

ITALY

MINISTRY OF FOREIGN AFFAIRS AND INTERNATIONAL COOPERATION
Inter-ministerial Committee for Human Rights
Comitato Interministeriale per i Diritti Umani

Italy's Remarks,
Following Joint Communication from UN Working Group on
discrimination against women and girls; UN Special Rapporteur on
the right of everyone to the enjoyment of the highest attainable
standard of physical and mental health; UN Special Rapporteur on
torture and other cruel, inhuman or degrading treatment or
punishment; and UN Special Rapporteur on violence against women
and girls,
its causes and consequences

(AL ITA 2/2023)

July 2023

ITALY'S REMARKS

Following UN Special Rapporteurs' joint communication (AL ITA 2/2023), dated April 19, 2023, the Government of Italy is in a position to provide the following information.

As for the measures to ensure the quality of pre- and post-natal care and service provided in maternity care, the birth pathway is the process of taking care of women and couples from pregnancy to childbirth, from pre-conceptual counseling to prenatal diagnosis, from screening tests to instrumental examinations required during pregnancy. The public task is to support the birth pathway by reducing stress factors, making information available, providing the skills of new parents, reducing anxiety and pain, encouraging the continuation of care and human support even after leaving health facilities and balancing the needs and standards of clinical safety with the recognition of birth, except in specific cases, as a natural phenomenon.

It is to be emphasized the uniqueness of each individual experience of birth, recognizing the need for personalized care and respectful of the physiological times of labor-birth. In this perspective, the Ministry of Health (MoH) dedicates its utmost attention to the entire issue relating to the Birth Pathway. In this regard, by the Italian Ministerial Decree of 12 April 2011 the National Birth Pathway Committee (acronym in Italian, CPNn) was established.

This Committee ensures permanent coordination between central and peripheral institutions for the quality and safety of the Birth Pathway, as provided for by the State-Regions Agreement (acronym in Italian, ASR) dated 16 December 2010. This ASR contains Guidelines for promoting and improving the quality, safety and appropriateness of healthcare measures in the birth pathway and for reducing caesarean sections.

The CPNn supports all the Regions and Autonomous Provinces in implementing the best strategies for the re-organisation of the Birth Centres and verifies that they are consistent with what is defined in the ASR, with full power to decline and implement appropriate monitoring measures on the operational, technological and safety requirements of Levels I and II Birth Centres, on the integration between the levels of local and hospital maternal/neonatal care, on the full implementation of the national guidelines on maternal/neonatal issues and on staff training.

In the Essential Levels of Care (acronym in Italian, LEA) audit a specific point is dedicated to the Birth Pathway, which allows further monitoring the implementation status of the 10 lines of action signed by the Regions and Autonomous Provinces in the Agreement, dated 16 December 2010.

The CPNn has always taken great care to ensure that the Birth Centres are as safe and performing as possible. In this regard, by the Italian Ministerial Decree of 11 November 2015, the CPNn was given the additional task of expressing an 'advisory' opinion on waiver requests concerning Birth Centres with activity volumes submitted by Regions and Autonomous Provinces below 500 deliveries/year.

The CPNn has thus issued a document entitled '*Protocollo Metodologico per la valutazione delle richieste di mantenere in attività punti nascita con volumi di attività inferiori ai 500 parti/annui e in condizioni orogeografiche difficili*' (Methodological Protocol for the evaluation of requests on the operation of birth centres with volumes of less than 500 deliveries/year and in difficult oro-geographic conditions), which is an integral part of the Italian Ministerial Decree of 11 November 2015. This

Protocol also provides for the use of the Check List for the safety of the Birthing Pathway based on the WHO programme.

In recent years, the Committee has constantly monitored the implementation by Regions and Birth Centres of the following 10 Agreement guidelines:

1. Health policy measures and accreditation;
2. Charter of Services for the Birthing Pathway;
3. Territory-hospital integration;
4. Development of guidelines on physiological pregnancy and guidelines on caesarean section by the Italian SNLG-ISS;
5. Guideline Implementation Programme;
6. Development, dissemination and implementation of recommendations and tools to ensure the Birth Pathway safety;
7. Pain control procedures during labour and delivery;
8. Staff training;
9. Monitoring and verification of activities;
10. Establishment of permanent coordination for the Birth Pathway. Specifically the Committee monitors the birth centres in order to ensure the best clinical experience and organization necessary to prevent and possibly address the rare situations at risk that could occur. For a safe birth pathways, there must be some essential conditions: adequate and equipped spaces; medical staff (doctor, midwives, nurses, support staff) shaped on the new needs: control of pregnancy in labor in a relationship «one to one» on the one hand; management of emergencies in complete safety on the other, with immediate availability of neonatological and anesthesiological staff (nurses, doctors) competent and in an adequate number.

In recent years, all the regulatory tools have been put in place to optimize the network of birth centres in Italy in order to ensure, through an integration between local and hospital care, to all those involved during the birth pathways, from the preconceived stage up to the puerperium and breast-feeding, complete care to ensure their health.

Structured and safe care continuity, involving the level of primary care during pregnancy, assistance in hospital during childbirth and then back on the territory in the following months, is crucial in order to efficiently take care of women, not only by strengthening and homogenizing psychological support services during pregnancy, childbirth and post-partum through continuous work between counsellors and hospitals, but also by improving emotional support, support in difficulties, in listening.

In a historical moment like the one we are living in which there is a sharp decrease in the birth rate, it is necessary that the path of accompaniment to the birth assures the utmost attention to the demands of the couples that must be accompanied in their parenting path by staff who know how to combine competence with empowerment, that can guide the couple in the evolution of pregnancy and childbirth, also by carrying out the most appropriate care indicated in the individual case, emphasizing, at the same time, that human relationship is fundamental in such a complex and delicate moment as labor, childbirth and the first days after birth. To achieve this, the woman is guaranteed the necessary analysis during pregnancy, at the expense of the National Health System and hospitals are required to organize their services to meet needs and requests.

Multiple acts of address were produced by Birth Pathways Committee.

The Charter of Services for the Birth Pathways is of particular interest. Specifically dedicated to the Birthing Process, the Charter is a binding commitment with which all health authorities are called upon to comply. It represents the most suitable and appropriate instrument not only to illustrate the

services and care pathways that the birth centre offers for pregnancy, delivery and the post-partum phase, but also to enable the local health authorities, with the active support of their Birth pathways Committees and on the basis of a proper regional organisation of the Birth Pathways, to reflect the implementation of some of the 10 lines of activity contained in the Agreement.

Also in the framework of clinical risk, two recommendations are dedicated to the Birthing Process: [Raccomandazione per la prevenzione della morte o disabilità permanente in neonato sano di peso >2500 grammi non correlata a malattia congenita \(Recommendation for the prevention of death or permanent disability in healthy infants weighing over 2.500 grammes not related to congenital disease\)](#)

[Raccomandazione per la prevenzione della morte materna correlata al travaglio e al parto \(Recommendation for the prevention of maternal death related to labour and delivery\)](#)

These recommendations are aimed at preventing deadly events related to childbirth.

Furthermore, in order to also safely manage the 'transport' phase of the Birthing Process, the [Linee di indirizzo per l'attivazione del trasporto in emergenza materno \(STAM\) e neonatale \(STEN\) \(guidelines for the activation of emergency maternal and neonatal transport - STAM / STEN\)](#) have been implemented.

The CPNn has contributed to the implementation and validation of the [Linee guida sulla gravidanza fisiologica \(Guidelines on physiological pregnancy\)](#) that are currently being updated by the National System Guidelines, and the [Linee guida sul taglio cesareo \(Guidelines on caesarean section\)](#) drafted within the framework of the Italian SNLG-ISS and together with the scientific societies; National Agency for Regional Healthcare Services - AGENAS also participated in the implementation of the [Manuale sul Sistema di valutazione della qualità dei punti nascita \(GINS\) \(Manual on the Quality Assessment System for Birth Centres\)](#) These guidelines address the need to promote appropriate obstetric care for low-risk pregnancy, physiological delivery and puerperium and to ensure the quality of midwifery care.

All the above-mentioned documents are available on the MoH website: <https://www.salute.gov.it/portale/home.html>

Research and monitoring activities specifically dedicated to the perinatal area have been implemented and are being further implemented. Since 2012, the National Agency for Regional Healthcare Services - AGENAS has implemented the National Outcomes Evaluation Programme (acronym in Italian, PNE) as a permanent observatory on hospital care, capable to ensure data with systematicity, temporal continuity and high territorial coverage.

Through the study of the variability of outcomes and care processes between providers and between population groups, the above PNE makes it possible to monitor effectiveness and appropriateness of treatments, equity of access and safety of care; it also produces epidemiological evidence - according to an Evidence-based Public Health approach – and detects critical aspects which may be managed through specific interventions aimed at improving the overall quality of care.

The PNE evaluations are based on administrative data available at a national level. The sources are the Hospital Discharge Records (acronym in Italian, SDO) relating to 1.377 Italian public and private hospitals, the Emergency Information System (acronym in Italian, EMUR) and the National Tax Registry (the latter to verify patients' life status).

The PNE 2022 Edition, as developed in collaboration with the Department of Epidemiology of Latium Regional Health Service and the Italian National Institute of Health, considered a total of 194

indicators (compared to the 184 of the 2021-Edition), of which 171 related to hospital care (73 outcomes/processes, 83 volumes and 15 hospitalizations); and 23 related to territorial care, indirectly assessed in terms of avoidable hospitalization (14 indicators), long-term outcomes (5) and inappropriate access to Emergency room (4).

Since April 2020, as part of the PNE activities, a technical team of statisticians and epidemiologists has been commissioned to develop new indicators in the perinatal area, refine the analyses and interpret the results.

At present, a newly introduced indicator concerns the proportion of episiotomies in vaginal deliveries, calculated for each hospital in Italy.

The following is a complete list of perinatal area indicators monitored by the PNE and published on the AGENAS website: <https://pne.agenas.it/>

- volume of hospitalizations for delivery;
- vaginal births: subsequent hospitalization during the postpartum period;
- birth with caesarean section: volume of hospitalizations;
- proportion of births with primary caesarean section;
- caesarean section: subsequent hospitalization during the postpartum period;
- proportion of vaginal births after caesarean (VBAC);
- proportion of episiotomies in vaginal deliveries.

Proportion of episiotomies

Episiotomy, a technique originally designed to reduce the incidence of severe perineal tears during labor, is still a common practice in Italy. Weighting the risks and benefits, the scientific literature supports its selective use. Several surveys carried out in the last decades by the Italian National Institute of Health estimated an episiotomy proportion of 69% in 2002, decreased to 45% in 2008-09 and to 42% in 2010-11. Recent PNE analyses show the use of episiotomy further decreased in the last 5 years, from 24.4% in 2015 to 12.3% in 2021 (Figure 1).

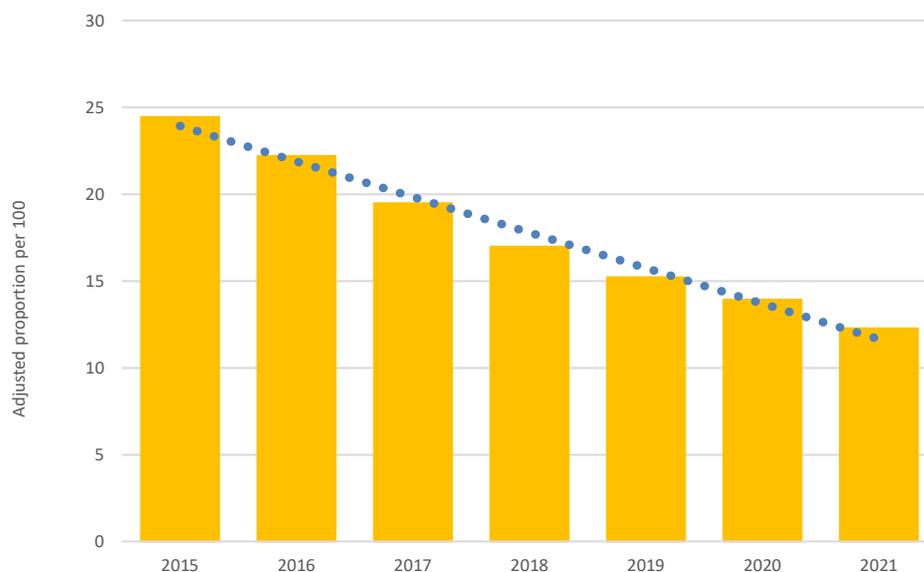


Figure 1 - Proportion of episiotomies. Italy, 2015-2021.

Birth with caesarean section

The proportion of primary caesarean deliveries decreased in the last years, from 24% (median value) in 2015 to 21% in 2021 (Figure 2). It should be noted that the current proportion of primary caesarean section is below the levels in the early 2000s (around 40%), due to several initiatives aimed at promoting in Italy a cultural change towards vaginal birth.

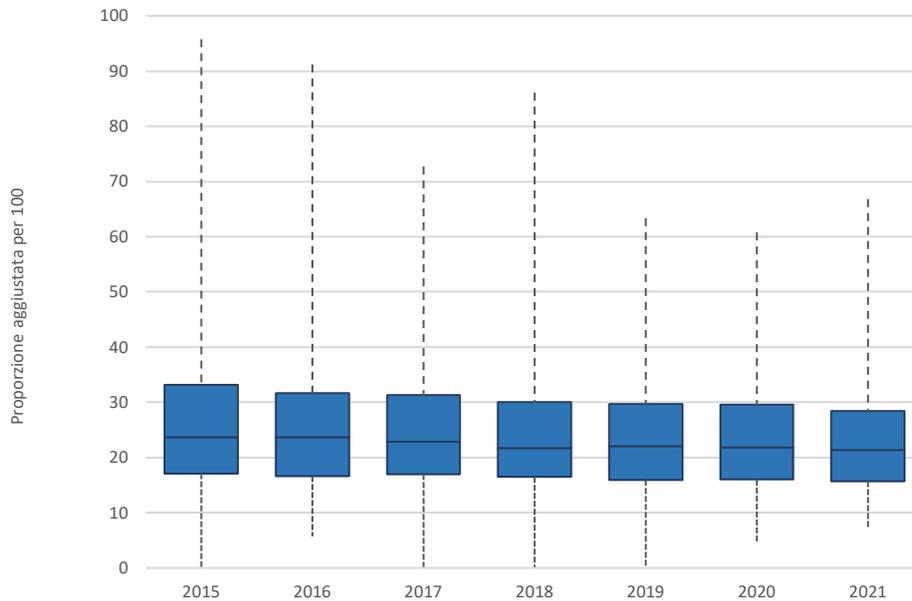


Figure 2 - Proportion of primary caesarean deliveries. Italy, 2015-2021

Vaginal births after cesarean section

The proportion of vaginal births after caesarean (VBAC) is an indicator that allows to assess the quality of care provided to pregnant women. Higher values may reflect more appropriate clinical practice, since international guidelines does not exclude vaginal delivery in absence of risk conditions for women who previously performed a C-section.

In Italy, the proportion of VBAC slightly increased from 4.5% in 2015 to 6.7% in 2021 (Figure 3).

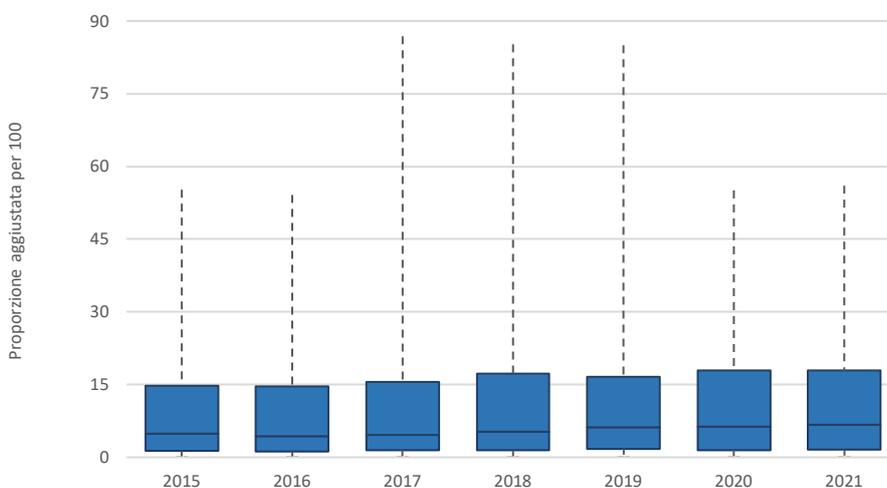


Figure 3 - Proportion of vaginal births after C-section. Italy, 2015-2021

Always within the monitoring activity, in consideration of the importance in the field of public health of the use of medicines in pregnancy, for the outcomes that this event may have on the state of health, even in the long term, of both women and children, the National Observatory on the Use of Medicines (acronym in Italian, OsMed) of the Italian Medicines Agency (acronym in Italian, AIFA), through the establishment of the mom-based networkNet, conducted a population study based on the integration of different regional health information flows that allowed to carry out a representative analysis of the prescription of medicines before, during and after pregnancy in Italy and to evaluate the interregional variability of the prescriptive patterns of medicines in the field of assistance to the woman of childbearing age, pregnant and post-partum.

In 2020, the AIFA Report on the use of medicines in pregnancy was published: a population study based on the linkage record of several regional health information flows that made it possible to detect which medicines are prescribed to pregnant women in Italy and for which clinical conditions. The main objective was to analyze the trend of prescriptions of medicines before, during and after pregnancy in women living in eight Italian regions (Lombardy, Veneto, Emilia Romagna, Tuscany, Umbria, Latium, Apulia, and Sardinia) and to evaluate the interregional variability of prescriptive patterns in order to identify any critical issues related to prescriptive appropriateness in this field, in order to improve clinical practice.

The integration of different regional databases, together with the sharing of data, has allowed to produce sufficiently representative results and to obtain an exhaustive overview of the use of medicines during pregnancy in Italy, stressing at the same time the importance of periodic monitoring of the information flows produced, training and information addressed both to prescribers (and pharmacists) and to women on the appropriate use of medicines in the field of assistance to women of childbearing age, pregnant and post-partum.

https://www.aifa.gov.it/documents/20142/1228539/Osmed_uso_farmaci_in_gravidanza.pdf

As for recent statistics and qualitative data gathered by the ItOSS on the prevalence of and trends in obstetric care including investigations into maternal deaths and reports of obstetric violence, the Italian Obstetric Surveillance System (ItOSS) is a population-based network of over 300 health facilities coordinated by the *Istituto Superiore di Sanità* (Italian National Health Institute - INHI), ensuring evidence for decision-makers, health professionals and citizens, in the field of obstetric and perinatal care in Italy. The ItOSS Maternal Mortality Surveillance System was established in 2008, as a pilot project funded by the Ministry of Health, in six Regions that covered 49% of national births. Today, the coverage of the surveillance has reached 97% of national births and by the end of 2023, it will be nationwide.

Since 2017, the surveillance is included in the National Government Decree on Registers and Surveillance of national interest, under the coordination of the INHI.

In accordance with the priority actions recommended by the 2030 Agenda for Sustainable Development to high-income countries, the ItOSS's main objectives are (i) to improve and harmonize data monitoring and reporting, and (ii) to link research results to policies and action.

As for the accountability objective (i), the ItOSS relies on a dual approach to detect maternal deaths. Retrospective vital statistics linkage procedures (1), and prospective incident reporting and Confidential Enquiries of maternal deaths (2). Confirming the validity of this dual approach the Euro

Peristat Report described the ItOSS as one of the seven enhanced maternal mortality surveillance systems active in Europe (3). The promotion of peer discussion and critical analyses of incident maternal deaths and near-miss cases, through multi-disciplinary audits and confidential enquiries is a major achievement of the ItOSS surveillance to prevent the recurrence of preventable events. Since 2012, the ItOSS is WHO's focal point for maternal mortality estimates review and participates in the International Network of Obstetric Survey Systems (INOSS), assuming its Presidency in 2023. The INOSS facilitates an international collaboration of researchers and clinicians collecting population-based data on maternal mortality and severe morbidity (4).

A recent INOSS paper compared maternal mortality patterns among eight European countries - Denmark, Finland, France, Italy, the Netherlands, Norway, Slovakia, and the UK - with established enhanced surveillance systems able to identify, document, and review maternal deaths (5). Maternal mortality ratios up to 42 days after the end of pregnancy varied by a factor of four, from 2.7 and 3.4 per 100,000 live births in Denmark and Norway to 9.6 in the UK and 10.9 in Slovakia. Italy reported an MMR of 8.7 for the years 2013-2015, and cardiovascular diseases and suicides were the leading causes of maternal deaths in all participating countries. In 2023, ItOSS estimated for the first time the Italian national MMR, equal to 8.3/100,000 in the years 2011-2019 with a 26% decrease in the trend from 11 to 8.6 maternal deaths per 100,000 live births. Among direct deaths, haemorrhage ranks first in frequency (37.8%), followed by sepsis (13.4%), hypertensive disorders of pregnancy (13.4%) and thromboembolism (11.9%). Among indirect causes of death, cardiac pathology is the first for frequency (28.8%), followed by sepsis (15.9%) and suicide (15.9%). An in-depth ItOSS study provided the first estimate of the maternal suicide ratio equal to 2.30 per 100,000 live births in 2006-2012 among 10 Italian regions, covering 77% of total national births (6).

As for research – intervention (ii), learning lessons and acting on the results is the core of ItOSS's active surveillance approach, aimed at saving more women's lives and improving the quality of maternity service (2). ItOSS links the results of the surveillance to action by adopting a “bundle” of activities able to enhance clinical practice (7). The bundle is composed of research activities on obstetric near-miss events aimed to define priorities and identify improvable aspects of care; guidelines development to disseminate evidence, and training of health professionals to improve quality of care.

Accordingly, many concrete initiatives were taken to disseminate results and promote positive change. Three free distance-learning courses on prevention, diagnosis and management of postpartum haemorrhage (PPH) have been offered by the ItOSS under the accreditation system of Continuous Medical Education to address the health professionals' training needs (8).

ItOSS implemented the first prospective population-based study on haemorrhagic near-misses providing original and useful information for clinical practice (9-11) and the first national guidelines on PPH prevention and treatment was developed by the Italian National Guidelines System of the INIH (12). The impact of the ItOSS bundle was evaluated reporting a statistically significant decrease in the haemorrhagic MMR from 2,45 to 0,77 (7).

As regards the form of violence at stake, mention may be made of the Commentary by Lauria et Al. (13), as published by the EJOGRB in response to the letter by Claudia Ravaldi et Al. “Abuse and disrespect in childbirth assistance in Italy: a community-based survey” (14), whose results are reported in the Joint Communication from UN Special Procedures.

Methodological flaws in web surveys: commentary to “Abuse and disrespect in childbirth assistance in Italy: a community based survey”

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To the Editor,

We have read the letter by Ravaldi et al. “Abuse and disrespect in childbirth assistance in Italy: a community based survey” published in the May 2018 issue of *Eur J Obstet Gynecol*. In our view, this survey has methodological flaws that should have been considered before publication.

The data refer to a 15 years’ interval, but the small sample size is inadequate for temporal trend analyses. Childbirth assistance has changed over years in Italy and describing perceived obstetric violence as a static phenomenon is unrealistic.

Strategies adopted to minimize selection and recall bias in the survey are not described and the response rate and information on non-responders are not included in the letter. In Computer Assisted Web Interviews, responders are often different from not responders (1). Specific groups, such as those with low educational level and ethnic minorities, can be under-represented in web surveys, which may result in biased estimates (1). According to the available information, the proportion of women with high educational level is strongly overrepresented in the survey and those with low education are underrepresented compared with the figures reported by the National Birth Register (2) in 2004 and 2014 (Table 1). Surprisingly, information on women’s citizenship is not reported by the authors, whereas 20% of women giving birth in Italy are not Italian citizens (2).

The Italian National Institute of Health (INIH) has carried out periodic sample surveys aimed at investigating aspect of care not addressed by routine statistics (3-5). According to these surveys, episiotomy in Italy has been reduced from 69% in 2002 to 42% in 2011. The episiotomy rate reported by Ravaldi is 54% but it has been computed among the entire sample. Computing it only among women who delivered vaginally, the rate rises to 80%, almost double the figure reported by the 2011 INHI survey which interviewed a population based representative sample of over 3500 women, with a 95% response rate (5). These points imply that the sample of the survey by Ravaldi is most unlikely to be representative of women giving birth in Italy.

To our knowledge, the questionnaire developed by the authors has not yet been validated. The proposed definition of obstetric violence is very broad, e.g. it also includes the unavailability of rooming-in in the maternity unit. The use of self-reported “unnecessary” obstetric interventions without any information regarding the clinical setting and maternal and neonatal outcomes is also unlikely to be a valid criticism of clinical practice.

With regard to the data analysis, the author states, they included 28 factors into the logistic model, showing the adjusted ORs without specifying the adjustment factors. The inclusion of such a large number of factors despite the small sample size undermines the goodness of model adaptation. Possible confounders, effect modifiers and multicollinearity should also be evaluated. The different management of vaginal delivery compared to caesarean section would have also required a stratified analysis by mode of delivery. In the light of these methodological weaknesses and due to the scarce information presented, we believe that the title and the results of the letter do not describe properly the childbirth assistance and the issue of disrespect in childbirth in Italy.

To ensure that clinical practice will respect not only the best available evidence, but also the values and preferences of the woman, it is urgent to address the organization of care and the training of physicians and midwives. It is also crucial to guarantee the implementation of periodic population-based surveys which are able to assess woman’s birth satisfaction as well as the aspects of the quality of care that are not available in national vital statistics.

Table 1 Women’s educational level distribution

	Survey by Ravaldi et al.	National Birth register year 2004*	National Birth register year 2014*
Low educational level (≤ 8 years)	12%	39%	29%
Medium educational level (8-13 years)	50%	45%	44%
High educational level (≥ 14 years)	38%	16%	27%

*Ministry of Health, CeDAP

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To follow up to the need to verify the quality of maternity services perceived during pregnancy and childbirth by the Italian women who gave birth, the INHI has implemented a sample survey in 16 Italian hospitals located in nine Italian Regions and one Autonomous Province.

Women aged 18 years and older giving birth to a live birth in participating hospitals, including the Careggi hospital, were offered to participate in the survey.

Two questionnaires adapted to the Italian context from the 2020 National Maternity Experience Survey in Ireland (<https://yourexperience.ie/wp-content/uploads/2020/09/National-Maternity-Experience-Survey-results.pdf>) were translated into five languages. Both questionnaires were administered by trainee health personnel not involved in the care of the women, or filled in by the women through a self-reported online form. The first questionnaire was administered before woman's hospital discharge, to investigate antenatal and intra-natal care; The second one was administered after three months from birth to investigate care during the post-delivery hospital stay, neonatal nutrition and neonatal specialized care, and care received within 3 months after birth.

3,642 women who gave birth participated in the first survey from May to October 2022 with a response rate of 78%, and 2,805 out of 3,642 in the second one, between August 2022 and January 2023. On a whole, 89.9% of participants said that they had a good or very good overall experience of maternity care, namely 1,160 women (42.5%) rated their maternity experience as very good; 1,269 (47.4%) as good, and 276 (10.1%) as fair to poor.

1. With specific regard to labour and birth care:

- 91.4% (n=3,269) said that they always had confidence and trust in the healthcare professionals;
- 83.8% (n=2,999) said that their questions were always answered in a way they could understand;
- 79.7% (n=2,851) said that they were always involved in the decisions about their care;
- 83.2% (n=2,804) thought that healthcare professionals did everything they could to help them manage pain during labour and birth.

2. With regard to postpartum hospital care:

- 77.0% (n=2,159) of the women felt having been always treated with respect and dignity;
- 71.8% (n=2,013) said that they were always involved in decisions about their care.

On a scale from zero to ten, with zero indicating a very negative experience and ten indicating a very positive experience, the average rating was:

- 8.4 out of 10 for the ‘antenatal care’;
- 9.0 out of 10 for the ‘care during labour and birth’;
- 7.7 out of 10 for the ‘care during hospital stay after birth’;
- 8.3 out of 10 for the ‘care at home within 3 months after birth’.

The following figure shows the scores of the questions related to the perceived quality of care during labour and birth.



This survey, although not representative of the Italian national context, offers a detailed insight into the quality of maternity care from the perspective of women in 16 Italian maternities with more than 1000 deliveries/year, located in different geographical areas of the country.

The perceived quality of care reported by the women who gave birth is overall good from pregnancy to postpartum, with the best scores for care received during labour and birth.

The adoption of national periodic maternity surveys would be a turning point to collect women's experiences in maternity services and to foster improvement actions centred on women's needs.

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The Department for Equal Opportunities has recently addressed the issue of gender medicine within the framework of the National Strategy for Gender Equality 2021-2026, adopted by the Italian Government in full agreement with European guidelines. In this context, the Department has taken a broad and participatory pathway that has enabled it to acquire and integrate the contributions and ideas of central government, regional and territorial authorities, as well as the social partners and the main NGOs active in the promotion of gender equality. Among the Strategy's cross-cutting measures is the one related to gender medicine, by which is meant not only medicine that adequately takes into account the differences between men and women in the face of health and illness. This Strategy stipulates that special attention should be paid to specific issues, including reproductive health. An important step in this direction is the Plan for the implementation and dissemination of gender medicine, provided for in Article 3 of Law No. 3/2018 approved on June 3, 2019 after agreement in the State-Regions Conference.

The National Strategic Plan on Male Violence Against Women 2021-2023 adopted by the Department of Equal Opportunities also focuses on the issue of women's health in the medical field, partly in the wake of General Recommendation No. 35 of July 26, 2017 adopted by UN CEDAW Committee, which expanded the definition of gender-based violence to include those forms that affect the right to reproductive health. The Plan takes into broad consideration the international targets set for the adoption of the UN 2030 Agenda including that of ensuring universal access to sexual and reproductive health and rights. Among the Plan's priorities is cultural awareness-raising with specificity, for example in the academic context for those disciplines that provide direct intervention in cases of gender-based violence (medicine and midwifery). In the area of strengthening the skills of professional figures, the Plan provides for mandatory specific training interventions for all health professions and physicians.

The need for strengthening gender medicine was also addressed at the last meeting of the Assembly of the National Observatory for the Integration of Gender Equality Policies (April 13, 2023), as chaired by Minister Roccella.

CONCLUSION

We take this opportunity to reiterate our firm willingness to continue cooperating fully with all UN Special Procedures.

Once additional information is available, we will share it promptly.