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Italian midwives in Europe: a qualitative study on the experiences of professional migration

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Abstract

Aim. *To explore the reasons for Italian midwives' decision to migrate, and their lived professional and emotional experiences.*

Methods. *A descriptive phenomenological study was conducted recruiting Italian midwives who were working abroad in European countries. We offered a telephone or web interview. Two researchers conducted, audio-recorded, and fully transcribed the interviews and other two researchers, independently, performed a content analysis.*

Results. *Thirty-two midwives having professional experiences in the UK, Ireland, Germany, Switzerland, and Spain were interviewed. Five themes emerged: 1) Education, 2) Migration decision-making, 3) Professional experience abroad, 4) Midwives' perceptions of their role, 5) Satisfaction versus desire to return. Our findings show a general dissatisfaction with Italian job opportunities in terms both of access to employment and work conditions. This scenario is complicated by the status of the professional midwifery in Italy.*

Conclusion. *Stakeholders should ensure that the migration of Italian midwives is not synonymous with dispersion but is a channel of professional growth and mutual exchange.*

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Introduction

In recent decades, migration by healthcare professionals (HCPs) has become a significant and controversial issue (1), lately also involving Italian midwives drawn to go and work in other European countries (2).

The mobility of professionals in Europe, including HCPs, is permitted by Directive 2005/36/EC, which allows citizens of a member state of the European Union, citizens of countries of the European Economic Area (Norway, Iceland, Liechtenstein) and citizens of the Swiss Confederation to pursue the regulated profession for which they obtained the relevant qualification in their state of origin in another member state.

The World Health Organization (WHO) recognises the strengths of international migration (1), and it is believed that working in different National Health Systems (NHSs) can improve HCPs' competencies and offer a comprehensive perspective on healthcare needs and settings (3).

In recent years, Italian midwives have migrated, in large numbers, to other European countries, mainly owing to a combination of the status of the profession of midwife in Italy and of the national economic crisis. There are about 21,000 registered midwives in Italy, the number having almost doubled in the last 15 years (4, 5). For various reasons, including the predominance of a mixed-care model (midwives and nurses) rather than the midwife-led care model in midwifery and gynaecology units, it is not possible to achieve a good balance between supply and demand (2). In fact, the Italian midwifery institutions declare that if the mixed-care model were replaced by the midwife-led care model in all maternity hospitals, the employment rate of midwives would increase (2). The employment rate is an important factor to consider, because it may contribute to the Italian migration of midwives. In fact, among the 22 non-medical healthcare professions in Italy, the employment rate of midwives (calculated one year after graduation) is 53.9%, ranking among the lowest five positions (6).

At the same time, high-skilled immigration is a constant in countries such as Germany and the UK, which have developed targeted immigration policies aimed at foreign HCPs (7) and which are very attractive also for Italian midwives.

Unfortunately, there is no record of the number of midwives who are emigrating. On the basis of our experience and unofficial data, we can assert that the "brain drain" of Italian midwives is a significant phenomenon, comprising about 1,000 Italian midwives who are currently working abroad.

Elsewhere also, little is known about migration by midwives. Deasy et al. conducted a survey on Irish nursing and midwifery students' intention to migrate after graduation, reporting that pay, work conditions and career opportunities were the main reasons behind the expatriation (8). In any case, midwives' lived experiences of migration are unexplored.

This study therefore aimed to explore the reasons for Italian midwives' decision to migrate and their lived professional and emotional experiences abroad.

Methods

A qualitative descriptive phenomenological approach was chosen because this approach is highly recommended when researchers are interested in understanding lived experiences of patients or professionals (9). Therefore, a descriptive phenomenological study was carried out from October 2019 to October 2020, involving Italian midwives who were working or had worked abroad. They were enrolled through snowball sampling, that is one of the most common methods of sampling in qualitative research; this consists of a technique in which study participants suggest other possible subjects to include (10).

In line with the assumptions of qualitative research, sample size was not estimated but the data saturation was obtained when no new information emerged (11).

The inclusion criteria were: being of Italian nationality; having graduated in Italy; working in Germany (DE), Switzerland (CH), the United Kingdom (UK), Ireland (IR) or Spain (SP) for at least a year; age < 40 years.

Italian nationality and graduation in Italy guaranteed the enrolment of participants who possessed the characteristic skills and competencies of Italian midwifery. The European countries included were chosen taking into account knowledge and direct and indirect experiences of the research group. Following a brainstorming, these European countries appeared to hold the greatest professional attraction for midwives. However, the list of European countries would have been left open if the snowball sampling had discovered Italian midwives who had migrated elsewhere. The duration of work abroad had to be at least one year to guarantee a professional lived experience that could be considered exhaustive of the understanding of local professional practices and organisation, as well as of the host country's laws and values. The age limit of < 40 years was adopted for two reasons: 1) to minimize the recall bias, so that the participants still had a clear enough memory of their pre-service education and any work experience they had in Italy; 2) to obtain a homogeneous sample of midwives graduated only after the national reform of the university system, according to the Decree n. 509/1999 and the following Ministerial Decree of 2 April 2001, which transferred the formation of all kinds of health professionals (nurses, midwives, health visitors, technicians, etc) into the medical schools

Midwives were invited to participate in the study and contacted by phone to arrange an interview once they had given informed consent. We offered a web or telephone interview, depending on the different geographical locations of the participants.

The interview questions were built starting from a brainstorming session in which the researchers defined the study's specific objectives, considering both scientific literature and their own knowledge of the Italian context. Then, the objectives were converted into open-ended questions and summarized in a semi-structured interview form (Table 1). This included a table in which to note the non-verbal communication (e.g. facial expressions, body language, tone of voice, pauses) of each interview, used as a complement of verbal data. A protocol was developed to guide the interviews and to standardize the approach among

Table 1 – Interview's objectives and questions

Objectives	Questions
To explore experiences and opinions related to pre-service midwifery education	How do you consider the pre-service education received during the three years?of bachelor degree in Midwifery, in terms of theoretical contents and clinical practice?
	In your opinion, what are the strengths and criticalities that you notice in local midwives with respect to ours?
To describe the phase of insertion into the world of work	How was your initial experience of entering the world of work?
To describe competencies and job satisfaction	What are the main differences you notice in the role of the midwife in the EU country where you are working compared to Italy?
	Are you satisfied with your current job? What are the positive aspects? What are the negative ones?

the three interviewers. Participants' main sociodemographic data were collected through an anonymous online form.

The interviews lasted on average 40 minutes and were digitally recorded and transcribed verbatim.

Long table analysis was performed for coding and content analysis as described by Krueger and Casey (12). More specifically, two researchers independently performed the content analysis, coding the data inductively and deductively, then discussed and checked the emergent themes using an extension of Colaizzi's method (13). This latter consists of the following 8 steps: 1. Transcribing all the participants' narratives; 2. Extracting significant phrases directly related to the studied phenomenon; 3. Formulating meanings of any significant statement; 4. Aggregating formulated meanings into clusters of themes; 5. Reporting a comprehensive description of participants' experiences; 6. Researchers' analysis of symbolic representations occurred during interviews to pareticipants; 7. Identifying the essential structure of the phenomenon; 8. Validation by the participants.

All the other researchers supervised the process, intervening in case of disagreement to achieve a consensus. To reduce biases and preconceptions and to guarantee credibility, various methods of bracketing were applied: the interviewers adopted neutral nonverbal approach and active listening skills and they noted any comments by the participants on significant facts, as well as any observable feelings emerged during the interviews (14). Confirmability and absence of preconceptions were ensured by sharing the themes with the interviewees, and all approved the findings.

Approval by the Ethics Committee was not required by Italian regulations for this type of study (GU n. 76 of 2008). Before inclusion in the study, we obtained written informed consent from all midwives via e-mail or, if not possible, verbal informed consent documented by audio recording.

The COREQ checklist was used to report the study (15).

Results

We interviewed 32 Italian midwives, of whom 15 worked in Germany, 6 in Switzerland, 5 in Spain, 4 in the UK and 2 in Ireland. They had been moving abroad for an average of 3 years (range: 1-13 years). Four of them had two experiences of professional migration (e.g. Germany and Switzerland (n=2), Ireland and Germany, Ireland and Switzerland).

The participants' ages ranged between 23 and 39 years, with an average age of 28.5 years.

Five themes were identified: 1) Education, 2) Migration decision-making, 3) Professional experience abroad, 4) Midwives' perceptions of their role, 5) Satisfaction versus desire to return (Figure 1). The main statements made by the participants are quoted here *in italics*, identified by the sequential numerical code attributed to the midwife and by the abbreviation of the European country where she wss working. Nonverbal communication was found to be in line and consistent with the verbal information reported by the participants.

Theme 1: Education

The theme "Education" was characterised by two sub-themes: "Theoretical knowledge versus practice" and "Education oriented to the world of work".

Theoretical knowledge versus practice. Some differences in pre-service education were described by the participants. Specifically, these differences were mainly perceived by the interviewees who were in European countries (e.g., Germany), where midwifery education was provided through a "professionalizing" course.

We have good theoretical education, but

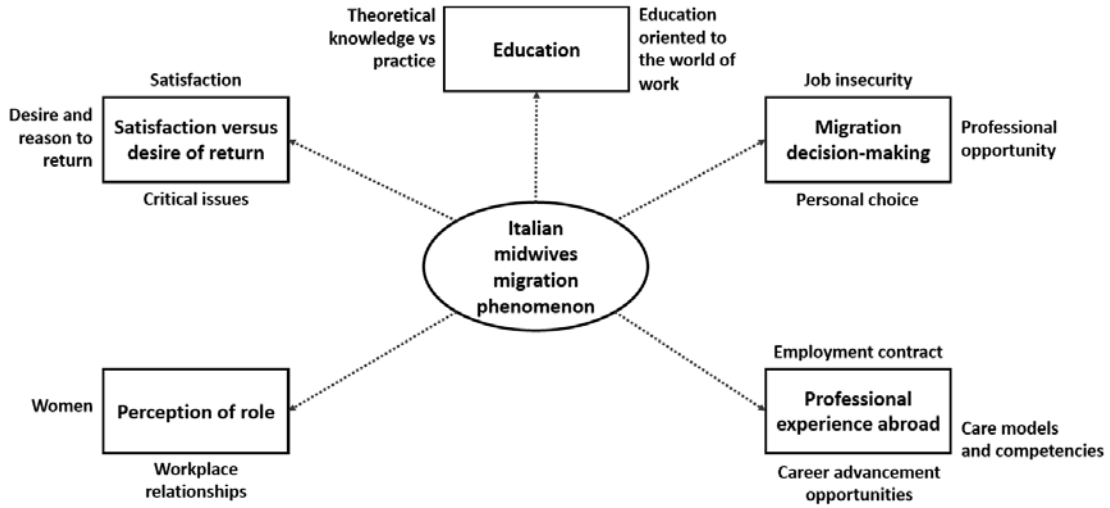

Figure 1 - Emerged themes and sub-themes related to the midwives' migration phenomenon.

poor practice. ... lots of ideas and then in practice there was little training. They are much more independent than us, although theirs is not a university degree; they are more autonomous and prepared in practice. (Midwife 1, DE)

I believe that we have more in-depth theoretical knowledge, even if it is mostly limited to pregnancy and the puerperium. But we have many ideas that are less useful in practice, so I had to learn a lot when I started working here. (Midwife 2, SW)

These differences were not only perceived at the educational level but also concerned a different way of thinking and acting in the professional field. Italian midwives consider themselves to be better prepared on etiopathogenesis an pathophysiology, but less prepared on, recommendations and how to act.

The Italians are much better prepared from a theoretical point of view. If you mention pre-eclampsia or gestational diabetes, I know why this happens, what the disease entails for the woman's body from a pathophysiological point of view. They tend to see the "problem" but not what it brings about. For example, in the case of pre-eclampsia, the focus for them is that the blood pressure rises. However, they know how to deal with physiology and are very strong on guidelines. (Midwife 3, IR)

Education oriented to the world of work. Participants declared that there were more job opportunities offered by pre-service education abroad than in Italy. Moreover, in the interviewees' opinions, in some countries (e.g., the UK and Spain), education is more oriented toward preparing midwives for the professional world.

They are better prepared for the world of work because they are hired by the Trust where they have been interns, so they are in an environment they already know. They already know how routines, policies, protocols, etc., work. (Midwife 4, UK)

In Spain they become midwives after they have already qualified as nurses. Therefore, they do not have to be trained on nursing practices, injections, sampling, etc. ... but they attend two years of courses dedicated entirely to midwifery practice. (Midwife 5, SP)

Theme 2: Migration decision-making

Regarding the theme "Migration decision-making", we identified three sub-themes:

"Job insecurity", "Professional opportunity" and "Personal choice".

Job insecurity. The intention to migrate did not involve only recent graduates looking for their first job, but also unemployed midwives or those in precarious employment looking for job stability after having entered several competitive job application processes in Italy or having periods of fixed-term work or volunteering experiences.

I was quite lucky, because a few months after graduation I took part in a public tender to fill a vacancy. I got a good score in the ranking and I was therefore hired on a two-year fixed-term contract. Then they ran a public competition for some permanent positions but I didn't get a good score. The vacancy was awarded to the winners of the competition and so my contract was not renewed. (Midwife 3, IR)

After graduation, I did another job for a year and at the same time entered competitive job application processes. I had thought about volunteering to get some experience, but I had to pay for insurance, pay for petrol to get there, etc. It would have been an expense without recompense and with the risk of not being able to do anything, because they clearly told me that I would just observe but not practice. So then I decided to leave. (Midwife 4, UK)

Professional opportunity. Some interviewees described the choice to migrate abroad as an opportunity of professional growth in order to improve their working position.

I did a year of volunteering in a community centre, because I wanted to train in that area, given that the internship offered by the university was only in a hospital. Then I worked at a medical centre in collaboration with an obstetrician. Then, I got this opportunity to work abroad and I made the leap in quality. (Midwife 6, DE)

Personal choice. In some cases, people chose to work abroad for personal, not work-related reasons (e.g. personal challenge, life change, etc.).

I worked in Rome and I also had the opportunity to continue. I said no to three hospitals: I wanted to come here because I really didn't like Italy any more. I wanted a different life. (Midwife 5, SP)

Theme 3: Professional experience abroad

The theme "Professional experience abroad" was described by the following three sub-themes: "Employment contracts", "Care models and competencies" and "Career advancement opportunities".

Employment contract. The jobs carried out abroad by the interviewed midwives are regulated by permanent contracts. Often, the contracts do not exclude the possibility of simultaneously working as an independent midwife.

In Italy, contracts are fixed-term, if that's right for you. Otherwise, they are VAT-registered or with cooperatives, with a very low wage compared to the taxes you have to pay. Moreover, the contract and salary are not adequate in relation to the responsibility you have. In the UK they still give you stability, offering you a permanent role. (Midwife 7, UK)

I can reconcile freelance work with outpatient work. In Italy, if you work in one sector, you cannot work in the other. (Midwife 8, SP)

Care models and competencies. Especially in the case of Ireland, the UK and Germany, the participants mentioned maternity hospitals that are specialised exclusively in the maternal–infant area. They reported that this allows midwives to take on many posts, including in coordination and management, but that maternity hospitals have a high volume of births, which adds to workload and stress.

Here there are maternity hospitals, hospitals for births and infant care only. The head of the hospital is a midwife; under her there are sisters. The negative aspect is that I work in a 9,000-birth hospital, so there

are very few opportunities to learn about physiology. (Midwife 9, IR)

Furthermore, it emerged that the experience abroad had finally demonstrated that the active offer of continuity of care is a feasible goal if there are appropriate organizational arrangements and economic and human resources.

When women are discharged, they are seen by a local midwife. This setup is called the midwife community. You send the woman home, inform your colleagues and they visit on the second, fifth and 10th day after discharge and then they assess if there is a need for more visits. (Midwife 10, UK)

The midwife-led models imply that the midwife also takes care of low-risk newborns. This emerged as a novelty for all the midwives interviewed.

In Italy there was always a paediatrician or in any case a nurse who would take care of the child. Here, it is the midwife who takes care of the newborn. (Midwife 3, IR)

Abroad, the opportunities for specialisation are greater both in the clinical and educational areas, but also in research.

There are a lot of job profiles here. For example, from the university point of view, those who do training and teaching are paid to do that, not like in Italy where you do it for free in your time off! In hospitals there are specialised staff in various fields: those specialised in gestational diabetes look after diabetic women, those specialised in breastfeeding, etc. (Midwife 3, IR)

Career advancement opportunities. The interviewees reported that foreign countries offer greater career advancement opportunities both in economic terms and in support of employees' postgraduate education.

I am always encouraged by the coordinator to take on additional duties. They always try to stimulate you. You can become a lactation consultant, an expert in nursing–midwifery practices and guidelines. In short, there are lots of opportunities to have more roles if you want to take them on. (Midwife 1, SW)

In two years, I have gone up to a higher level. I moved from Band 5 to Band 6, so my salary has increased. Obviously, the responsibilities also increase, but they give me the opportunity to grow professionally. In Italy this does not exist. (Midwife 4, UK)

If you undertake a Master's degree in Midwifery Practice & Leadership, you are doing something good for the hospital because you can become the Advanced Midwife Practitioner of that hospital. The hospital benefits, so it pays you to do the degree. (Midwife 11, IR)

Theme 4: Midwives' perceptions of their role

According to the participants, social recognition of the midwife is indisputably better abroad than in Italy. All the interviewees stressed that the role of midwife in Italy is little known among women, who believe that the midwife's skills are limited to supervising labour and birth. Two subthemes emerged: "Women" and "Workplace relationships".

Women. Women in other countries know that the midwife is a HCP dedicated to low-risk pregnancy, childbirth and newborns and to women's health in general.

It is a job that has value in this country. In Italy I felt much less valued because the midwife is seen by women as the person who "helps" at the moment of delivery, just as an obstetrician's assistant. (Midwife 12, UK)

Here in the UK, as soon as the woman discovers she is pregnant, she goes to the midwife because the midwife is the person who has responsibility for the care of the woman throughout her pregnancy. (Midwife 10, UK)

The women here appreciate it so much, because they know the midwives and know that once they leave the hospital they are not just left to their own devices; they know that there is a midwife who will give them practical help, who will visit them at home. (Midwife 12, DE)

Workplace relationships. Abroad, the midwife and the physician are simply seen as two different professionals, each with their own areas of expertise. In Italy, by contrast, the midwife is assumed to be subordinate to the obstetrician and the paediatrician.

Midwifery is not seen abroad as a profession that is subordinate to the medical one. There is a positively crazy level of mutual respect. (Midwife 11, IR)

The relationship between colleagues is also always reported as positive and constructive, based on reciprocity and teamwork.

The most positive aspect of working here is the mutual support between colleagues. We never argue, we never look for a scapegoat, but there is always team responsibility. (Midwife 7, UK)

Theme 5: Satisfaction versus desire to return

The theme "Satisfaction versus desire to return" was characterised by three subthemes: "Satisfaction", "Critical issues" and "Desire to return".

Satisfaction. In general, midwives are very satisfied with their professional choice. Professional autonomy, job stability, economic uplifts, flexibility of work shifts, good relationship with the work team, work organisation, respect and dignity of the worker and professional growth are the main reasons mentioned in reference to job satisfaction.

I feel very satisfied because I have the opportunity to put into practice what I have studied for and I feel satisfied because my work is highly appreciated and I get paid more. (Midwife 13, DE)

Critical issues. The main critical element, from the moment of entering the world of work abroad, was the language barrier. The latter was felt by many as a strong limitation to being able to express themselves and provide care to pregnant women, although there were recruitment agencies that represented a bridge between the midwife and the health facility and were responsible for hiring and for organising language courses. Other critical aspects included distance from family and work stress (if they had to work full-time).

The negative aspects were the distance and the language, which is difficult. (Midwife 14, SW)

The downside of working in the UK is the amount of work, which is still a lot. I worked in a very large hospital that cared for 7,000 births a year. I often followed three or four women simultaneously, and at the end of the 12 hours I was half dead. (Midwife 7, UK)

Desire and reason to return. The desire to return to Italy was common but limited exclusively to emotional reasons. Indeed, none of the participants would return for work: they declared that they would not be able to integrate into the team and accept Italian working conditions after their experience abroad.

The climate and my family, certainly, not the job! I am terrified of returning. I'm terrified of returning to Italy for work where team working doesn't exist as a concept! (Midwife 15, DE)

I will come back only if my boyfriend does not want to join me abroad, even though I have now found this compromise by working in Switzerland: I work one week here and I go to Italy the week after. If I were to return to Italy, I would not work as a midwife! I would try to do something else because I would find being a degrades midwife. (Midwife 16, SW)

I could not go back to Italy, even though I would really like to. I would not feel comfortable because of all these differences, especially in mentality and the level of hierarchy that exists. (Midwife 6, UK)

Discussion

To the best of our knowledge, this is the first study conducted to explore lived

experiences by midwives who have migrated to pursue their profession elsewhere. In the light of these findings, the Italian phenomenon may be an interesting starting case.

It is well known that HCPs' low wages may lead to a reduction in the workforce, driving people to leave the profession prematurely, as in the UK (16), or to migrate. However, the reasons for professional migration cannot be reduced to mere economics, as there are several contributory factors. This finding is in line with a study involving Polish nurses migrated to Norwey, which reported that nursing migration was initially attributed to economic reasons (17). However, the lived experiences of professional recognition and optimal working conditions became a key element to confirm the decision and remain abroad (17).

Our findings show a general dissatisfaction with Italian job opportunities, in terms both of finding work within a short time after graduation and of work conditions. Italian midwives mentioned atypical contracts and high workloads that do not allow an adequate work–life balance, exclusivity clauses that do not allow them to seek an additional job that would be useful to boost their income and the lack of opportunity to work as an independent midwife because they have to pay too many taxes.

The economic crisis has played an important role in Italian midwives' migration. The employment rate of midwives is heavily affected by the hiring freeze in public healthcare services. Most of the Italian hospitals are public and the recruitment procedure involves participation in national competitions, which are currently blocked owing to the hiring freeze. The only quick routes to employment are offered by private hospitals or self-employment. However, private hospitals are failing to absorb large numbers of midwives and the profession suffers from a culture in which Italian women are loath to be cared for by an independent midwife. Add to all that the drastic reduction of pregnancies in the last decades in this Country. For these reasons, Italian midwives have a low employment rate compared to other health professions that can operate easily as freelancers (6).

Another key finding of our study is that the perception of job insecurity stemmed not only from having a fixed-term contract but also from several concurrent factors related to work conditions and environments. In line with Bloxsome et al. (18), also our participants described any setting as stressful, where there were lack of trust and appreciation by obstetricians and "senior" midwives, unclear job roles and subordination of midwives to obstetricians.

This scenario is closely related to the problem of professionalization of Italian midwifery (19). At the end of the 1970s, a national health service was created in Italy, involving the transfer of birthplace from home to hospital. The midwifery care model gradually became medicalized and education began to promote "active" care by obstetricians and midwives. Moreover, technological innovation has undermined the relationship of intimacy at the centre of one-to-one care between the woman and the midwife. This led to the disempowerment of women with respect to pregnancy and childbirth.

Furthermore, the current socio-demographic characteristics of Italian mothers must also be considered. Recent national data on maternal and infant outcomes show that 21% of births concerns non-Italian mothers, the average age of the first-time mothers is over 31 years and 28.9 years for Italian women and non-Italian women respectively (20). The progressive increase in maternal age is a well-known risk factor for various diseases (e.g. gestational diabetes, gestational hypertension, preeclampsia, etc.) which have increased significantly in the last few decades worldwide (21). In general, the growing burden of non-communicable

diseases is a challenge for public health and it is starting to impact on reproductive and maternal-infant outcomes (22, 23). This requires advanced skills and services, and the ability of midwives to work fully in multidisciplinary teams in collaboration with many medical specialists.

The combination of medicalization, women's disempowerment, midwives' limited autonomy and current maternal sociodemographic and obstetric characteristics has resulted in various criticalities in the Italian perinatal care, including high rates of caesarean section, low-risk pregnancies attended by obstetricians, and suboptimal breastfeeding rates (24-26). Likely for these reasons, our participants reported that Italian women are unfamiliar with midwives' skills, believing that they are limited solely to labour and birth. As such, all interviewees were very impressed by the social recognition of midwives abroad. These findings are in line with the study of Dell'Omodarme et al. (27), who reported that English midwives were more satisfied with their role and social recognition than the Italian midwives.

Regarding the current work condition, professional satisfaction is a cross-cutting topic that emerged from our findings: participants are very satisfied with their professional life abroad, and those who desire to return to Italy have almost exclusively non-work reasons, in particular being reunited with their family. HCPs' job satisfaction is inversely proportional to work-related stress, burnout, medical errors and reduced quality, all of which may drive people to leave their job, resulting in staff shortages (28). Furthermore, a shortage of HCPs impacts user satisfaction. The literature on women's needs and their satisfaction with their treatment during childbirth shows that, when there is understaffing of HCPs, women feel undersupported, which negatively affects their level of satisfaction (29, 30).

Comparing Italian education with that provided abroad, although our participants mentioned some aspects to be improved, they were generally quite satisfied. The midwives who migrated to Germany or Spain offered more considerations and reflections on midwife education, as in these countries, different training models were adopted with respect to a three-year bachelor's degree.

Regarding the career advancement opportunities experienced abroad, it's interesting to point out that postgraduate education is encouraged by healthcare coordinators and managers. In fact, the acquisition of advanced skills is considered an enrichment for the institution where the midwife works and where she will put the new skills into practice. According to Massimi et al. (2018), Italian nurses and midwives are satisfied with the acquired level of education obtained by the Italian two-year Master of Science in Nursing (MSN) programmes, but there are limited national opportunities to fully put in practice these advanced competencies (31). This could be a critical issue that does not make postgraduate education attractive to nurses and midwives in Italy.

Regarding integration in the host country, it is very interesting to note that no negative aspects have emerged, most likely because the host countries have a long tradition of professional immigration and recognize the value that foreign HCPs bring to their health service, citizens' health and the economy. The main difficulty encountered was the language barrier. However, local colleagues have always shown themselves not only tolerant but also proactive in trying to help Italian midwives to improve their language skills. On the contrary, the literature on nursing migration reports the presence of conflicts between foreign-educated and locally educated nurses (32).

All the collected experiences of migration have a common element, which is pride in being a midwife. Moving abroad, away from one's family, learning a new language, integrating into a new culture

and understanding the rules of a different health service are challenges that can only be met by nurturing a very strong passion for midwifery and women's health (33).

On the basis of the criticalities emerged from the interviews regarding the Italian professional context, it would be useful to expand midwives' scope for action and responsibility. This is also recommended by the Italian Federation of Midwives, that suggests the Government to adopt an extraordinary plan to integrate all those professional competencies related to women's health not completely exploited by the health service (34). Among these, the priority is to disseminate the midwife-led model in hospital and community services and to encourage the national implementation of the guidelines for midwives to have responsibility for low-risk women and newborns (35).

Finally, as widely urged in the literature on professional migration, the need to have a national database of midwives who have migrated abroad clearly emerges. This would allow key indicators to be collected, to measure the extent of the phenomenon, which is usually underestimated (36), and to ensure international comparability.

This study has some limitations, related to the qualitative nature of the study. The precise meaning of some interviewees' opinions expressed in Italian could have been lost in translation. Moreover, our participants may not be representative of all Italian midwives who have migrated abroad. The inclusion criterion regarding the duration of work abroad could have generated a bias. More specifically, having recruited midwives abroad for over a year could justify their reported high level of satisfaction.

Future research should include quantitative approaches in order to add other useful information on migration of Italian midwives, including non-European experiences, even if they represent less frequent cases. We did not identify differences in experiences related to the duration of migration, so this aspect should be investigated. Moreover, further research on this topic should involve all the HCPs, considering that the COVID-19 pandemic might further affect the shortage/migration of HCPs due to a high increase in demand.

Conclusions

This study adds to our understanding of the reasons for Italian midwives' migration. The decision to migrate abroad depends on several factors, including job dissatisfaction due mainly to work conditions and environments, as well as contractual and economic terms. Italy's low social recognition of midwives affects perceived dissatisfaction. The desire for personal and professional growth can also contribute to the decision to migrate abroad. The factors that emerged from this study warrant attention from governmental and professional institutions. Improving the work conditions and professional status of midwives in Italy could ensure that their migration is not an "almost obligatory choice", but an opportunity among many possible alternatives.

Riassunto

Ostetriche italiane in Europa: uno studio qualitativo sulle esperienze di migrazione professionale

Obiettivo. Esplorare le motivazioni alla base della decisione da parte delle ostetriche italiane di migrare all'estero e le esperienze professionali ed emotive vissute.

Metodi. È stato condotto uno studio descrittivo fenomenologico reclutando ostetriche italiane che lavorano nei Paesi europei. Sono state proposte interviste telefoniche o via web. Due ricercatrici hanno condotto, audio-registrato e trascritto le interviste; altre due hanno eseguito la content analysis in modo indipendente.

Risultati. Sono state intervistate trentadue ostetriche con esperienza professionale nel Regno Unito, Irlanda,

Germania, Svizzera e Spagna. Sono emersi cinque temi: 1) Formazione, 2) Decision-making process relativo alla migrazione, 3) Esperienza professionale all'estero, 4) Percezione del proprio ruolo professionale, 5) Soddisfazione versus desiderio di rimpatriare. I nostri risultati mostrano una generale insoddisfazione per le opportunità professionali in Italia, in termini sia di accesso al lavoro sia di condizioni di lavoro. Questo scenario sembra essere complicato dallo status della professione ostetrica in Italia.

Conclusione. Gli stakeholder dovrebbero agire in modo tale che la migrazione delle ostetriche italiane all'estero non sia sinonimo di dispersione, ma un canale di crescita professionale e di scambio reciproco.

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