discuss participation with interested midwives.

Data collection

The survey was developed to describe the professional characteristics of Italian midwives, based on the competencies, knowledge, and skills considered essential for the midwifery profession, as defined by the national legislative framework¹⁹, the professional code of ethics²⁰, and educational regulations. These regulatory documents provided the foundation for the design and content of the questionnaire. In addition, the questionnaire was informed by a review of the relevant scientific literature on midwifery competencies and professional roles, to ensure alignment with existing evidence. An expert panel composed of midwifery professionals, including clinicians and academics with expertise in midwifery practice and education, was involved in the development of the questionnaire. The panel contributed to item generation and reviewed the questionnaire for relevance, clarity, and completeness, and consensus was reached through iterative discussion.

The questionnaire comprised seven sections. Section 1 collected socio-demographic and work-related characteristics and included 11 items. Section 2 explored professional skills and levels of autonomy across different areas of practice: obstetric care (20 items), neonatal care (10 items), gynaecological care (19 items), and transversal competencies and professional autonomy (9 items). Section 3 focused on professional knowledge and included 15 items. Section 4 assessed work-related and organizational well-being, considering the “Availability of resources”, “Team support and professional recognition”, and “Workplace safety”. Section 5 investigated professional visibility and recognition through 11 items. Section 6 examined job satisfaction and consisted of 3 items. Finally, Section 7 addressed organizational communication and professional involvement and included 5 items. Italian version and English translation of items related to work-related and organizational well-being are described in **Supplementary Material 1**.

Variables

The main variables of interest in this study were 20 items assessing midwives’ work-related and organizational wellbeing, measured on a 5-point Likert scale ranging from 1 (“Strongly disagree”)

to 5 (“Strongly agree”). These items were grouped into three dimensions: “Availability of resources” (items 1, 7, 8, 9, 11, 17, 18, 19, 20), “Team support and professional recognition” (items 2, 3, 4, 5, 6, 10), and “Workplace safety” (items 12, 13, 14, 15, 16).

For the evaluation of associations between these items and selected personal or professional characteristics, items were dichotomized: responses of 4 or 5 were coded as “yes,” indicating agreement, and responses of 1, 2, or 3 were coded as “no,” indicating disagreement or neutrality. This approach was adopted to distinguish between positive (agreement) and non-positive (neutral or negative) perceptions, thereby facilitating the interpretation of results and allowing the identification of factors associated with more favourable *versus* less favourable evaluations.

Among the professional characteristics, post-bachelor education was dichotomized as “no” for midwives with only a bachelor’s degree and “yes” for those with any additional educational qualification. Years of work experience were categorized into three groups: ≤ 5 years, 6–20 years, and >20 years. Work setting was categorized into three dichotomous variables: Level I maternity units, defined according to national organizational, structural, and technical standards (Accordo Stato-Regioni, 2010), Research Hospitals, including university hospitals and IRCCS centers with a research and academic focus, and self-employed midwives. Each setting variable was coded as “yes” or “no” depending on whether the respondent worked in that setting.

Statistical analysis

Sample characteristics were described using frequency tables and percentages for categorical and discrete variables. Additionally, stacked bar charts were generated to visually describe the distribution of work-related and organizational wellbeing across the different items within each dimension, allowing a detailed representation of midwives’ perceptions for each statement. To evaluate the associations between the dimensions “Availability of resources,” “Team support and professional recognition,” or “Workplace safety” and personal or professional characteristics (including geographical area, educational level, years of working experience, and work setting), chi-squared tests were performed using the dichotomized versions of the items (responses of 4 or 5 coded as “Agree,” 1–3 as “Disagree”). A p -value < 0.05 was considered statistically significant. Data were analyzed using Stata/MP 18.0 (StataCorp LLC, College Station, TX, USA).

Results

Socio-demographic and Professional Characteristics

A total of 2,330 midwives participated in the survey, representing 11.99% of all midwives currently practicing in Italy. Regarding age, the most represented group was 30–39 years, accounting for 37.6% of the sample. With respect to geographical area of practice, more than half of participants were from Northern Italy, with 28.5% from North-West Italy and 30.7% from North-East Italy.

With regard to educational level, 57% of respondents held a bachelor’s degree as their highest qualification; among those with additional education, the most common qualification was a postgraduate diploma.

Concerning professional characteristics, most respondents reported 10–20 years of work experience (30.8%), followed by those with less than 5 years of experience (23.6%). The majority of participants held a permanent contract (84.6%) and primarily worked in Level I maternity units (34%) or Level II maternity units (27%). All sociodemographic and professional characteristics are detailed in Table 1.

Description of availability of resources, team support and professional recognition, and workplace safety

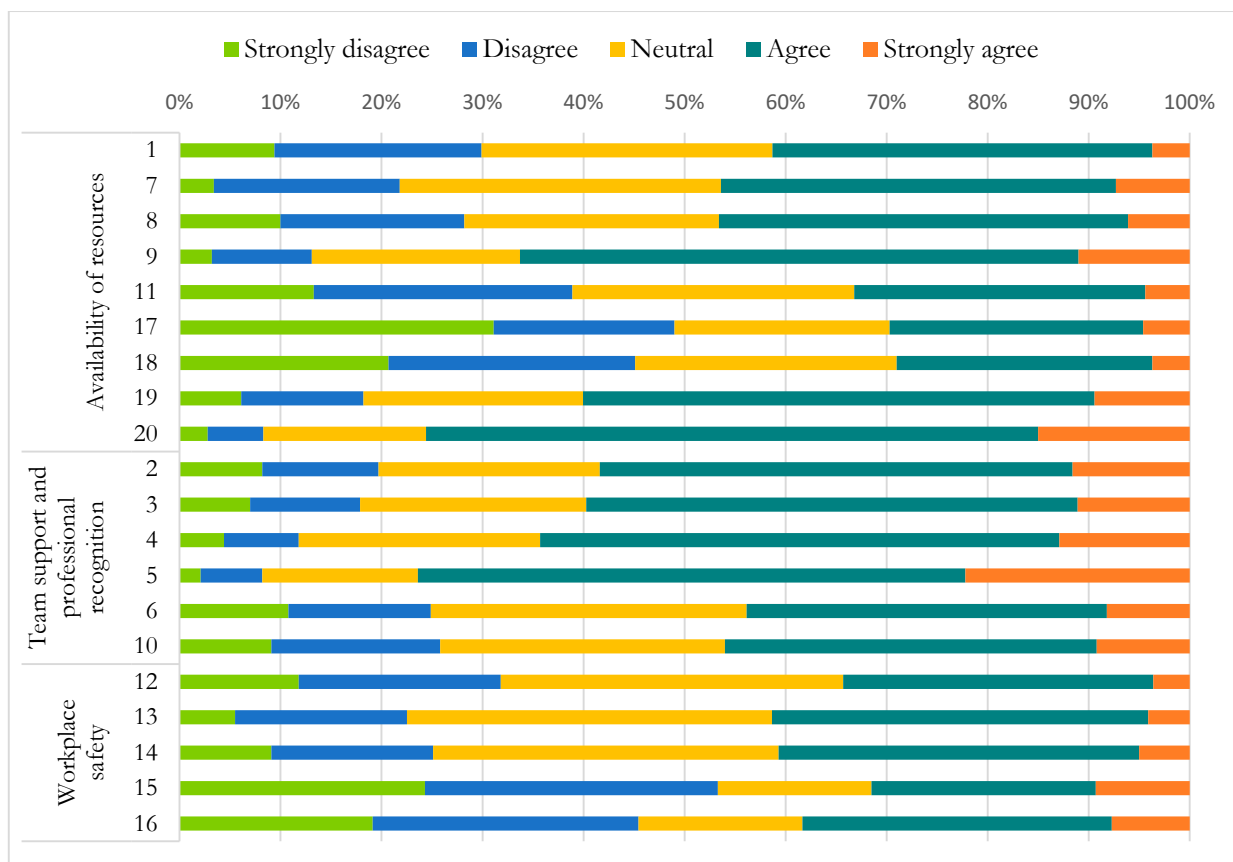
Figure 1 presents the distribution of Italian midwives' perceptions regarding work-related and organizational wellbeing across three core dimensions: "Availability of resources", "Team support and professional recognition", and "Workplace safety". Overall, the dimension "Availability of resources" (items 1, 7, 8, 9, 11, 17, 18, 19, 20) reveals a mixed perception. While many midwives agree or strongly agree with statements related to access to resources and opportunities for professional development, a substantial proportion express neutral or negative perceptions regarding workload sustainability and access to psychological support.

The "Team support and professional recognition" dimension (items 2, 3, 4, 5, 6, 10) shows generally favourable perceptions, with the majority of respondents agreeing that they feel recognized by medical colleagues, supported by their team, and free to express their opinions. However, a notable minority report disagreement or neutrality, indicating areas for improvement.

Table 1: Sociodemographic and professional characteristics of the sample.

	N	%		N	%	
Age			Years of work			
	20-29	459	19.7	≤ 5	550	23.6
	30-39	878	37.7	6 - 9	415	17.8
	40-49	481	20.6	10 - 20	718	30.8
	50-59	375	16.1	21 -30	276	11.8
	60-69	137	5.9	> 30	371	15.9
Geographical area			Contract type			
	North-West Italy	664	28.5	Permanent contract	1971	84.6
	North-East Italy	715	30.7	Fixed-term contract	143	6.1
	Central Italy	520	22.3	Self-employed (VAT registered)	188	8.1
	Southern Italy	289	12.4	Contract through cooperative	28	1.2
	Islands	142	6.1	Main practice setting		
Educational level				I Level Maternity Unit	792	34
	Bachelor's degree	1329	57	II Level Maternity Unit	630	27
	Master degree	272	11.7	University Hospital	329	14.1
	Postgraduate diploma (Level I)	608	26.1	Private Hospital	24	1
	Postgraduate diploma (Level II)	55	2.4	Public research Hospital	74	3.2
	PhD	4	0.2	Self-employed professional	153	6.6
	Other	62	2.7	Accredited private hospital	79	3.4
				Multiprofessional study	26	1.1
				Other	223	9.6

Figure 1. Distribution of responses to survey items related to “Availability of Resources”, “Team Support and Professional Recognition”, and “Workplace Safety”.



Each bar represents the percentage of respondents selecting each response category for individual survey items.

Regarding “Workplace safety” (items 12, 13, 14, 15, 16), perceptions are more polarized. While many midwives feel protected and adequately informed about safety, some respondents report experiences of verbal aggression from colleagues, superiors, or service users, highlighting concerns about workplace violence.

Data are fully described in **Supplementary material 2** and **Supplementary material 3**.

Factors associated with ‘Availability of resources’, ‘Team support and professional recognition’, and ‘Workplace safety’

All factors examined as potential determinants of perceived work-related and organizational wellbeing were significantly associated with at least five items across the three investigated dimensions (“Availability of resources”, “Team support and professional recognition”, and “Workplace safety”). Geographical area of practice and years of work experience were associated with a larger number of items, whereas post-bachelor education showed associations with a more limited subset of items. Detailed results are reported in Table 2 and Table 3.

Post-bachelor education was negatively associated with sustainable work pace and perceived quality of work within “Availability of resources” (items 8 and 9), as well as with freedom to express thoughts and opinions within “Team support and professional recognition” (item 10). A positive

Table 2: Comparison of responses to survey items on Availability of Resources, Team Support and Professional Recognition, and Workplace Safety across groups defined by Post-bachelor Education (Yes vs. No), Years of Work Experience (≤ 5 years, 6–20 years, > 20 years), and Geographical Area (North-West Italy, North-East Italy, Central Italy, Southern Italy and Islands).

	n	Post-bachelor education					Years of work					Geographical area										
		Post-bachelor education NO		Post-bachelor education YES		p-Value	≤ 5 years		6 - 20 years		> 20 years		North-West Italy		North-East Italy		Central Italy		Southern Italy and Islands		p-Value	
		N	%	N	%		N	%	N	%	N	%	N	%	N	%	N	%	N	%		
		N=1329		N=1301			N=550		N=1133		N=647		N=664		N=715		N=520		N=431			
Availability of resources	1	566	42.6	398	39.8	0.170	222	40.4	469	41.4	273	42.2	0.814	295	44.4	334	46.7	198	38.1	137	31.8	0.000
	7	609	45.8	472	47.2	0.524	169	30.7	522	46.1	390	60.3	0.000	281	42.3	324	45.3	235	45.2	241	55.9	0.000
	8	649	48.8	435	43.5	0.010	247	44.9	480	42.4	357	55.2	0.000	268	40.4	325	45.5	238	45.8	253	58.7	0.000
	9	904	68	641	64	0.044	356	64.7	736	65	453	70	0.063	424	63.9	490	68.5	335	64.4	296	68.7	0.152
	11	423	31.8	351	35.1	0.101	182	33.1	325	28.7	267	41.3	0.000	217	32.7	273	38.2	149	28.7	135	31.3	0.003
	17	375	28.2	316	31.6	0.080	105	19.1	355	31.3	231	35.7	0.000	222	33.4	211	29.5	155	29.8	103	23.9	0.010
	18	367	27.6	310	31	0.078	164	29.8	292	25.8	221	34.2	0.001	225	33.9	274	38.3	120	23.1	58	13.5	0.000
	19	818	61.6	582	58.1	0.096	332	60.4	677	59.8	391	60.4	0.950	444	66.9	461	64.5	289	55.6	206	47.8	0.000
	20	1019	76.7	744	74.3	0.191	447	81.3	849	74.9	467	72.2	0.001	537	80.9	574	80.3	376	72.3	276	64	0.000
Team support and professional recognition	2	767	57.7	593	59.2	0.459	277	50.4	644	56.8	439	67.9	0.000	407	61.3	430	60.1	288	55.4	235	54.5	0.051
	3	775	58.3	618	61.7	0.095	281	51.1	661	58.3	451	69.7	0.000	424	63.9	430	60.1	297	57.1	242	56.1	0.036
	4	840	63.2	659	65.8	0.190	317	57.6	721	63.6	461	71.3	0.000	464	69.9	456	63.8	325	62.5	254	58.9	0.002
	5	1034	77.8	747	74.6	0.074	436	79.3	880	77.7	465	71.9	0.004	521	78.5	574	80.3	396	76.2	290	67.3	0.000
	6	602	45.3	420	42	0.108	247	44.9	475	41.9	300	46.4	0.163	314	47.3	331	46.3	199	38.3	178	41.3	0.005
	10	642	48.3	430	43	0.010	233	42.4	506	44.7	333	51.5	0.003	321	48.3	349	48.8	202	38.8	200	46.4	0.002
Workplace safety	12	477	35.9	321	32.1	0.054	194	35.3	360	31.8	244	37.7	0.034	237	35.7	277	38.7	139	26.7	145	33.6	0.000
	13	522	39.3	440	44	0.023	199	36.2	451	39.8	312	48.2	0.000	288	43.4	327	45.7	195	37.5	152	35.3	0.001
	14	541	40.7	408	40.8	0.980	240	43.6	428	37.8	281	43.4	0.019	294	44.3	375	52.4	176	33.8	104	24.1	0.000
	15	364	27.4	369	36.9	0.000	135	24.5	371	32.7	227	35.1	0.000	195	29.4	218	30.5	162	31.2	158	36.7	0.069
	16	490	36.9	403	40.3	0.096	191	34.7	483	42.6	219	33.8	0.000	291	43.8	256	35.8	175	33.7	171	39.7	0.001

Table 3: Comparison of survey responses on Availability of Resources, Team Support and Professional Recognition, and Workplace Safety across different working setting. Groups compared include I Level Maternity Unit (No vs. Yes), Research Hospitals (No vs. Yes), and Self-employed Professionals (No vs. Yes).

	I Level Maternity Unit NO N=1538			I Level Maternity Unit YES N=792			Research Hospitals NO N=1927		Research Hospitals YES N=403		Self-employed professional NO N=2177		Self-employed professional YES N=153		P-Value	
	n	N	%	N	%	P-Value	N	%	N	%	P-Value	N	%	N		%
Availability of resources	1	620	40.3	344	43.4	0.147	808	41.9	156	38.7	0.233	916	42.1	48	31.4	0.009
	7	701	45.6	380	48	0.271	922	47.8	159	39.5	0.002	1011	46.4	70	45.8	0.869
	8	678	44.1	406	51.3	0.001	945	49	139	34.5	0.000	1001	46	83	54.2	0.048
	9	1001	65.1	544	68.7	0.081	1325	68.8	220	54.6	0.000	1403	64.4	142	92.8	0.000
	11	510	33.2	264	33.3	0.933	643	33.4	131	32.5	0.738	731	33.6	43	28.1	0.165
	17	460	29.9	231	29.2	0.710	565	29.3	126	31.3	0.437	661	30.4	30	19.6	0.005
	18	465	30.2	212	26.8	0.081	536	27.8	141	35	0.004	652	29.9	25	16.3	0.000
	19	946	61.5	454	57.3	0.051	1183	61.4	217	53.8	0.005	1281	58.8	119	77.8	0.000
	20	1184	77	579	73.1	0.039	1469	76.2	294	73	0.163	1626	74.7	137	89.5	0.000
Team support and professional recognition	2	856	55.7	504	63.6	0.000	1145	59.4	215	53.3	0.025	1313	60.3	47	30.7	0.000
	3	864	56.2	529	66.8	0.000	1183	61.4	210	52.1	0.001	1346	61.8	47	30.7	0.000
	4	952	61.9	547	69.1	0.001	1267	65.7	232	57.6	0.002	1423	65.4	76	49.7	0.000
	5	1168	75.9	613	77.4	0.433	1470	76.3	311	77.2	0.703	1675	76.9	106	69.3	0.031
	6	660	42.9	362	45.7	0.198	853	44.3	169	41.9	0.391	974	44.7	48	31.4	0.001
	10	713	46.4	359	45.3	0.636	926	48.1	146	36.2	0.000	969	44.5	103	67.3	0.000
Workplace safety	12	553	36	245	30.9	0.016	684	35.5	114	28.3	0.006	727	33.4	71	46.4	0.001
	13	627	40.8	335	42.3	0.477	799	41.5	163	40.4	0.706	929	42.7	33	21.6	0.000
	14	646	42	303	38.3	0.081	786	40.8	163	40.4	0.899	905	41.6	44	28.8	0.002
	15	488	31.7	245	30.9	0.695	601	31.2	132	32.8	0.538	691	31.7	42	27.5	0.269
	16	597	38.8	296	37.4	0.497	705	36.6	188	46.7	0.000	868	39.9	25	16.3	0.000

association was observed only for exposure to verbal or aggressive behaviour by colleagues or superiors within “Workplace safety” (item 15) (Table 3).

Years of work experience were significantly associated with nearly all items, with the exception of three items within “Availability of resources” (items 1, 9, and 19) and one item within “Team support and professional recognition” (item 6). Similarly, geographical area of practice was associated with all items except item 9 (“Availability of resources”) and item 15 (“Workplace safety”) (Table 3).

Across work settings, each setting examined was associated with at least seven items related to perceived work-related and organizational wellbeing.

Midwives working in Level I Maternity Units reported higher work sustainability and perceived quality of work within “Availability of resources” (items 8 and 9), alongside a lower perceived ability to apply professional skills daily (item 19). Within “Team support and professional recognition”, positive associations were observed for recognition by the medical profession, acknowledgment

of professional contribution, and feeling valued by the multidisciplinary team (items 2, 3, and 4). A higher perception of protection and safety was reported within “Workplace safety” (item 12).

Midwives working in Research Hospitals reported consistently lower perceptions across multiple dimensions. Within “Availability of resources”, lower work sustainability, perceived quality of work, and daily application of professional skills were reported (items 8, 9, and 19), alongside higher satisfaction with continuing education and perceived adequacy of training (items 18 and 7). Negative associations within “Team support and professional recognition” were observed for recognition, acknowledgment of contribution, feeling valued, support from superiors, and freedom of expression (items 2, 3, 4, 6, and 10). Similarly, within “Workplace safety”, lower perceptions of protection, training on safety updates, and organizational interventions, as well as higher exposure to verbal aggression by service users, were reported (items 12, 13, 14, and 16).

Among self-employed midwives, negative associations within “Availability of resources” were observed for access to resources, access to psychological support, and satisfaction with continuing education (items 1, 17, and 18), while work sustainability was positively associated (item 8). Within “Team support and professional recognition”, lower recognition, acknowledgment of contribution, perceived value, support from colleagues and superiors, and freedom of expression were reported (items 2, 3, 4, 5, 6, and 10). In contrast, within “Workplace safety”, feeling protected and safe and being informed or trained on safety issues were positively associated (items 12 and 13), whereas perceived organizational interventions to improve quality and safety were negatively associated (item 14).

Discussion

This national-scale survey provides a comprehensive overview of Italian midwives’ perceptions regarding their work-related and organizational wellbeing, addressing a critical gap in national data. Importantly, unlike previous Italian studies conducted in specific settings or during emergency contexts such as the COVID-19 pandemic, this survey captures midwives’ perceptions under routine working conditions and across heterogeneous organizational models, offering a nuanced picture of everyday professional wellbeing. The results highlight a complex scenario where key resources and team support are generally perceived positively, yet challenges remain, especially concerning workload sustainability and workplace safety.

Aligned with the Job Demands–Resources (JD-R) model^{2,3}, “Availability of resources” emerges as a fundamental element for midwives’ wellbeing. While midwives report good access to training and development opportunities, many express concerns about sustainable work pace and psychological support availability, consistent with findings linking resource inadequacy to burnout and compromised care quality^{4,6}. The importance of adequate staffing, material resources, and mental health support aligns with International Confederation of Midwives (ICM) standards emphasizing safe and supportive work environments²¹. The positive perceptions in “Team support and professional recognition” are consistent with the protective effect of collegial support and professional acknowledgment, consistent with prior research indicating that supportive teams are associated with resilience and professional satisfaction among midwives^{7,8}. From this perspective, team support and professional recognition may be interpreted as factors associated with midwives’ perceived professional empowerment. Feeling valued, listened to, and recognized

by colleagues and other professionals may be associated with midwives' sense of autonomy and legitimacy in clinical decision-making, which has been shown to be associated with both professional wellbeing and the delivery of woman-centered care⁹.

Nevertheless, a meaningful minority of midwives report limited recognition and freedom of expression, suggesting ongoing challenges related to professional identity and workplace culture, which may influence retention and quality of care⁷. More polarized responses in "Workplace safety" reflect enduring issues of verbal aggression and perceived inadequate organizational measures, echoing international evidence on violence against healthcare workers^{12,22}. The high prevalence of reported verbal aggression—particularly from colleagues or superiors—may suggest that workplace violence is not only an external threat but may also be related with organizational cultures. Such experiences may be associated with psychological safety, professional confidence, and long-term retention, reinforcing the need for systemic rather than individual-level interventions. This underscores the need for effective workplace violence prevention strategies, staff training, and psychosocial support systems to promote safety and wellbeing.

The associations observed between post-bachelor education and selected items indicate a nuanced relationship: midwives with additional education reported lower perceived work pace sustainability and reduced perceived quality of work, as well as less freedom to express opinions. The negative associations observed among midwives with post-bachelor education may reflect a structural mismatch between advanced professional competencies and organizational recognition or role utilization. When higher skills and expectations are not matched by corresponding autonomy or decision-making authority, frustration and disengagement may ensue. This may be related to higher expectations or critical appraisal skills among more highly educated midwives, leading them to perceive gaps in organizational support more acutely, as observed in other professional groups³.

Differences across settings highlight that midwives in Level I maternity units experienced higher satisfaction in terms of team support, professional recognition, and some aspects of resource availability. In contrast, midwives working in Research Hospitals reported lower perceptions across several dimensions, including work sustainability, professional recognition, and workplace safety. These differences suggest that organizational contexts may be associated with not only access to resources, but also shape midwives' perceived ability to exercise their professional role. Settings characterized by stable teams and clearer role boundaries may be associated with higher levels of perceived empowerment, whereas highly medicalized or fragmented environments may be related to reduced professional autonomy and voice. Self-employed midwives reported lower satisfaction regarding professional recognition, team support, and access to resources for training and psychological support, while perceptions of work sustainability were generally maintained or even slightly higher compared with other settings. These patterns suggest that organizational structure, team cohesion, and professional autonomy may be associated with midwives' perceptions of support and wellbeing, consistent with prior studies linking smaller, cohesive teams to higher job satisfaction and resilience^{7,23}.

Strength and limitations

This study benefits from a large, nationally representative sample of 2,330 midwives, covering

diverse geographical areas and professional contexts across Italy. This enhances the generalizability of the findings and allows for a comprehensive understanding of three core dimensions of organizational wellbeing: “Availability of resources,” “Team support and professional recognition,” and “Workplace safety.” However, some limitations should be acknowledged. Selection bias may have influenced participation, as midwives with particularly positive or negative experiences might have been more motivated to respond. The cross-sectional design prevents causal inferences, and self-reported data are subject to response and recall biases. In addition, although the questionnaire was developed based on regulatory frameworks, relevant literature, and expert input, it did not undergo a formal, comprehensive psychometric validation process. This may have influenced the precision and consistency of the measurements. Furthermore, the dichotomization of Likert-scale items, although useful to facilitate interpretation and to distinguish between positive and non-positive perceptions, may have led to a loss of information and reduced variability, potentially limiting the ability to capture more nuanced differences in responses. Additionally, some contextual factors, such as local organizational policies or staffing ratios, were not directly measured, which may have affected perceptions.

Conclusions

This study provides the first large-scale, nationally representative insight into Italian midwives’ perceptions of organizational wellbeing under routine working conditions. While team support and professional development opportunities are generally viewed positively, challenges remain in workload sustainability, access to psychological support, professional recognition, and workplace safety, particularly in Research Hospitals and among self-employed midwives. These findings highlight the need to prioritise resource allocation, mental health support, and the professional recognition. Enhancing autonomy and safe working environments may support midwives’ wellbeing and be associated with better maternity care quality, in line with WHO and ICM standards^{24,25}. Furthermore, education and training programs should address the potential mismatch between higher education and perceived organizational support, providing targeted interventions to bridge expectations and available resources. Ensuring organizational wellbeing is thus not only essential for midwives’ professional satisfaction, but also a key determinant of safe, woman-centered care.

Promoting organisational wellbeing requires coordinated actions at organisational and system levels, including safe staffing policies, violence prevention, and strategies to strengthen professional autonomy. These efforts are important for workforce sustainability and woman-centred care.

Declarations

Artificial Intelligence (AI) – Assisted Technology Statement

No AI-assisted technologies were used in the preparation of this manuscript.

Authors’ Contributions

All authors meet the four authorship criteria as defined by the International Committee of Medical Journal Editors (ICMJE). Each author has contributed substantially to the conception and design of the study, the analysis and interpretation of data, and the drafting and critical revision of the manuscript, as follows: Caterina Masè: Conceptualization; Methodology; Supervision; Writing – review & editing. Maria Panzeri: Formal analysis; Visualization; Data curation; Writing

– original draft; Writing – review & editing. Simona Fumagalli: Formal analysis; Visualization; Data curation; Writing – original draft; Writing – review & editing. Nadia Rovelli: Data curation; Investigation; Writing – review & editing. Silvia Vaccari: Conceptualization; Methodology; Writing – review & editing. All authors have approved the final version of this manuscript.

Conflict of Interest

No conflict of interest to declare.

Data Availability Statement

The data used and analyzed during the current study are available upon reasonable request from the corresponding author.

Ethics Approval

Ethical approval was not required for this study in accordance with local legislation and institutional requirements.

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Informed Consent

All participants provided written informed consent prior to inclusion in the study.

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