And Understand I am a Person and Not Just a Number:
Reproductive Healthcare Experiences of Italian Women

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ABSTRACT
Patient-centered care may provide women autonomy in their reproductive health choices. The study’s objective was to explore Italian women’s reproductive health decision-making experiences through a shared decision-making lens. Researchers conducted 46 interviews (June-July, 2017) with women ages 18-45 living in or near Florence, Italy. Expanded grounded theory was used to explore women’s experiences. Findings suggest the Italian women in this sample desire decision-making involvement but conceptualize this as listening, respect, and information provision. Social network served an important function in decision-making. The economy and religion influenced decision-power. Findings offer practical recommendations to guide patient-centered care opportunities in Italy.

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Women’s reproductive health in Italy rests within contradictions. Italy’s fertility rate is among the lowest in Europe at 1.35 births per woman. Despite low fertility rates, Italy represents an imperfect contraceptive society (Gribaldo et al., 2009). Women there experience fewer unintended and intended pregnancies than in the United States and other European countries, yet also use less effective contraceptive methods (i.e., oral contraceptive pill, condoms, withdrawal versus long-acting reversible contraception) (Gribaldo et al., 2009). Further, economic situations may mediate women’s reproductive health experiences (Braggion et al., 2015; Franzini & Giannoni, 2010), including pregnancy (Chiavarini et al., 2014) and wellness care (Braggion et al., 2015; Damiani et al., 2012). Italy has both public and private healthcare delivery systems; the public system provides free or low-copay services to Italian citizens and residents, and the private system provides a paid alternative (Donatini, 2017). This dual system may increase women’s available care options for those who can access private services. Patient-centered care is the ideal paradigm in reproductive healthcare, and studies of it may provide insight into women’s experiences and improve patient outcomes (Dehlendorf et al., 2014, 2017; Street Jr. et al., 2009).

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Patient-centered communication focused on patients’ needs and preferences enhances emotional health and symptom resolution (Altshuler et al., 2016; Edwards & Elwyn, 2006; Greene & Hibbard, 2012; Gulbrandsen et al., 2020; Stewart, 1995; Stewart et al., 2000; Street Jr. et al., 2009), and shared decision-making (SDM) serves as one means to support patients’ roles in their healthcare experience (Elwyn et al., 2017; Frosch et al., 2012; Ketler, 2000; Thomas, 2015). SDM advocates for patient-provider decision collaboration, two-way information exchange, and elicitation of a patient’s preference (Elwyn et al., 2017; Frosch et al., 2012; Ketler, 2000; Thomas, 2015). SDM and patient-centered care may also enhance relationship building, as patients feel more informed and listened to by their providers (Fumagalli et al., 2015; Kirkscey, 2018; Volkman, 2018). Studies of SDM among Italian providers show that less than 1% scored well, which indicates SDM absence or minimal skill level (Goss, Fontanesi, Mazzi, Del Piccolo, & Rimondini, 2007; Goss, Fontanesi, Mazzi, Del Piccolo, Rimondini, et al., 2007). This suggests a gap in SDM and patient-centered care practice in Italy.

Reproductive healthcare provides an ideal opportunity to engage in SDM as many decisions are preference-sensitive. Nappi et al. (2015) noted a need for SDM during contraceptive consultations among Italian women; in particular, the women expressed apprehension and misinformation about hormone use safety. Johnson et al. (2013) found that only 27% of Italian women expressed high satisfaction with combined hormonal contraception, and one reason for dissatisfaction was a desire to forego hormone use. Guida et al. (2014) developed a contraceptive consultation framework for Italian women who desired the contraceptive implant, which incorporated key aspects of SDM and highlighted a need for increased SDM in reproductive healthcare. Pregnancy provides another avenue for SDM use as greater SDM engagement during prenatal care and childbirth may improve the birthing experience (Attanasio et al., 2018; Baijens et al., 2018; Nieuwenhuijze et al., 2014). In line with decision-making as a dynamic and multifaceted process, Sciaioli et al. (2015) argued for increased communication between patients and healthcare providers about e-health pregnancy information and improved patient-provider communication during pregnancy check-ups to increase knowledge and reduce misinformation, especially because sources outside the patient-provider dyad may impact decision-making, including online sources (Bert et al., 2013; Sciaioli et al., 2015; Siliquini et al., 2011) and partners, friends, and family members (Entwistle & Watt, 2006; Rapley, 2008; Stephens & Thomas, 2014; Sundstrom, 2012).

Little research is available on women’s reproductive health decision-making experiences and needs in Italy. In addition, there is limited research on patient-centered care and SDM experience in southern Europe, which may differ from northern Europe and the United States and offer insight into best practices in varied cultural settings, (Camerini & Schulz, 2016; Gartlehrer & Matyas, 2016; Ocloo et al., 2020; Smissen et al., 2019), including within Italy (Camerini & Schulz, 2016; Edwards & Elwyn, 2009; Goss & Renzi, 2007; Renzi et al., 2008). In particular, Goss and Renzi (2007) and Renzi et al. (2008) noted additional need to understand patients’ micro and macro contexts that may influence healthcare experiences and decision-making (Camerini & Schulz, 2016;
Cosgrove et al., 2018; Mosavel et al., 2016; Ocloo et al., 2020). As few studies have focused specifically on reproductive health decision-making in Italy using the SDM model and patient-centered care perspectives (Edwards & Elwyn, 2009; Goss et al., 2011), exploring Italian women’s voices and needs related to their specific contextually and culturally situated reproductive healthcare experiences is critical for enhancing patients’ autonomy and provision of patient-centered care.

The Present Study

To address the literature gap, we conducted in-depth interviews to explore women’s SDM experiences. As part of a larger mixed-methods study of Italian women’s reproductive health attitudes and behaviors, we sought to understand Italian women’s reproductive healthcare experiences, including decision-making. Interviews provide an in-depth and detailed understanding of individuals’ opinions and experiences, including how women make decisions about their reproductive health (Malterud et al., 2016; Rubin & Rubin, 2012). SDM provided the conceptual lens for the data analysis. To explore women’s voices, meaning construction, and experiences (Corbin & Strauss, 2008; Gulbrandsen et al., 2016), we used the following research question to guide our study:

RQ: How do women living in Italy perceive their reproductive healthcare experiences, including decision-making experiences?

We hoped that findings from the present study would offer practical opportunities for healthcare providers to engage women in their healthcare care and meet their reproductive health needs.

Method

Participants

A total of 46 reproductive-aged (M = 32.1 ± 6.3 years; Range = 19-45) women were interviewed. The majority (n = 43, 93.5%) resided in Florence at the time of the study. Most participants indicated that they were in a non-marital relationship (65.2%, n = 30); some were married (13.0%, n = 6) or single (19.6%, n = 9). Only two participants (4.3%) had children. A majority of the participants self-identified as heterosexual (84.8%, n = 39); others self-identified as bisexual (13.0%, n = 6) or lesbian (2.2%, n = 1). Most participants had initiated or completed a college degree (84.8%, n = 39), and seven (15.2%) participants had a high school education or less.

We conducted the in-depth interviews during June and July, 2017. Inclusion criteria were reproductive-aged women (18–45 years), living in or near Florence, Italy, using the Italian healthcare system at the time of the study, and comfortable being interviewed in English. Purdue University’s institutional review board (IRB) approved this study, and we obtained a letter of support from the Florence University of the Arts, our partner in the research collaboration.
Recruitment flyers were placed on advertisement boards in libraries, schools, restaurants, and stores. To reach a larger audience, a Facebook advertisement was created and expanded to a 25-mile radius around Florence. In addition, we approached women in person and invited them to participate in the study by providing them a flyer if they expressed interest. Participants were also encouraged to refer other eligible women to the study (Berg & Lune, 2012). Following each interview, participants completed anonymous demographic surveys, which were collected in a sealed envelope to ensure privacy and confidentiality.

**Interviews**

In-depth interviews were conducted in a location convenient for participants and researchers (e.g., private offices, university buildings). All researchers were female, which may have increased participants’ comfort level to share their reproductive health experiences. We obtained informed consent before the start of the interviews, which lasted approximately 1 hour and were recorded using the SoundNote iOS application. Each participant received a 20-Euro gift card as compensation for her participation.

The interview guide was informed by a previously conducted case study that incorporated a content analysis and perspectives of Italian healthcare and culture experts. The protocol was reviewed for cultural competency, and approved by the Italy- and US-based institutions. Interviews were conducted by research assistants who had received graduate-level methodology training and were immersed in the community as part of an extended study abroad experience. Interviews followed a semi-structured protocol. The semi-structured interview guide allowed flexibility for the researchers to add, change, or reorder questions and for the participants to introduce new and relevant concepts during the interview process (Berg & Lune, 2012; Rubin & Rubin, 2012). The participants had the opportunity to present ideas and narrate their experiences.

Interviewers began by asking each participant general questions about her daily routine to increase rapport and disclosure (Berg & Lune, 2012). The interviews also inquired into healthcare access (e.g., Where do you go for your healthcare? Do you ever have trouble accessing quality healthcare that you are happy with?). We also explored women’s communication about reproductive health (e.g., Can you describe how Italian women typically feel when talking about women’s health issues? Who are women likely to talk to about sex and sexual health issues?). Further, we investigated healthcare providers’ attributes (e.g., How do you choose your healthcare provider? What are important traits you want your doctor to hold?). Finally, interviewers asked about women’s reproductive health decision-making (e.g., How do you (or women like you) choose the childbirth method that is right for them? How do you (or women like you) make decisions regarding contraception?). This range of questions allowed participants to discuss reproductive healthcare access and decision-making holistically and provided a robust understanding of Italian women’s healthcare perceptions and needs. For questions where the participant did not have personal experiences, they were asked to comment on the experiences of others like them. Interviews continued until data reached theoretical saturation (e.g., no new concepts emerged during the interviews) and study concepts were fully developed.
Data were collected and transcribed verbatim by 15 undergraduate and graduate students participating in a research-based study abroad program offered by Purdue University, which is why all interviews were conducted in English. All students were trained in graduate-level qualitative research methodologies and had been immersed into the Florence community and culture for 2 months before the data collection period and during data collection. Coding and analyses were completed by the first author and one undergraduate student. The third author, the principal investigator, oversaw data analysis and interpretation. The authors utilized data tables and mind mapping as a strategic approach to analysis.

All interviews were transcribed verbatim throughout the study period; we also used memos and observer comments to maintain reflexivity (Rubin & Rubin, 2012). We used techniques from grounded theory for a constant comparative approach to data analysis. This inductive approach highlighted participants’ personal experiences (Corbin & Strauss, 2008). Participants’ words, phrases, and experiences provided in vivo codes throughout coding, consistent with grounded theory’s goal of building theory from within a phenomenon (Corbin & Strauss, 2008). Expanded grounded theory allows for existing theoretical construct incorporation (Corbin & Strauss, 2008); as such, the SDM model provided a conceptual framework to initiate data analysis. SDM concepts were included in the coding scheme during the data analysis process. HyperRESEARCH 3.7.5, a qualitative data management software, assisted the coding and analysis process through data input and organization. We completed iterative, line-by-line, open and axial coding to build conceptual categories and themes (Corbin & Strauss, 2008). Open coding describes the creation and application of tentative codes to portions of data based upon meaning established by the participants’ words (Corbin & Strauss, 2008). Axial coding identifies relationships among codes and to broader categories and patterns (Corbin & Strauss, 2008). A constant comparative approach within and between interviews allowed us to identify emerging themes. We met frequently to discuss emerging themes to ensure consistency and resolve any discrepancies via consensus.

Results

Three themes and associated subthemes emerged in the analysis: Reproductive Healthcare Experience: Perceptions of Involvement; Decisional Roles; and Social Context of Choice. These are presented below with illustrative quotes and corresponding participant identification numbers.

Reproductive Healthcare Experience: Perceptions of Involvement

More than “just a number.” Some participants reported healthcare providers engaging in extensive conversations with women about reproductive health needs and priorities. One participant said:

Visits, in general, are pretty long with doctors. You talk a lot… even when I go now, it’s never less than 1 hour. You go there… and you start talking and then there’s the visit, … and they talk again and give you the prescription and make sure you understand what you have to do and if you have additional questions. [P1]
Relationship-building via communication offered the opportunity to exchange information and share experiences and needs. One participant demonstrated personalized care by saying, “the other thing, too… it’s really personal. If I call them in the morning and say, ‘look doctor I’m really not feeling well, would you be able to come to my house?’ He’ll do a house visit” [P34]. Another participant mentioned the importance of relationship-building: “because I think… the social relationship is important for our health” [P36]. Open discussions with healthcare providers represented a significant component of healthcare for these women. This was, by no means, standardized, however. One participant said: “sometimes the relationship can be meaningful and sometimes it’s superficial. Doctors in the US are probably told they need to make small talk with their patients, whereas here, no one is expecting their doctor to make small talk” [P47]. Thus, there were different expectations and opinions regarding the level and standardization of interpersonal relationships between women and their providers in Italy.

Many participants, however, noted a lack of communication despite the value the women placed on the conversation during appointments. One participant stated it was important to feel valued and for the provider to “understand I am a person and not just a number” [P9]. Participants felt less informed about their choices when they perceived healthcare providers did not have time for consultations. One participant said: “I think she has probably a lot of patients because [doctors] get assigned patients and… so she doesn’t take a lot of time for each one” [P10]. Another participant stated: “because they don’t seem to have time to talk. The doctors have many patients. You go there, you tell them … how you feel. [They say] this is the drug, then bye” [P36]. Less communication resulted in participants feeling less informed and less engaged.

**Option discussions.** Conversations about options often occurred during wellness and contraceptive consultations. One participant described the contraceptive discussion generally: “… [you] go to the doctor and figure out what’s the best thing to use because every [sexual] relationship is different with different needs” [P39]. She noted appropriate options may change depending on women’s contexts. This same participant continued: “for example, when I went to my doctor, she showed me [each] kind of contraception and she explained the pros and the… [cons]” [P39]. Presentation of in-depth information facilitated contraceptive method choice. In contrast, one participant described a negative consultation experience:

> When I had this problem, this internal bleeding, I didn’t really feel protected by my present doctor. It would have been easier… if she would have explained that girls can have this problem if they do not control their period. I didn’t feel happy about that because it could have been easier for me to simply take the pill from the beginning … so from this perspective, I did not felt very protected by the health system. [P8]

This participant did not feel informed about options to address her health problem, which reduced trust in her provider and which she conceptualized as not being protected and valued.

Women also described knowledge barriers regarding various reproductive health options. One participant said: “sometimes … in sexual activity we use [condoms] and we think ‘Ok, I’m good’ but sometimes it’s not so simple. Maybe we should be more informed about relative risk [of different contraceptives]” [P15]. Another participant
said: “… I think it would be useful for people to know the differences, the risks, how to use [contraception] because often they are not using [them] the right way” [P8]. This participant emphasized a need for improved risk/benefit information, and, even more important, discussion of a range of options and their correct use.

**Listening.** Participants frequently cited the importance of listening during clinical consultations. One participant said:

> The important thing is that [healthcare providers] listen to you. It’s hard enough, even if you’re somewhat informed, to think about the things you want to tell your doctor especially when you’re in the seat - sometimes you can blank on the things you want to ask. [P7]

This participant indicated that providers ought to initiate discussions about women’s health concerns so that patients can express their needs, and said that active listening would improve women’s comfort in sharing. Another participant said: “I’ve seen a few different gynecologists here and finally have found one I like, that I feel listens to me” [P10]. Listening served as an opportunity for women to open up about their experiences and needs with their provider. One participant said: “I think having a good conversation with the doctors [with] a person that you really feel like talking to” [P1]. This participant highlighted the value she placed on two-way discussions, which illustrates the importance of relationship-building via listening in reproductive health decision-making.

In contrast, some women had negative experiences with discussing health issues with providers. One participant said: “I think … there is still judgment. Especially when you go to the doctor … but I do feel [providers] are more judgmental when they are Italian. That is why I prefer my doctor to be English” [P2]. This participant was unable to be open with providers because of perceived judgment that counteracted listening to her. Another participant noted that judgment and stigma may exist during communication with healthcare providers: “so I think it’s possible… that you may encounter stigma from doctors…” [P7]. One participant related her experience:

> There is a family doctor but I haven’t seen her for years because last time I saw her… I took… a contraceptive pill, the day-after pill. I took it two times very close together and I asked her to… give me the prescription… and she told me to shut my [legs]. [P40]

The doctor’s judgment prevented addressing the participant’s needs. This same participant continued: “I mean she was right because it was stupid, but she should have told me ’be careful you should go to this place to get … to do something about your sexual life’” [P40]. The provider did not listen to this participant’s reasons for repeat emergency contraception use; rather, judgment impeded conversation, relevant information provision, and the patient-provider relationship.

One woman expressed satisfaction with her care and highlighted that her provider elicited preferences: “he is like ‘can we try this, what do you think?’ Not exchanging opinions, of course, because I am not a professional. But at least consulting before just writing a… prescription” [P35]. She appreciated how her provider engaged her and asked her to discuss her preferences related to contraception. It was important for providers “to listen to my request and my needs… I like when they explain what they are doing and what they are thinking when they see there is something wrong” [P14].
Higher levels of engagement in patient-provider communication were associated with better overall reproductive healthcare experiences, according to the participants.

**Decisional Roles**

**Decision respect as autonomy.** The women expressed varied perceptions of control when making reproductive health decisions. Some women described their decisions as foremost. One participant said: “…personally what works best for them. So whether they… want to take the routine [oral contraceptive pill]. Whether they… want to get pregnant in the near future… it depends on the woman” [34]. Another participant described a similar desire for autonomous choice: “every person requires different things, and I want to be able to choose” [P31]. She prioritized her own decision-making when engaging in reproductive healthcare consultations. Participants also recognized a lack of decision support during clinical consultations with providers. One participant described her experience:

I have a couple of [doctors] that will say ‘no don’t say that you will change your mind, oh it happened to me I never wanted kids and then I changed my mind,’ and I say ‘okay it’s your life’… so I changed my last gynecologist just for that because …she wanted to convince me [to have children]. [P24]

This participant felt her provider neither prioritized her preferences nor respected her decision. Another woman said:

…She had the right to decide for body. So, she decided on abortion…I brought her to the hospital. And they were all looking at me… But I felt the same shame she had. The people at the hospital were like number 5, number 6…we’re not numbers. She was a woman seeking what she needed. [P35]

Despite the perceived judgment, this participant valued a woman’s autonomy in decision-making.

Some participants described providers as the source of decision-making. One said: “usually the channel that looks better definitely is your doctor, if he says you need to take this, you take” [P16]. This participant saw providers as the primary determinant of reproductive health decisions. Another participant described her doctor’s opinion as central when choosing contraception:

My new doctor told my sister that he believes the [IUD] is really dangerous so he would never suggest a woman who wants to have a kid to use it before having a kid. He would only suggest it to someone who doesn’t want to…like a mom who doesn’t want to have kids anymore. [P9]

The provider held strong opinions about method acceptability, and he promoted decisions based upon his belief. Another participant discussed birthing-decision respect:

If I choose water birth, there’s a big movement now about respect toward future mothers because when you go to the hospital, sometimes, they treat you like you are herds, when there needs to be respect for this very beautiful moment. [P31]

This participant detailed a need for increased respect for women’s decisions, rather than merely telling women what to do or which option to choose.
Though many participants preferred autonomous or provider-driven decisions, several participants described the decision-making process as shared. One said:

I tried to speak with the doctor about something that is permanent and now I found a gynecologist that is pretty positive and she says ‘well if it’s something that you want… it’s a smart choice’… She told me to think about it during the summer [before making a decision]. [P24]

This participant and her provider worked together toward a decision that prioritized this participant’s goals.

**Social networks.** Participants described input from valued others as a decision-making consideration. One participant said: “I do a lot of research online, I ask my friends… I ask my doctor. I ask my good friend, then… talk with my gynecologist and make a decision” [P31]. Another said:

I have not wanted to take the pill because I would never remember it every single night… I wanted something that I didn’t need to think about. So, I chose [the implant] … one of my really good friends had it for 2 years and she told me how it was and she convinced me. [P39]

Although an interplay of factors impacted this participant’s decision, her friend’s experience pushed her toward this contraceptive method. Partners also influenced women’s reproductive health decisions. One participant said: “I use condoms because I don’t want to take any kind of pills, that is my decision … actually a decision I share with my fiancé … so we actually use the natural method … withdrawal. Or the condom” [P25]. Another participant said: “my partner doesn’t want to have children either, so I’m pretty sure about a permanent [option] but we will discuss it” [P24]. This participant valued her partner’s input in decision-making. One participant also described her parents as influential: “of course my parents can give me advice, but I decide” [P45]. Her decisional role was central, but she highlighted her parents’ part in the process.

**Social Context of Choice**

**Economic environment.** The women noted Italy’s economic situation as a barrier to health decision-making, especially as related to family planning. Participants described barriers specific to the recent economic downturns as key reasons for foregoing child-bearing. One participant said: “money is one of the things that impacts [this]. There’s a crisis in terms of finding a job. So people don’t want to have children if they [can’t] afford to give them a good life” [P1]. Italy’s economic situation resulted in families choosing to delay pregnancy. As a participant stated: “because the people… are moneyless… Italy used to be a rich place… And if you wanted to have a baby you didn’t have many difficulties… But with the economy declining, many industries are closed… you have many difficulties finding work” [P3]. This participant described how a depressed economy decreased individuals’ opportunities to make family planning decisions. One participant said: “we are not [guaranteed a job right away]… people try to have safe situations from an economic point of view because a baby needs a lot … that’s why people are less pregnant than in the past” [P8]. Another participant said: “because there is little work, little money… there aren’t any of these things here, we can’t [raise a] baby in the right way… and that’s the reason why they have less
children” [P28]. Economic influences drove women’s pregnancy-related choices. One participant said: “I think it is all about the crisis… maybe families who already have a kid will decide not to have two or three just because of the money issue” [P9]. Thus, a complex interaction of economics and reproductive autonomy determined fertility goals.

**Religion.** Religion emerged in participants’ interviews, and illustrated a nuanced perspective of cultural norms and choice. Some participants described the Catholic Church as not very influential. One said:

> The Catholic Church influences politics, influences public and political life of Italians, and there are consequences in terms of women’s health - if there are 80 percent of doctors who don’t want to perform an abortion, it is because of the influence of the Catholic Church. But not in the hospital, in the politics. Most Italians define themselves as Catholic [but this does not] drive their actions. [P26]

This participant described religious systems as present but not impacting personal choices, although she noted religious influence on policies that may impact women’s health. Another participant said: “Italian people are not so religious in the very strict [sense]. We are Catholic but on Sunday, nobody wants to go to church to listen to the Pope or priest. So, [it is not influential] in sexual decisions” [P15]. This participant argued that fewer Italians today make religion-driven reproductive health decisions.

However, other participants expressed different views, especially regarding conscientious objection to emergency contraception and abortion. One participant said:

> We’re in a Catholic country so I’ve had friends go to the hospital and have been turned down by many doctors saying ‘I’m not going to give you [emergency contraception].’ I think it’s a horrible thing, but whether you like it or not this is the Pope’s country. [P19]

Thus, the Catholic Church’s influence on personal choice reduced women’s reproductive autonomy because of providers’ beliefs. Another participant said:

> It’s a problem because a lot of these people are working in public institutions… if it’s a Catholic hospital, I understand, the institute is based on those beliefs, but if it’s a public institution, it’s a problem because where am I supposed to go? [P30]

This participant continued: “so sometimes they…bounce you from one place to another until the time is up and there is nothing you can do…you get trapped” [P30]. Conscientious objection decreased the opportunity to make autonomous decisions regarding reproductive health options. Another participant expressed frustration regarding the impact of providers’ religious beliefs on care:

> I think if someone is a doctor…he has to respect my decision. It is not easy…to find a doctor who wants to give [abortion]… because if I have to make this decision, it’s not an easy decision, and so if I also have problems getting this service, it’s frustrating. [P15]

Religion impacted participants’ ability to make real choices about their reproductive healthcare.

**Discussion**

Three themes emerged in the interviews. First, women valued listening and understanding when engaged in reproductive health decision-making. Second, decisional role preferences varied from self to provider-driven decisions. In addition, some participants
indicated a desire for shared decisions. Participants also valued input from others. Third, sociocultural factors, including the economy and religion, influenced women’s available choices and impacted their reproductive decisions.

Some women described lengthy doctor visits with time to converse; however, others perceived inadequate conversation in consultations. The women desired discussion of options, yet, considerations, such as quality of the patient-provider relationship and feeling like a person and not a number, often superseded a desire for probabilistic information. Participants reported that information provision on a range of options is necessary because choice acceptability often related to their lives outside of the medical encounter (e.g., sexual relationship status in contraceptive method choice). These results add to work that shows that patients enter the medical decision-making space with all of their contextual needs, relationships, and beliefs and that these influence patients’ choices beyond medical risks and benefits (Clayman et al., 2017). Option discussion may relate less to detailed information of all risks and benefits and more to demonstrating women’s valuable role in decision-making (Clayman et al., 2017; Davis, 2010; Edwards & Elwyn, 2006; Gulbrandsen et al., 2016).

Most participants highlighted the importance of providers listening to their needs. Yet, some described negative experiences, such as providers’ judgment and untreated reproductive health issues that stemmed from limited listening during consultations. Research in primary care contexts has demonstrated that listening to patients’ priorities may not occur frequently (Goss, Fontanesi, Mazzi, Del Piccolo, & Rimondini, 2007; Goss, Fontanesi, Mazzi, Del Piccolo, Rimondini, et al., 2007). In reproductive healthcare, the tendency not to listen may reduce women’s decision-making power, patient-provider relationship quality, and positive healthcare experiences, and prevent women from full engagement in their reproductive health decisions (Liuccio, 2015). Thus, patients’ perceptions of involvement in decision-making, conceptualized as listening, may improve healthcare experiences (Edwards & Elwyn, 2006; Moreau et al., 2012; Shay & Lafata, 2014). Recent work in SDM has incorporated active listening as a key aspect of team and option talk (Elwyn et al., 2017). Conceptualizing preference elicitation as listening may be more culturally acceptable in Italy and build opportunities for improving patient involvement in healthcare, an extension of prior work on culturally centered and accommodating communication (Dutta, 2007; Jones, Sheeran, Lanyon, Evans, & Martinovic, 2018). Though Italian women did not identify SDM as something they had discussed with providers, they did conceptualize effective healthcare experiences as positive patient-provider relationships, information provision, and listening to their contextually-based reproductive health needs. Thus, adapting patient-centered care frameworks, such as SDM, to particular macro and micro cultural contexts represents an important opportunity to enhance women’s healthcare involvement and experience across various settings.

Our findings show that Italian women desire autonomy in reproductive health decisions; however, the women in our sample framed autonomy as decision respect. Women who felt dismissed by their provider when discussing contraception or family planning equated this with disrespect and reduced autonomy during appointments, a result that extends others’ findings that women typically desire greater decision-making involvement in reproductive healthcare than in other healthcare types (Dehlendorf et al., 2010,
In contrast to work underscoring the need to restore autonomy to those with illnesses (Gulbrandsen et al., 2016; Ubel et al., 2018), women in our sample primarily engaged with healthcare providers for non-illness related needs (e.g., wellness, contraception, family planning). Therefore, autonomy needs also exist among women not impacted by illness, and this requires attention during reproductive health appointments. Thus, patient-centered care and autonomy considerations extend beyond illness narratives to women’s needs and priorities in women’s wellness and pregnancy care (Dehlendorf et al., 2010; Meier et al., 2019; Thachuk, 2007). Therefore, establishing respect for women’s experiences may be critically important to contextualized discussions about reproductive health options that prioritize women’s concerns, plans, and goals in their reproductive lives.

Participants also described other people’s influence in healthcare decisions, beyond the patient-physician dyad. Little research describes this concept in terms of SDM; however, Elwyn et al. (2012), Entwistle and Watt, (2006), and Rapley (2008) all noted that clinical decision-making may include other people. Most participants in our sample described information and advice-seeking from friends, partners, and family members outside of the clinical setting or a specific consultation. Further, they weighted these opinions highly when making reproductive health decisions. The participants described high social integration with reproductive health decision-making, which demonstrates that others’ views are very important to their own preferences and goals. This suggests a need to explore family and friends’ involvement in reproductive health decision-making during consultations (Elwyn et al., 2012; Rapley, 2008; Smissen et al., 2019; Stephens & Thomas, 2014). Similar to Clayman et al. (2017), our findings demonstrated that women enter the clinical consultation as people, including all of their contextualized experiences and relationships. Thus, our sample’s healthcare experiences reflect relational autonomy (Clayman et al., 2017; Meier et al., 2019; Smissen et al., 2019), which indicates that decisions are informed by lifestyle needs, priorities, and valued members of women’s social support systems. Because women in our sample incorporated their social support network’s perspectives and experiences into their own decision-making, exploration of women’s relational needs during appointments should not be an afterthought. It may be necessary for providers to understand the roles that valued others play in patients’ decision-making, as this may offer insight into women’s reasons for choosing a specific option and may assist in aligning choices with patients’ preferences. Further, it may allow greater patient-centered care and SDM adaptability in cultural settings where social relationships greatly impact healthcare decisions.

Added layers of religious conservatism in Italy, specifically providers’ conscientious objection to abortion and emergency contraception (Fiala & Arthur, 2014), may decrease women’s opportunity to engage in reproductive health decision-making. Although participants reported decreased religious influence on their personal reproductive health choices, religion continued to impact healthcare policies and opportunities. Thus, patient-centered care, including SDM, that advocates for decisional autonomy may experience effects from religion at the national and institutional level. Positioning patients and providers as the only players who matter in decision-making spaces is insufficient and disregards broader societal structures that impact decision-making. Further, participants noted the economic situation as a reason for decreased
childbearing, which extends previous findings related to employment status and income (Braggion et al., 2015; Chiavarini et al., 2014). The economic climate reduced women’s opportunities to make preference-sensitive fertility decisions and presents a possible indicator for low and declining fertility rates. Women may, therefore, make reproductive health choices (Gribaldo et al., 2009) that contradict their family planning goals because some choices are not reasonable or reflective of their current situation. Lack of awareness of these considerations among providers may result in decreased care quality and decision engagement. Together, religion and economy impact women’s reproductive health choices and influence how and whether patient-centered care, specifically SDM, is practiced in Italy as it is described in existing models (Elwyn et al., 2017; Gulbrandsen et al., 2016). Recognition of the role of religion and economic climate on real and perceived choices available to women should be further explored by providers; patient-centered care provides an opportunity to do so.

Reproductive healthcare exists within a wider framework of experiences and factors that must be considered, as they can impact women’s actual and perceived choices (Meier et al., 2019). How providers incorporate women’s contexts and priorities may positively or negatively influence women’s ability and desire to engage in their reproductive healthcare decision-making. Further, autonomy has to be achieved and involvement attained through methods women indicated as improving their healthcare experiences, including feeling listened to and respected by providers and engaging in detailed, but not necessarily probability-based, option discussions. Rather than existing frameworks that prescribe bidirectional involvement and in-depth option talk, the preferred behaviors discussed by our participants may enhance healthcare involvement and reflect women’s contextually- and relationally-driven priorities and needs, thus building on the importance of preference elicitation in SDM and patient-centered care and adapting it to the Italian reproductive healthcare context.

Implications for Policy and Practice

Healthcare providers serve as facilitators to patient-centered decision-making, and Italian women valued increased time spent building relationships and engaging in conversations with their providers. Therefore, healthcare providers should initiate such discussions and explore women’s preferences and lifestyle goals, as this was critical to the women who identified positive healthcare experiences. Preference elicitation, demonstrated as listening, may improve women’s involvement in decision-making, enhance feelings of value, and reduce experiences of stigma and judgment. Women’s social networks require increased attention, which may extend patient-centered care and SDM in reproductive health beyond patient-provider decision-making, or even family or friend involvement within a clinical setting. Understanding social norms around reproductive health may improve providers’ ability to collaborate in decision-making. Engaging in discussions about lifestyle may assist in building reproductive life plans consistent with the lived experiences of women, including recognition of the economic and social influences that affect their perceptions and needs.

Recent Italian policy has incorporated patient-centered care and SDM (Bottacini et al., 2017; Di Paolo et al., 2019); however, extant policy struggles to define SDM
components as critical to enhancing patient involvement, particularly within a more conservative setting. Thus, patients’ voices, and particularly women’s voices—given Italy’s goal of increasing fertility rates—are essential for crafting policy that recognizes the varied social contexts and positive healthcare experience factors that demonstrate to women the valued role they play in decision-making. Including women’s voices in policy discussions may enhance patients’ involvement in healthcare decision-making contexts. Further, our findings suggest that a one-size-fits-all approach to patient-centered care and SDM may not resonate across all settings, but incorporating listening, demonstrating respect, and thoughtfully explaining information may enhance decision-making involvement among women seeking reproductive healthcare in Italy and elsewhere.

**Limitations and Future Research**

The qualitative method allowed participants to share personal stories and experiences and provides in-depth insight into healthcare decision-making. However, we would be remiss if we did not present our limitations. Interviews were only conducted with women who felt comfortable speaking English, which may have limited our findings. In addition, results may not be generalizable to geographically and demographically dissimilar populations, as participant recruitment was limited to Florence, where we primarily captured the views of educated, employed women. Underrepresentation of lower SES and educational attainment may reduce insights into how varied contexts influence women’s reproductive health choices. Our research team members were equipped with the same knowledge and skills; however, interview experiences may have varied due to the nature of a large research team. This may have introduced heterogeneity into interview quality and subsequent transcriptions. However, each interviewer was trained extensively in qualitative research, and interviews were checked for depth and quality by the principal investigator (third author) throughout the process. Though this may not limit all heterogeneity, it facilitated conversations about ways to improve in later interviews. Further, the involvement of only the three authors in close reading, coding, and analysis reduced heterogeneity in theme interpretations. Despite these limitations, our study provides novel information on the reproductive healthcare experiences of women living in Italy.

Future research should include interviews with women in geographically diverse regions of Italy, as regional differences in culture and healthcare access exist. Future researchers should explore how demographically diverse women perceive their decision-making experiences, including how their specific contexts influence their choices, healthcare quality, and decisional involvement.

**Conclusion**

This study offers insight into Italian women’s perceptions of and experiences with healthcare and reproductive health decision-making. Findings provide a deeper understanding of this population’s experiences and needs as they relate to reproductive healthcare experience and decision-making dynamics. By engaging in patient-centered care and SDM, women and healthcare providers can work together to make the best
decisions for women’s lifestyle needs and goals, which provides a unique opportunity to empower Italian women in their reproductive health choices.

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