"You're Left to Fend for Yourself": Navigating Maternity Care, Employment Barriers, and Postpartum Well-being in Florence, Italy

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Abstract

This qualitative study explores how maternity care systems, workplace policies, and sociocultural norms shape pregnancy and postpartum experiences among women in Florence, Italy, a context characterized by declining fertility, low maternal employment, and persistent gender inequities. Twenty-four women aged 25–62 participated in 60-minute, in-person interviews conducted in May and June 2023. Reflexive thematic analysis identified four interrelated themes: (1) mixed experiences with Italy's public healthcare system, (2) employment challenges shaped by gender discrimination and workplace pressures surrounding maternity benefits, (3) impacts on postpartum well-being amid limited support and follow-up care, and (4) women's recommendations for improving maternity policies and support systems. Participants described dissatisfaction with fragmented public healthcare services, limited communication with providers, and insufficient attention to postpartum mental health. Workplace narratives revealed wage disparities, hiring discrimination toward women of reproductive age, pressure to return to work early, and barriers to accessing maternity protections among self-employed workers. These structural challenges were reinforced by cultural expectations that mothers assume primary caregiving roles, contributing to isolation, maternal shame, and identity loss during the postpartum period. Participants advocated for longer paid maternity and paternity leave, improved postpartum education and mental health support, community-based programs for new mothers, and more affordable childcare. Collectively, these findings highlight a disconnect between maternity policy design and women's lived experiences and showcase the need for culturally responsive, gender-equitable reforms that integrate maternal health care, workplace protections, and social support systems to promote maternal well-being and workforce participation.

Keywords: Maternal Health, Postpartum Care, Gender Equity, Workplace Discrimination, Parental Leave Policy, Italy

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Introduction

Italy has one of the highest global average ages of first childbirth, at 31.8 in 2023, as well as low maternal employment rates and a declining fertility rate (Eurostat, 2023). In 2002, Italy's total fertility rate was 1.72 (Salvati et al., 2020); by 2023, it had dropped significantly to 1.21 (Eurostat, 2023), the fifth-lowest in the European Union (EU) (Eurostat, 2023). No single cause can be attributed to Italy's fertility decline; however, research highlights the interplay of higher female education attainment, increased

female labor force participation, coupled with limited childcare (Del Boca et al., 2005; Del Boca & Vuri, 2007; Kertzer et al., 2009; Pacelli et al., 2013), and strong cultural gender and familial norms (Comolli & Vignoli, 2021).

Existing supportive measures include the establishment of the Servizio Sanitario Nazionale (SSN), Italy's national health service, set up in 1978, which provides universal health care, encompassing maternity and childbirth services, as well as the implementation of EU parental leave policies mandating a minimum of three months of parental leave and 14 weeks of maternity leave since the 1990s (France et al., 2005; Salvati et al., 2020). Currently Italy mandates a five-month maternity leave, with 80% of wages covered for those who contribute to social security, including self-employed and freelance mothers. Fathers receive only ten days of compulsory, fully paid paternity leave, although only about one-third of eligible Italian fathers actually take this leave (International Monetary Fund. European Dept, 2024). Mothers and fathers are also entitled to ten months of parental leave within the first 12 years of the child's life, receiving 30% of their salary for three months (International Monetary Fund. European Dept, 2024).

Despite these policies, the Italian labor market remains highly gendered. Italian women, particularly mothers, continue to face significant barriers to workforce participation, exacerbated by cultural expectations (Bertolini et al., 2015; Cutillo & Centra, 2017; Del Boca et al., 2005), the dual burden of paid and unpaid labor (Barigozzi et al., 2022; Casadio et al., 2008), and limited childcare (Del Boca & Vuri, 2007). In general, Italy has one of the lowest employment rates (67.1%) and the largest gender employment gap (19.5%) (Eurostat, 2024a). In 2014, a study surveying women aged 15-49 found higher employment rates among women without children: 54.3% of mothers, 68.8% of women in romantic relationships without children, and 77.8% of single women were employed (Lombardi, 2016). Unlike most EU countries, women's employment rates in Italy continue to decline as children age, contributing to a long-term motherhood income penalty (Cutillo & Centra, 2017; Casarico & Lattanzio, 2023).

Influenced by cultural expectations, women continue to perform a disproportionate amount of unpaid work, such as caregiving and household chores, reinforcing gender inequities in women's opportunities for paid work, economic independence, and well-being (Cutillo & Centra, 2017). In Italy, women average 22.7 hours of household work per week compared to 8.5 hours for men, this gap often widens after becoming parents (Barigozzi et al., 2022; Craig & Mullan, 2010). Cultural pressure in Italy dictates that the mother is primarily, if not completely, responsible for the baby's well-being until the age of three (Bertolini et al., 2015). This cultural belief, coupled with a very short and sparsely utilized paternity leave, enforces men's return to work and women's inclination to stay home following the birth of a child by means of maternity leave or unemployment.

Childcare accessibility and postpartum policies in Italy heavily influence women's workplace participation. Although childcare is partially subsidized, most facilities lack flexible hours of operation, thus restricting many women's employment opportunities (Del Boca & Vuri, 2007). Approximately 60% of children under three are not enrolled in any formal childcare, leaving the majority of parents to rely on informal childcare such as relatives (Del Boca et al., 2005; Eurostat, 2024b). The lack of affordable, available public or private childcare options, particularly for infants and preschoolers,

delays motherhood and increases the likelihood that mothers will leave the workforce (Pacelli et al., 2013).

Postpartum mental health is a critical yet often underexamined factor in women's employment trajectories. Data suggests that, globally, one in seven women will experience postpartum depression (PPD) with many cases remaining undiagnosed due to diagnostic barriers and limitations in the Italian PPD screening process (Mughal et al., 2022; Bauman et al., 2020; Gigantesco et al., 2021). In efforts to recognize these symptoms, the World Health Organization (WHO) recommends at least four postnatal care contacts, specifically recommending a home visit during the first week, to ensure a healthy mom and newborn (WHO, 2025).

Working mothers are at increased risk of PPD (Selix & Goyal, 2015), with research particularly suggesting that returning to work 12 weeks or less after giving birth increases the likelihood of developing PPD (Kornfeind & Sipsma, 2018). However, data suggests that maternity leave extended to 14 weeks reduces depressive symptoms and improves mother-infant interactions (Staehelin et al., 2007). Additionally, fathers who take paternity leave have higher levels of father involvement compared with fathers who do not (Knoester et al., 2019). Despite Italy's relatively generous five-month maternity leave, the combination of these challenges creates ongoing issues for maternal well-being and workforce participation.

Prior qualitative research conducted in Florence has explored women's reproductive and maternal health experiences within the broader cultural, healthcare, and policy context of Italy. Studies have examined women's interactions with reproductive healthcare systems, perceptions of communication with providers, and the ways institutional practices shape reproductive decision-making and care experiences (DeMaria et al., 2020; Meier et al., 2020). Additional qualitative work has explored family planning decision-making, highlighting how cultural expectations, gender norms, and structural barriers influence reproductive intentions and autonomy (Amidei et al., 2023). More recent research has further documented how sociocultural norms influence women's perceptions of their bodies and reproductive health experiences across the life course (Hughes-Wegner et al., 2024; Morley et al., 2025). Collectively, this body of qualitative research points to the importance of understanding women's reproductive health through lived experiences shaped by healthcare systems, social expectations, and policy environments. However, less qualitative research has specifically examined how women interpret and navigate maternity care systems, workplace policies, and postpartum support within this context, particularly as these factors intersect with maternal well-being and workforce participation.

Study Purpose

Existing research documents structural and cultural influences on women's employment and fertility in Italy, yet limited qualitative work examines how women themselves interpret and navigate these dynamics during pregnancy and the postpartum period. Researchers investigated the nuanced cultural and social influences on Italian women's maternal experiences to understand the factors affecting their pregnancy, postpartum, and employment experiences and challenges. A scarcity of qualitative studies remains in exploring the intersection of cultural, economic, and policy factors that shape maternal employment, well-being, and overall fertility outcomes in Italy. This study aimed to fill that gap by examining Italian women's maternal

experiences through personal narratives, centering on women's voices and recommendations. It offers insights into the barriers preventing Italian mothers from returning to work, the perceptions of existing policies and services that support working mothers, and proposes necessary improvements to create a more inclusive and supportive environment. This study centers women's narratives to identify barriers and opportunities to strengthen maternity care and workplace protections. Given the declining fertility rate and persistently low maternal workforce engagement, it is crucial to identify comprehensive solutions to enhance women's well-being and professional participation.

Materials & Methods

Study

This analysis draws from a larger qualitative dataset examining women's reproductive and maternal health experiences in Florence, Italy (Morley et al., 2025). Researchers conducted 24 interviews in May and June 2023 on topics such as family planning, fertility, healthcare support, birth plans and their implementation, breastfeeding, body image, and workplace policies during pregnancy and the postpartum period. This variety of topics allowed participants to share their experiences comprehensively, offering a strong understanding of the challenges, perceptions, and experiences of women who have given birth in Italy. This study employs a qualitative methodology to analyze the experiences and attitudes of mothers in Italy and their relationship to workplace policies regarding pregnancy and postpartum care. The study received approval from the first author's university, with support from the partnering Italian institution.

Participants

The study's inclusion criteria specified self-identifying women aged 18 years or older who had given birth through the Italian healthcare system (private or public), lived in or near Florence, Italy, and were comfortable being interviewed in English. Those who did not meet these criteria were excluded from the study.

The mean age of the 24 interview participants was 44.9 years (SD=11.1, range=25-62). Most women identified as Italian by nationality (n=18, 75%); however, the participant pool also included individuals from the United States (n=2, 8%), Australia (n=1, 4%), Canada (n=1, 4%), the United Kingdom (n=1, 4%), and Romania (n=1, 4%). Of the 48 total reported pregnancies, participants averaged 2 pregnancies, with approximately half (n=23; 47.9%) resulting in vaginal births. Most participants had either started or completed higher education (n=22; 92%), while the remaining participants (n=2; 8%) had a high school education or less. Half of participants were employed full-time (n=12, 50%), 33.3% part-time (n=8), 12.5% self-employed (n=3), and 4.2% were not employed (n=1). Nearly all participants reported having a comfortable income (n = 20, 83%). See **Table 1** for additional participant information.

Research Team

Data were collected and transcribed by 24 undergraduate students participating in a research-focused study abroad program in Florence, Italy. Immersed in the local culture, students received intensive training in qualitative research methods and conducted interviews under faculty supervision. The research team includes early career scholars and a faculty mentor trained in public health and the social sciences with prior experience conducting qualitative research on maternal health and health equity. Primarily trained in

Table 1.
Participant Characteristics.

Item	N (%) or M±SD
Age (years)	44.9 ± 11.1 (range = 25-62)
Gender Identity	
Cisgender woman	24 (100)
Relationship Status	
Single	2 (8.3)
One partner	22 (91.7)
Primary Language	
Italian	20 (83.3)
English	4 (16.7)
Other	1 (4.2)
Pregnancies	48 Mean = 2; Mode = 2
Vaginal birth	23 (47.9)
Cesarean birth	12 (25)
Miscarriage	8 (16.7)
Abortion	4 (8.3)
Education	
High school	2 (8.3)
Undergraduate	12 (50)
Graduate	10 (41.7)
Born	
Italy	18 (75)
United States	2 (8.3)
Elsewhere	4 (16.7)
Household Income	
Comfortable	20 (83.3)
Just enough	4 (16.7)
Employment Status	
Full-Time	12 (50)
Part-Time	8 (33.3)
Self-Employed	3 (12.5)
Not Employed	1 (4.2)

Note: Data presented as Avg ± SD or n (%). Numbers that do not add to 100% reflect missing data. The age range is presented alongside the mean and standard deviation.

Table 2.
Interview Questions.

Primary Question	Probing Questions
What types of policies support pregnant people in Italy?	● Tell me about your maternity leave experience. ● What does a typical maternity leave look like? ● How long is a typical maternity leave? ● Did your partner have paternity leave? ● How much time did you or your partner have off? ● Did you get paid while on maternity leave? ● What percentage of your wages were you paid? ● What types of policies have you heard or experienced that support people who have had a miscarriage? (stillbirth)? Were they entitled to time off? ● What types of policies or resources have you heard or experienced that support women postpartum (after maternity leave)? Are there policies that support postpartum depression? ● Where do people hear information regarding pregnancy and postpartum workplace policies? ● What impacts do current policies have on women? (support, shame, etc.) ● Have you or someone you know ever lost a job because you/they were pregnant? Tell me about this.
Would you like to see any changes or additions to workplace policies regarding pregnancy?	● What is your opinion on the length of maternity leave? Was this enough time for you? ● What is your opinion on the length of paternity leave? What is enough? ● Should maternity leave require people to take time off before they give birth? ● What should the compensation be like for people on maternity/paternity leave? ● What policies should be created to support people who have had a miscarriage (stillbirth)? ● What additional policies could have been in place to make your maternity experience better? What policies could have made you feel more supported? ● What policies should be created to support people who have ongoing challenges/complications after pregnancy (postpartum depression, critical health conditions)? ● Who should be responsible for these policies? (ex. government, individuals' workplace)

the United States, we recognize that our perspectives on maternity care systems, workplace protections, and postpartum support are shaped by our own cultural and policy contexts. To mitigate interpretive bias, the team engaged in collaborative coding and reflexive discussions about cultural context, language, and positionality. The first two authors, who also served as interviewers, conducted coding and analysis, ensuring consistency and familiarity with the data. Senior faculty provided ongoing oversight to maintain methodological rigor. The team used code manuals and mind mapping to identify themes, met regularly to discuss coding decisions, and resolved discrepancies through consensus.

Recruitment and Data Collection

Recruitment took place in May 2023 and was primarily conducted in person through city canvassing at local establishments and public spaces throughout Florence. Snowball sampling was also used, in which participants were asked to recommend other eligible individuals for the study (Rubin & Rubin, 2011). Communication and follow-up with participants occurred mainly via email or phone. All identifiable information was omitted, and participants were recognized only by their assigned identification number. All participants read and signed a written informed consent form and provided oral consent before the interview and audio recording. Each interview lasted approximately 60 minutes and took place at a convenient location for each participant. After the interview, participants completed an anonymous demographic questionnaire and received 20 euros in compensation for their time.

The interview guide was primarily developed by the last author, an expert in interdisciplinary women's health, with contributions from the rest of the research team. It was shaped by existing literature and previous findings from earlier studies (Amidei et al., 2023; DeMaria et al., 2020b; Hughes-Wegner et al., 2024; Meier et al., 2022) and approved by the partnering Italian institution to ensure sufficient cultural competency. The interviews began with general questions about the participants' backgrounds and relevant family information to establish rapport and enhance their comfort (Rubin & Rubin, 2011). Subsequent questions provided a comprehensive understanding of participants' experiences and knowledge regarding maternal workplace experiences before, during, and after pregnancy, as well as during maternity leave and under other supportive family policies. The interviews followed a semi-structured protocol, giving researchers the flexibility, while allowing participants to share insights and elaborate on their unique personal experiences. Interviews continued until thematic saturation was reached, defined as the point at which no new substantive themes emerged in the final interviews. See **Table 2** for the full interview guide.

Data Analysis

All interviews were audio-recorded using Otter.ai, transcribed verbatim, and revised manually to address errors. Observer comments and memos were used during and immediately following the interview to capture both verbal and nonverbal information from the participants.

We used reflexive thematic analysis following Braun and Clarke's (2006) six-step approach as the analytic method to identify patterns and themes across participants' narratives. The entire research team conducted a thorough content review noting recurring ideas for potential codes and themes (Braun & Clarke, 2006; Roberts et al., 2019). Code manuals and mind-mapping

techniques were used to identify themes from participants' words and the existing literature. A deductive-inductive approach to codebook development was employed during the content review, enabling a comprehensive representation of the data throughout the coding process. Researchers conducted coding and codebook development using HyperRESEARCH 4.5.1, a qualitative data management tool. The first round of coding employed an open coding approach, allowing researchers to create and assign tentative codes to related content within the transcripts (Braun & Clarke, 2006; Corbin & Strauss, 2007). Researchers conducted axial coding to uncover relationships among codes, seek disconfirming evidence, and refine thematic associations through multiple rounds of coding. Strategies to foster enhanced trustworthiness and credibility– such as regular peer debriefing, audit trail of analytic decisions, and investigator triangulation– were utilized throughout the coding process (Stahl & King, 2020).

The study was conceptually informed by a sociocultural perspective emphasizing how gender norms, policy environments, and workplace structures shape women's lived experiences of pregnancy and postpartum in Italy. Drawing on interpretive qualitative approaches that foreground social theory as a framework for designing studies and interpreting health experiences (Willis et al., 2007), the team approached the data interpretively, prioritizing participants' meaning-making while attending to broader social and structural contexts that influence maternal health and employment. All codes were preliminarily reviewed and similarities were identified in order to determine final codes via author consensus based on novelty or repetitive nature. The final themes were collaboratively reviewed and refined to ensure they were grounded in participants' voices and aligned with the study's purpose of illuminating the policy, cultural, and behavioral dimensions of maternal well-being.

Results

After conducting 24 interviews, four major themes emerged regarding pregnancy and postpartum policies: (1) mixed experiences with the public healthcare system, (2) employment challenges shaped by gender discrimination, (3) impact on postpartum well-being amid limited support, and (4) participants' recommendations for enhancing support and protections for mothers. Themes and subthemes are presented with participant ID numbers (101-124) and ages (25-62) (e.g., (101, 37)).

"I didn't feel comfortable": Women's Mixed Experiences with Public Healthcare

Positive Public Healthcare Experiences

Some women reflected that their interactions with the publicly funded Italian healthcare system during pregnancy and postpartum were positive. One participant shared, "I'm happy to have given birth in this country because there are a lot of services which support women and they are free, which is very important so everyone can access the services" (102, 32). Another participant echoed this sentiment, highlighting the range and financial accessibility of maternal services: "They offer everything. And it is completely free" (117, 40).

Concerns with Public Healthcare Quality

Although accessible, several participants expressed dissatisfaction with the quality of public-sector services. A participant described, "In Italy, they do a very poor job" (119, 42), with another adding, "I didn't feel

comfortable there [public healthcare facility]" (124, 46). Additionally, numerous participants showed concern for the lack of communication within the public system: "I've always found the lack of communication is quite shocking in the medical field. There's not enough communication" (118, 54). Another woman shared, "You're not used to having to fight to be heard" (104, 32). This same participant later described, "Even just trying to understand what I had to do and where I had to go. And there were several occasions where I wasn't informed of information that I needed" (104, 32). Due to these downfalls, some women chose to utilize or switch to private healthcare. One woman who previously used the public healthcare system described it as a "Bad, bad, bad. Very bad" (101, 37) experience, going on stating strong sentiments: "Most of the professional figures in charge are all women and they are devils. Really! Devils!" (101, 37). When describing her reasoning for her switch, she said, "In Italy, sometimes it's better to spend money to really be well treated and followed" (101, 37). In addition to negative healthcare experiences due to poor quality care, women encountered challenges in accessing accommodating workplace environments.

"Oh, no, we don't want to hire her": Employment Challenges Driven by Gender Discrimination

Gender Discrimination and Limited Economic Opportunities

Several participants described difficulties finding jobs and reliable career opportunities in general: "This country really gives you not a lot of hope in the future, not a lot of good job opportunities" (101, 37). However, most participants expressed that women of reproductive age, regardless of their maternal status, face further career-related challenges, such as wage differences or being denied job opportunities. For example, one woman shared, "In terms of salaries and wages, for the same level, they [women and men] have different wages. Different opportunities" (112, 58). Furthermore, another woman explained the presence of gender-based discrimination in the workplace, stating:

> They're [the employers] are like, "Are you married?" "Yes, I'm married." "Do you have kids?" "No, I don't have." "Oh, no, we don't want to hire her because she's likely to cost our company a lot of money." So, then a lot of young women are not hired... It's hard to find a job that will hire you because they're going to say, "Oh, you have kids, you're going to need a lot of time off. (105, 42)

Many participants conveyed that this discrimination is specific to women: "I know that when you're interviewing for a job, if you're a man, nobody asks you if you have children. Nobody asks you if you're married. Nobody asks you what are your thoughts on the future" (107, 36). Moreover, a subset of participants shared that pregnancy itself initiates additional employment challenges, such as threats to benefits being retracted or losing their jobs. One woman noted, "They were trying to take away one of my benefits just because I was pregnant" (105, 42). Another shared, "I know of women who were laid off because they got pregnant" (119, 42). This discrimination forces women to further consider the costs associated with becoming a mother and its implications on workplace opportunities: "Before, mostly you had to pay to decide to have children. If you decided to have children, [you] probably didn't get a promotion at work" (103, 53). Collectively, these circumstances left women feeling unempowered: "Women, you are kind of screwed no matter what" (105, 42).

Pressure from the Employer

Some women expressed that even though they had legal rights to parental leave, their employer would pressure them to return to work before their allowed time off ended. While working part-time after maternity leave, one participant commented on the pressure to return to work after childbirth: "There was a pressure, 'We are going to need you full-time in the fall'" (105, 42). The participant described the impacts of this pressure: "Even though I have the right, you're not exercising it because there's already the pressure from your supervisor saying there's no way that you could do part-time, even though you're legally allowed to. But the walls are already up" (105, 42). Another shared a demanding request made by her employer: "It's difficult because you are asked, 'Okay, okay, we understand the situation, but would you manage to come back one month earlier?'" (113, 59). Another participant commented on her observations related to the autonomy of when to return to work:

There seems to be a pressure to return to work relatively quickly… other moms that I've talked to have been talking about, oh, going back to work part-time by like kind of three months, four months. I'm not sure if that's because their workplaces putting pressure on them or because that's what they want to do. (104, 32)

Many women, despite being eligible for five months of maternity leave followed by part-time accommodations, returned to work earlier due to insistent pressure from their workplaces.

Self-Employment Parental Leave Challenges

Self-employed women expressed extended difficulties throughout their pregnancy and postpartum experiences, such as reduced maternity and paternity leaves and income loss:

My husband owns a business. And people that own their own businesses are screwed. Even other moms that I knew that own their own business and they don't have the same rights as other people and so they're kinda like, "Okay, what do I do because if I stopped working, I have no income" … Even after I have my child, like my husband was still working 12-hour days, and that doesn't change. (105, 42)

Several self-employed women expressed having no maternity leave: "I'm a freelance[r] so I had to go back. If you are a freelance[r] in Italy, you don't deserve maternity leave" (101, 37). Many participants' partners or husbands took no time off because they were self-employed. When asked if her partner took any paternity leave, one participant answered, "No, he didn't. He didn't because … he works. He has his own business" (121, 51). Another woman elaborated on her husband's experience, saying, "So, he also had a partita IVA, which is like a freelancing license here in Italy. So, he didn't have like benefits to or access to paternity leave that we used, or that we knew of" (115, 38).

Insufficient Governmental Financial Support

Certain participants shared that there is a lack of governmental financial assistance for working mothers, particularly for those who are self-employed: "I had no assistance from the government. I was independent…I couldn't have any maternity leave because I started immediately working again because I had my own business" (112, 58). Other mothers shared that though they received aid, it was insufficient. One participant, a farmer and business owner, who received government financial support as an agricultural worker, described the inadequate aid, stating, "Fifteen euros a month! Until

they [twins] were 18. Are you joking? I can't even buy a pizza once [with that]" (120, 55). Another mother shared how government policies and the COVID-19 pandemic impacted her maternity leave compensation: "I know they calculated my maternity leave based on the taxes I paid two years before. And the pandemic happened so I didn't pay enough taxes in those two years to deserve more than 300 euros" (101, 37). A lack of government support made the role of a working mother difficult.

"It changes your life, your body, your mind": Impact on Postpartum Well-being Amid Limited Support

Lack of Postnatal Care and Appointment Uptake

Interviews revealed many participants did not attend any postnatal appointments: "No, there's no nurse checkups or home visits, that doesn't exist here" (118, 54). Others reported attending only one postnatal appointment: "One. Just one" (123, 29). Moreover, one participant shared that she chose not to attend any postnatal appointments since the one prenatal appointment she attended "wasn't so accessible, and I didn't find it super useful. So, I didn't go back. I just went to one [prenatal appointment] unfortunately" (115, 38). One immigrant participant suspected this lack of uptake might be attributed to the stress of working: "I think for people who get pregnant here, it could probably be a little stressful to miss an exam or to have to get this time off of work" (105, 42). A lack of supportive policies for expecting and new mothers in Italian workplaces impacts not only employment opportunities but also the physical and emotional health of mothers.

Mental Health and Postpartum Depression

Almost all participants shared they experienced feelings of abandonment, loneliness, depression, and identity loss during the postpartum period: "I'm seeing a lot of women that are going into depression postpartum. I'm sure that it's because they are not supported even after the pregnancy" (107, 36). Many women described maternity and motherhood as an isolating experience:

> We are alone because maternity is isolation, first of all. Because you are isolated, you can have all the friends you want, but you are alone. Your friends are at work, they don't have kids, and so it is isolating a lot. A woman has to be supported. (123, 29)

Another woman noted the vast implications of these emotions: "I felt like it is depression…It changes your life, your body, your mind" (110, 25). In addition, some women felt life after giving birth restricted them to fulfilling traditional female gender roles: "A woman should have some time for herself…maybe feel useful for other things, not only taking care of the baby and cleaning the house and preparing dinner" (107, 36). Other women noted this sense of lost identity: "I wasn't feeling just like a woman. I was just feeling like a mother" (107, 36). Another woman shared how she felt unable to address her depression due to the demands of work and motherhood by stating, "At first, I was thinking a lot: the language barrier, the future, the work, the baby, my husband. So, I had no time to deal with the depression, you know?" (110, 25). She later went on to explain that the perceived inability to address postpartum depression is a widely shared belief: "When you have a baby, I think that most of the mommies are thinking like that you cannot think of depression because you have a baby to feed. You need to be healthy" (110, 25). Adverse mental health effects of pregnancy and postpartum were perpetuated by workplace demands and ultimately

diminished some participants' identities. Yet Italy's current policies and federally funded healthcare programs do not fully address these impacts.

Competing Demands and Cultural Expectations

Most participants described limited opportunities to prioritize their physical health postpartum due to work and caregiving demands. One participant mentioned, "I think maybe women who don't work, they have more time to think about [exercise]. I have no time, I work. I have to work" (101, 37), while another echoed, "You have to stay with your kids. No time for anything that is gym or anything like that" (124, 46). Beyond time constraints, some women described a "traditional" (102, 32) culture, impacting their maternity experience: "People judge you too much if you do sports during pregnancy, if you decide not to breastfeed, or go back to work too early or too late, people judge you too much" (102, 32).

Breastfeeding in the Workplace

Many participants were aware of workplace breastfeeding policies and reported a seamless experience if they chose to breastfeed. One participant explained, "If you decide to return to work, you have breastfeeding hours. So, your hours are reduced to be able to breastfeed" (105, 42). Another participant echoed, "You have two hours for this job [breastfeeding]. So, if you are working, you go home [two hours] earlier" (114, 57). Many women appreciated the reduced time when they returned to work to accommodate breastfeeding. However, despite accommodations, some participants struggled when returning to work: "I was working and after three hours, your boobs are exploding. It's stressful if a woman has to go back to work" (101, 37). Although some women were given opportunities to pump or breastfeed during the typical workday, some women chose alternative options, such as leaving their workplace to breastfeed at home:

It was a little bit hard. Because I was working. A few days [after giving birth], I came back home, and the day after I was starting working again. So, it was not easy. I was stopping during the day every three or four hours going back home, leaving, and then leaving, and then coming back. (112, 58)

"It's the hardest job…We have to be protected": Desired Policy Improvements

Improved Maternity Leave Policies

In light of the challenges participants reported, their subsequent recommendations were shared. Among these desires, most participants frequently expressed wishes to extend the existing five-month paid maternity leave mandate: "I would like the maternity leave to be extended to one year and paid 100% until one year. I think five months is not enough" (102, 32). Another participant shared the same desire but emphasized greater freedom and autonomy for all mothers, despite employment type:

I think a woman should be left at home and paid for a year. Maybe give me 80% of the salary, but you have to give me the choice. Every woman, working in freelance or for companies, everyone has to have the same rights. Because when we are in this situation, we are all the same. (101, 37)

Women supported this maternity leave extension for a variety of reasons, mostly related to providing optimal care for the child: "For me, it's one year because you need to feed your baby" (110, 25); "It's difficult to

practically leave the baby at home" (108, 39); "It's the hardest job… We have to be protected" (101, 37). Women also aspired for workplace protections allowing the opportunity to have a child and maintain a career: "If a woman wants a baby, she must be free to have the baby and to have the job. The same job. To have help from the administration" (112, 58). Not only did the women want to see improvements in maternity leave, but nearly all participants also longed for changes in paternity leave.

Improved Paternity Leave Policies

Along with consistent wishes for longer maternity leave, most participants also considered the current paternity leave policy was insufficient:

> In Italy, they just give you ten days and that's it. But it's not enough, of course. The first days are crazy and your life is completely changed in one minute. So, I think more parents need to leave three to six months to be all home together as a family and approach this new life. (123, 29)

Several women desired similar leave policies of five or six months to be provided to their husbands or male partners: "I would like to see the same amount of time given to men. And it would be compulsory" (119, 42). Several participants called for improvements in paternity leave policies as they "would like to see men with their children" (119, 42) because "It's not like it's just the mom's game, but also the father, you know?" (110, 25). Another stated, "Women need to be supported. Otherwise, the gender gap will never end" (112, 58). One participant shared her support for improved paternity policies and how Italian cultural beliefs have played a role in the lack of sufficient paternity leave:

> [When the child] feels sick or anything else, it is the mother that has to go resolve the situation. So the paternity [leave], nobody cares. Italy just has this point of view. Italy, like a lot of countries in Europe, still have. They [men] still have to learn how to protect and how to support the woman and not to destroy her. (107, 36)

Improved Public Healthcare Communication and Postpartum Education

Almost all participants shared aspirations to improve publicly funded services, such as public healthcare, to improve postpartum outcomes. Improved patient-provider communication was frequently mentioned: "I just feel like communication is very limited when it is huge and should be much bigger. In general, including pregnancy and postpartum" (118, 54). Another woman described how she felt forced to comply with the doctor's opinion or she would be shamed, later further elaborating on her experience with providers, stating, "And you don't get provided with much information, or like I often felt kind of like rushed through" (104, 32). Furthermore, several participants felt undereducated and underprepared, especially to cope with postpartum depression, aggravated potentially by social stigma, thus desiring enhanced psychological support and outreach postpartum: "Maybe a lot of women feel ashamed that they have a problem, shamed to ask for help…They think that it's normal and that something is wrong with them rather than asking for help" (107, 36). Despite present patient education efforts via prenatal classes, several women commented on the ineffectiveness of these classes and on an overall lack of awareness of what postpartum depression is: "They never say anything about postpartum depression…You feel like you're left to fend for yourself" (119, 42). In addition to prenatal education, women wanted more support and well-developed, comprehensive education on the postpartum period:

Women should be supported more after the birth. And they should be… aware more. I mean, all the courses, YouTube, that you do before birth are useless. You have to teach a woman, to really teach about breastfeeding, about all the problems. (101, 37)

Furthermore, one woman shared she wanted someone "to create courses to support opportunities for women" (121, 51) to help women suffering from mental health issues postpartum. She explained present services are not the same throughout Italy and wants these courses "to be uniform throughout the country" (121, 51).

Community Programs and At-Home Services

Certain participants expressed a desire to integrate community involvement postpartum as part of recovery. One method described was via community or mom support groups:

I think it would have been really helpful to have like a facilitated mom's group, either pre or post, in the area that you live in… That doesn't require you to have to go to the hospital… Because at the moment…most of the support is provided through like medical systems, through the hospitals, through appointments with midwives. And that system is what's very cumbersome and difficult. And so, if they had something close, local, where like moms could meet, moms could chat with somebody who's got some experience during their baby's first year… there isn't really anything where new moms meet here. (104, 32)

Additionally, women wanted postnatal medical care to be implemented via at-home services: "Looking back on it, it would have been really useful to have nurses be supportive of me trying to breastfeed, come to the house and, you know, help cope since those services exist in Australia and America" (118, 54). In addition to services after successful deliveries, one woman shared she wished there was "someone that follows you after [a miscarriage] for mental health" (123, 29). Overall, another woman shared her desire for their communities to take hold of a new perspective of women postpartum: "If we, like society, have to change something, maybe it should be the tension for the woman after the pregnancy and in the world of the working here" (107, 36).

Need for Affordable and Accessible Childcare

When participants wanted to return to work, they felt there were not enough full-day programs to watch their children: "I think there are not enough. For example, kindergarten. There are not enough daycare places around" (119, 42). Despite free kindergarten options, the only ones available are private and expensive:

Even if we have a good health system, we don't have good support. When you have the baby that needs to go, to allow you to go to the work and leave the baby through public places, they are very expensive. And there's a long waiting list. So that, I think, should be organized in a better way because it is hard for the parents. (122, 56)

Additionally, present childcare options are often not available for an entire workday, thus further complicating the issue and limiting financially feasible public options:

Because here, I have to say, there is not a lot of public support for your kids… If I have to go back to work at 4 pm, is not working for everyone. So, you need the nanny or you need a private place. And that's what I did. Like it was like really, really expensive. (124, 46)

Participants generally wanted more affordable, accessible daycare options, but ultimately prioritized longer maternity leaves, stating, "It's always difficult to leave

the baby" (106, 60). Overall, a lack of investment in childcare is just a part of the larger issue: "I think society is not investing in the importance of children" (120, 55). This participant later demonstrated her point: "If you go to the park in other countries…Germany, Switzerland, England. Their park [is] amazing! Where the mom can go. They can play. Here, there is a swing that is broken" (120, 55). Italy's limited investment in its children and the consequences for mothers it entails are a compelling topic for discussion.

Discussion

This study builds on limited qualitative research regarding perinatal policy experiences in Italy, a high-income country with low maternal employment rates and enduring gender inequity. Although national-level maternity protections exist, few studies have investigated how women understand, navigate, or experience these policies in practice (International Monetary Fund. European Dept, 2024). Through qualitative interviews, this study revealed structural and cultural dynamics shape maternal health, employment decisions, and postpartum well-being. Nearly all participants expressed dissatisfaction with publicly funded maternal health services, gender-based workplace discrimination, and limited access to fair postpartum and childcare support. These findings suggest a disconnect between the intent of national maternity policies and how women experience and navigate them in reality.

Participant narratives reported mixed experiences with Italy's public healthcare system, highlighting barriers in postnatal follow-up and mental health support. While some praised its accessibility and cost-free nature, others described it as poorly coordinated and impersonal, especially during pregnancy and childbirth. These findings align with previous literature noting low patient satisfaction in Italian maternity care and limited shared decision-making during prenatal care (Liuccio, 2015; Meier et al., 2020). Several women reported a lack of communication and support during appointments, often leading to a shift toward private healthcare. This dissatisfaction is concerning, as prior research indicates that poor childbirth experiences predict postpartum depression (Molgora et al., 2022). Many participants also reported limited or no uptake of postnatal appointments, a striking contrast to WHO's recommendation of a minimum of four postnatal contacts (WHO, 2025). Some women cited time constraints or work demands, while others found prenatal services unhelpful and chose not to return.

Italian mothers continue to face structural and cultural barriers in the workforce, including biased hiring practices, wage discrepancies, and pressure regarding benefit utilization. While these dynamics are documented globally, Italy's maternal employment rate remains among the lowest in Europe (OECD, 2017), and our findings suggest these cultural and structural challenges may contribute. Even when policies such as part-time return after maternity leave exist, women reported pressure to resume full-time roles or expressed guilt about using their legal entitlements. This aligns with prior work describing maternal stigma and limited enforcement of family-friendly workplace policies in Italy (Modena & Sabatini, 2012).

Importantly, a majority of participants were generally aware of existing maternity protections, including five months of paid leave and part-time work options. This awareness seemed to support policy utilization, contrasting with other studies that noted low uptake due to a lack of information

(DeMaria et al., 2020a; Meier et al., 2022). However, even when protection exists, self-employed mothers and those affected by economic shocks face additional barriers to accessing maternity benefits. Although Italian law technically offers maternity protections for self-employed women registered with INPS and who pay taxes, complex eligibility criteria, unclear communication, and administrative burdens may limit access (INPS, 2025). The COVID-19 pandemic highlighted how economic shocks can disadvantage mothers, as one participant noted her maternity benefit was calculated based on reduced pandemic income. These findings suggest that policy effectiveness should consider not only the existence of protections but also their visibility, accessibility, and enforcement in practice to ensure benefits remain equitable during financial disruptions.

Postpartum mental health emerged as a key concern, with limited support compounding the challenge of returning to work. The bulk of participants described feelings of isolation, shame, and a loss of identity after giving birth, with challenges intensified by limited psychological support and insufficient postpartum outreach. These findings align with global evidence indicating that postpartum depression is often underdiagnosed and undertreated, particularly in environments where care primarily focuses on the infant (Pope & Mazmanian, 2016; Stein et al., 2014). Women reported prenatal classes did not provide meaningful preparation for their postpartum emotional well-being, promoting a desire for standardized national guidelines on postpartum education and mental health support, especially for immigrant women and those lacking strong local networks.

Community-based support emerged as a key recommendation from participants. Women expressed a desire for local, peer-oriented postpartum programs and in-home breastfeeding or recovery assistance, which mirror WHO-recommended postnatal care services (WHO, 2025). Expanding community-based and in-home services may improve postpartum health outcomes and promote equity for socially isolated or working mothers. A greater investment in roles such as community health workers on a national level could greatly support these efforts, as well as postnatal appointment uptake, while enhancing overall trustworthiness in health systems (McLeish et al., 2023).

Participants identified several strategies to strengthen maternal support, including extending maternity, equitable paternity leave, and accessible childcare. Many women express a preference for one year of paid leave, consistent with the literature showing that longer leave benefits maternal mental health and child development (Dagher et al., 2014). The WHO recommends a minimum of 18 weeks of maternity leave, and research from other high-income settings suggests that extending leave to up to 1 year may provide additional psychological and developmental benefits (Van Niel et al., 2020). Many participants also advocate for equal parental leave for fathers, noting Italy's current ten-day provision is inadequate for shared caregiving or supporting maternal workforce engagement. Many participants reported public childcare options were limited, particularly for full-day care, while private options were prohibitively expensive. Working mothers and immigrant women faced difficulty finding care options that fit full-time work, often postponing returning to work, reducing hours, or later leaving the workforce, reinforcing gendered labor divisions. Prior research indicates that investing in childcare infrastructure boosts female labor force participation and supports child development (Staehelin et al., 2007).

International comparisons suggest that parental leave design and childcare access play an important role in shaping maternal workforce participation and gender equity. Countries with longer parental leave for fathers and more accessible childcare infrastructure often demonstrate higher maternal employment and shared caregiving responsibilities (Haas & Hwang, 2008; OECD, 2017). These comparisons highlight the importance of strengthening family policy support in Italy to better align maternal health, workforce participation, and gender equity.

Strengths & Limitations

This study offers one of the few qualitative analyses of maternal health and workplace policy experiences in Italy, a country with well-established maternity protections but limited empirical data on their real-world implementation. The use of in-depth, semi-structured interviews allowed participants to share nuanced personal experiences, revealing how cultural expectations and systemic structures influence health and employment decisions during the perinatal period. The interdisciplinary research team and cross-sectoral analytic approach further enriched the interpretation of findings across public health, gender studies, and policy domains. Efforts were made to ensure rigor in study design and analysis through piloting the interview guide, systematic thematic coding process, and reflexive analysis. Conducting the study during an academic immersion program provided valuable cultural context and access to a diverse participant pool, including both native and non-native residents of Italy.

However, the study also has several limitations. First, interviews were conducted solely in English, possibly excluding non-English-speaking women and potentially limited the diversity of perspectives captured. Although some immigrant voices were included, the sample may underrepresent more marginalized groups, such as undocumented workers or those in extreme poverty, whose experiences in accessing care or navigating employment challenges could differ significantly. Additionally, most participants were highly educated which may have resulted in findings that do not fully represent the experiences of women with lower educational attainment or limited health literacy. The geographic concentration of participants in and around Florence may also limit the generalizability of the findings to other regions of Italy, especially rural areas with different healthcare or employment infrastructures. Finally, as this was a cross-sectional qualitative study, it cannot assess the long-term effects of policy engagement or postpartum outcomes. Formal participant member checking was not conducted due to the study's short data collection timeframe, which may limit opportunities for participants to confirm the interpretation of findings. Future studies should aim to include more linguistically and socioeconomically diverse participants, incorporate longitudinal perspectives, and explore regional variation in policy implementation.

Implications for Health Behavior Research

Structural and cultural barriers identified in this study highlight a critical gap in how health behavior research conceptualizes and supports maternal well-being. Findings reveal that postpartum care engagement, mental health help-seeking, and parental leave use are shaped not only by individual motivation but also by the interplay of gender norms, employment policy, economic stability, and social context, highlighting the importance of situating maternal health

behaviors within broader structural and sociocultural systems. Framing these behaviors solely as individual choices risks overlooking the structural constraints shaping maternal health behaviors, particularly in a context where PPD remains underdiagnosed, postnatal care and childcare remains deficient, and Italian women face high workforce exit rates. Health behavior researchers should therefore investigate how perceptions of institutional trust, bureaucratic complexity, informal enforcement cultures, workplace stigma, and family expectations influence behavioral intention and perceived control surrounding key postpartum behaviors. Theory of Planned Behavior (Ajzen, 1991) and Social Cognitive Theory (Bandura, 1986) were not used to guide this study's design, data collection, or analysis; rather, they are introduced here to frame implications and inform directions for future health behavior research. This work can inform interventions that utilize and evaluate core constructs of the TPB and SCT, that, in turn, strengthen mothers' self efficacy and engagement with postpartum services, improve patient-provider communication, and reduce institutional and workplace barriers to perinatal care.

Additional research is needed to investigate barriers to postnatal care engagement, particularly in publicly funded systems, and to assess the effectiveness of at-home follow-up services, which participants identified as a preferred and WHO-recommended approach. Further research examining how paternal leave and flexible childcare arrangements influence maternal mental health, paternal involvement, family health outcomes, and maternal workforce participation would strengthen the evidence base for maternal health policy.

Health behavioral studies should apply longitudinal and intersectional designs to examine structural discrimination and benefit eligibility and compare diverse welfare and healthcare systems to identify strategies that reduce gendered inequities and strengthen maternal health policy globally. Insights from this research can inform multilevel interventions that normalize parental leave use, reduce workplace stigma, and integrate behavioral supports within postpartum outreach programs. By integrating behavioral and structural perspectives, this research advances theory-building in health behavior science and promotes equitable, context-sensitive frameworks for maternal and family health worldwide.

Policy Implications

Findings from this study highlight several actionable directions for policy reform. First, expanding and equalizing parental leave policies is essential. Italy's current system reinforces gendered caregiving norms and limits shared parental responsibility. Extending paid leave for both parents and ensuring inclusion of self-employed workers would promote maternal well-being, encourage equitable caregiving, and support long-term workforce participation. Second, greater investment in postpartum and community-based supports could substantially improve maternal health outcomes. Integrating home-based follow-up care, postpartum mental health screening, and local peer-support groups into public health services would reduce isolation, strengthen continuity of care, and align Italy's maternal support system with global best practices. Finally, increasing access to affordable childcare and improving workplace enforcement of family-friendly policies are critical to closing the gap between policy intent and practice. Strengthened oversight, combined with expanded childcare infrastructure, would reduce maternal workforce attrition, enhance gender equity, and create a more supportive

environment for families navigating the postpartum period.

Conclusions

This study reveals how structural inequities in healthcare, workplace policy, and social norms shape maternal health and employment experiences in Italy. Nearly all participants called for stronger communication, mental health care, equitable parental leave, and access to childcare, issues that transcend national boundaries. Advancing maternal well-being requires coordinated action across health, labor, and social systems grounded in gender equity and accountability. Policymakers, employers, and health leaders must transform maternal support from rhetoric to reality by investing in comprehensive postpartum care and inclusive workplace protections. Building systems that value caregiving and shared responsibility is essential to ensuring that no mother is, as one participant reflected, "left to fend for herself."

Ethics Statement

This study was approved by the Purdue University Institutional Review Board (IRB-2022-1472) with a letter of support from Florence University of the Arts. The research adhered to all ethical principles for medical research involving human subjects, as outlined in the Declaration of Helsinki.

Conflict of Interest: The authors have no conflicts of interest to declare.

Discussion Questions:

Drawing on the Theory of Planned Behavior, how might social norms, attitudes, and perceived behavioral control differentially influence the uptake of maternity versus paternity leave in Italy? Based on this study's findings, which policy domain—maternity or paternity—offers greater leverage for promoting gender-equitable caregiving and behavioral change?

What evidence-based and culturally responsive approaches can guide the design and evaluation of workplace and health system policies that promote maternal well-being, protect self-employed mothers, and support breastfeeding and postpartum recovery?

Data Availability: Data relevant to this study are available from the Purdue University Research Repository: https://purr.purdue.edu/publications/4726/1

Contributions:

Sophie E. Shank: Data curation**,** Analysis, Writing – original draft, Writing – review & editing.

Honor A. Fuchs: Analysis, Writing – review & editing.

Nicole A. Stepp: Conceptualization, Writing – review & editing, Supervision.

Andrea L. DeMaria: Conceptualization, Funding Acquisition, Writing – review & editing, Supervision.

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