Influence of culture, religion and experience on the decision of Pakistani women in Lothian, Scotland to use postnatal contraception: a qualitative study

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ABSTRACT

Introduction Evidence suggests that Pakistani women may experience difficulty accessing postnatal contraceptive (PNC) services. The study aimed to identify experience and decision-making around PNC provision for Pakistani women in Lothian, and to explore the views and experience of maternity staff who provide PNC counselling.

Methods Qualitative research including focus groups and 1:1 semi-structured interviews with women and staff. Participants were first- and second-generation Pakistani women with a child/children aged up to 5 years, or pregnant; community and hospital midwives, obstetric doctors who counsel or provide PNC. Data were coded and categorised using QSR NVIVO10. Inductive thematic analysis was carried out.

Results Women were receptive to discussion of contraception, including antenatally, and welcomed translated information. Some said the decision on PNC was theirs or made jointly with their husband; however, they acknowledged that in some marriages the husband will take the decision. Women stated they may face family expectation to have a baby early in marriage. Language was identified as a challenge by maternity staff, who utilised translation services to ensure women received the information they needed on contraception.

Conclusions Pakistani women value antenatal discussion about PNC. Maternity staff have an important role in providing quality information on contraception and should be supported with translated resources in a range of formats. Most importantly, staff should adopt a tailored approach to identify the individual woman's needs and preferences.

Key messages

- Advice and information on postnatal contraception (PNC) should be given according to what individual women want and need.
- Professional interpretation and translated information on PNC should be provided in different formats (eg, leaflets, internet) to minimise the effects of potential language barriers.
- Women value discussion and provision of PNC, and the training and education of maternity staff should support these services.

INTRODUCTION

Improving access to postnatal contraception (PNC) is an important public health strategy to reduce the risk of unintended and closely-spaced pregnancies. There may be barriers for women accessing PNC following discharge from hospital after childbirth, particularly in relation to long-acting reversible contraception (LARC), and consequently there is move towards earlier discussion and immediate postpartum provision.[1 2]

Ethnicity has been identified as a barrier to accessing general contraceptive and sexual health services,[3–6] with minority ethnic groups often experiencing higher rates of sexual ill-health.[4 7] While published data specifically relating to the postnatal period is limited, interview transcripts obtained from a pilot initiative of routine antenatal contraceptive counselling in Lothian (the APPLES study)[8] noted

ethnicity as a potential influence on provision of PNC advice.[9] In Scotland, South Asians (including Pakistani/Bangladeshi/Indian) represent the largest ethnic minority group,[10] and maternity professionals specifically identified this group as one with whom they raised the subject more 'cautiously' due to perceived cultural norms around acceptance.

Several studies have observed lower contraceptive usage rates among South Asian women.[4 5 11] A cross-sectional survey of 180 South Asian women aged 16 to 50 years found that 43% of women had never used any contraception.[5] Specifically, among married women aged over 30 years who had completed their family, contraceptive use was only around 50%.[5] Subanalysis of a national survey of sexual behaviour in the UK in relation to ethnicity also found that sexually active Pakistani and Indian women had the lowest rates of contraceptive use compared with white British women and were less likely to use more effective hormonal methods, with an increased preference towards non-hormonal contraception such as barrier or 'fertility awareness' methods. Particular barriers may include challenges in accessing appropriate language translation services and culturally sensitive information.[4 12]

However, there are likely to be a number of social and cultural influences on women's contraceptive behaviour and desire towards a specific method. A qualitative study of South Asian women attending family planning services in Scotland described differences between 'modern' and 'traditional' women in relation to contraceptive knowledge and access.[13] A similar qualitative study of contraceptive behaviour and needs of South Asian women in the UK[6] identified professional status as an important factor, with non-professional women (mostly non-UK-born) tending to have less knowledge about contraceptive options and efficacy and experiencing greater influence from their husbands and extended family. This study also noted that women frequently reported non-contraceptive use prior to their first childbirth, with contraceptive use thereafter increasing, and barrier methods most frequently used.[6]

First childbirth has been described elsewhere as a key point of engagement with contraception for South Asian women,[4] highlighting the important role of maternity professionals in providing high-quality and culturally-appropriate information. In order to explore current provision in more detail, we sought to determine the views and experiences of both Pakistani women and maternity staff around PNC.

METHODS

Qualitative research was carried out in Lothian, Scotland between June 2017 and January 2019. The research used a phenomenological approach to focus on the meaning and significance of participants' experience of PNC. Participants were first- and second-generation women who identified as Pakistani who were currently pregnant and/or with a child/children aged up to 5 years (see table 1), community and hospital midwives, and obstetric doctors who counsel on and/or provide PNC.

Table 1 Demographic details of the women who participated in the study*

Age (years)	Country of birth	Educational level	Main language spoken	Children (n)
27	Pakistan	School leaver	Urdu	2
34	Other country	Further education	Bengali	2
37	Pakistan	Further education	English/Urdu	3
37	Other country	Further education	Urdu	3
34	Pakistan	Further education	English/Urdu	2
34	UK	Further education	English/Urdu	2
28	UK	Further education	English/Urdu	1
23	Pakistan	Further education	English/Urdu	1
40	UK	Further education	English/Urdu	3
36	Pakistan	Further education	Urdu	4
33	Pakistan	School leaver	Urdu	4
30	UK	Further education	English	1
32	UK	Further education	English	2
27	UK	Further education	English	1
31	Pakistan	Further education	English/Urdu	2
35	Pakistan	Further education	Urdu	3
30	Other country	School leaver	English/Urdu/Punjabi	1
29	Pakistan	Further education	English/Urdu/Punjabi	1
31	Pakistan	School leaver	Urdu	2
28	UK	Further education	Bengali	1
36	Pakistan	Further education	English/Urdu	2
37	Pakistan	Further education	Urdu	4
43	Pakistan	Further education	English/Urdu	4

*Women were not asked to state their religion, nor to say whether they actively practised a religion.

Data collection

Three focus groups, eight 1:1 and one 1:2 semi-structured interviews were held with 23 women in Urdu, Urdu and English, or English. Community access was facilitated by a link worker from the Minority Ethnic Health Inclusion Service (MEHIS) and the bilingual qualitative researcher. Snowball sampling (non-probability sampling technique where study participants recruit other participants) was used to supplement recruitment. Interviews were conducted at a time and location convenient to the participants.

Five focus groups were held with maternity staff (2:hospital midwives, 2:community midwives and 1:junior doctors in obstetrics; and five 1:1 semi-structured interviews with consultants in obstetrics) in NHS Lothian. Participants were recruited via email from project group members and with the support of community midwife team leads and consultants.

The researcher (TI) has significant postdoctoral research experience with South Asian populations and is fluent in the main language spoken in Pakistan. This removed the need for interpreters and allowed a

Box 1 Research roles in data collection and analysis.

Data Collection

JS, AG and MC conducted the focus groups with maternity staff.

AG conducted the 1:1 interviews with maternity staff.

TI conducted the focus groups with women with support from RI and AG.

TI conducted the 1:1 interviews with women.

(See online supplementary files: Interview schedule: Pakistani women and PNC interviews; Interview schedule: Pakistani women and PNC focus groups; Interview schedule: Community midwives/hospital midwives/hospital doctors.)

Consent was taken from participants. Interviews and focus groups were recorded with permission, transcribed and anonymised.

Agreement by the research project group that data saturation was achieved determined the final number of interviews and focus groups.

Data Analysis

SC, MC, TI and AG identified and agreed key themes for coding. TI and AG discussed findings of research with women throughout data collection and analysis. There was general consensus during data analysis on the key themes.

AG coded and categorised the data using QSR NVIVO 10 and carried out inductive thematic analysis. Memos and reflective notes were used to limit researcher bias.

RI and TI were known to some participants through the role of the link worker (RI) and being part of the Pakistani community (RI and TI). This enabled recruitment of women that otherwise would not have participated.

MC and SC were known to health professionals through their clinical and teaching roles in NHS Lothian.

AG was known to a small number of health professionals as a researcher in NHS Lothian. JS was known to some health professionals through her role at the University of Edinburgh and as a researcher.

greater understanding of cultural nuances, enabling a rapid build-up of rapport and trust.[14] In addition to facilitating recruitment, insider knowledge can result in rich data collection,[15–17] particularly during discussion of sensitive topics, as participants will generally be more open with someone who they can believe has shared experiences and will understand.[18]

Ethical approval was received from the University of Edinburgh Biomedical Sciences Research Ethics Group.

RESULTS

The themes discussed below focus on women's views, referring to maternity staff interviews where these provide depth to the findings.

Approach

None of the women interviewed had strong objections to the subject of PNC being raised antenatally or postnatally by midwives. Sexuality was acknowledged as a sensitive topic in traditional families; however, PNC was viewed as part of the role of midwives and doctors.

> *"I didn't mind when they started discussing this; I don't remember thinking they shouldn't have asked me this or talked about that. Whenever they discussed it with me they were always sensitive."* [Woman X]

Format of information

Face-to-face information is valued as it gives the opportunity to discuss options.

> *"I think they should have a one-to-one conversation with you. If they sit with you and just discuss it it might give me a chance to talk about it."* [Woman J]

Some women suggested a group discussion, but noted this may not be acceptable among strangers. Provision of information in their language was important to women not fluent in English. Views varied on the best format for supplementary resources, with some preferring leaflets and others online. Women suggested that education level and how 'traditional' the woman is could influence this.

Maternity staff welcomed translated resources to provide the opportunity for women to consider contraception methods in their own time, as well as one-to-one with a midwife or doctor and interpreter

> *"…other people want to know a bit more and it's the time. And also sometimes the availability of leaflets if they want to have a think about it but there aren't always the leaflets to hand."* [Junior doctor]

Decision-making

Some women stated that decisions on PNC were primarily their own or made jointly with their husband. However, they acknowledged this might be different for some women due to the influence of husbands, family and extended family in Pakistani culture. Despite this being seen as less prevalent in the UK, one woman stated the decision on contraceptive use was made by her husband.

> *"I think the paediatrician asked and gave me a leaflet … and said if I wanted anything to let her know, then went away, but* [husband] *said tell them no."* [Woman J]

Maternity staff noted past experiences where a mother-in-law had heavily influenced a woman's decision on PNC. Women acknowledged that mothers-in-law may put pressure on a woman but did not see it as relevant to their personal experience.

Number and spacing of children

Women stated that large families were less common than in the past. Health and finance were factors

influencing the decision on family size. A small family enabled parents to raise and educate children as 'good Muslims'.

A number of women referred to the expectation for women in Pakistan and to a lesser extent for Pakistani women in the UK, to have a baby straight after marriage and not consider contraception until after the first baby.

> *"I … fell pregnant quickly after the wedding because we weren't using anything. Sometimes when I look back I think why did I not research more?"* [Woman I]

Two women stated they and their husbands took the decision to wait a few years before having their first child. Both referred to a precedent for this in their families. No women reported experience of pressure from extended family and friends on timing and number of children. They viewed this as common in Pakistan but less so in the UK.

> *"If your family is OK about it, there isn't that much pressure but society can also apply a lot of pressure which gets transferred to family who then pressure the couple."* [Woman F]

Religion

Views varied on the acceptability of using contraception in Islam. Women gave examples of families where contraception was seen as against Islamic teaching. However, this belief did not mean women did not use any contraception. Withdrawal was noted as an acceptable method. Contraception was seen as permissible by most women, although some stated that sterilisation was not allowed because it is permanent. One woman who had been sterilised had done so for health reasons.

> *"Yes God will provide so you shouldn't not have children for fear of resources. I was told it was a sin to stop children but … because of my health issues we decided on sterilisation."* [Woman R]

Many women commented on the inability to pray while bleeding, a reason cited for stopping contraception when continuous or frequent bleeding was a side effect. The tradition that a woman should rest and not leave the house during the 40day postpartum period was also noted. While women did not always follow this tradition, some thought they should wait for this time before deciding on PNC, while some believed they could not get pregnant in the first 40 days after childbirth.

Personal experiences

Three women were using fertility awareness-based methods (withdrawal or fertility apps). Reasons given were: not wanting anything in the body; fear of side effects; and husband's decision. Experience or concern over side effects was cited by a number of women for the decision to use condoms. Concern that long-term use of contraception may affect fertility was raised, although one woman acknowledged her belief was unfounded when she became pregnant after stopping contraception.

> *"I was worried about using contraception for a long time and then having problems with fertility. [….] I realised that it's not contraception that leads to fertility problems but something inside you."* [Woman P]

The need for more advice and knowledge to clarify these concerns was expressed.

> *"I think it's a lot to do with the misinformation out there. People hear about some experiences other women have about hormones or how it makes it difficult for women to get pregnant again."* [Woman T]

Interpretation

While acknowledging the local National Health Service (NHS) policy towards the use of professional interpretation services where possible, maternity staff highlighted occasions when a woman insisted on using her husband or family member to translate. Potential issues here include inaccurate interpretation, difficulty in translating clinical terms, and omission of information. Maternity staff noted the impact of additional time required for interpretation on an already busy workload. Time constraints restrict the ability to discuss PNC with all women waiting to be discharged from hospital.

> *"We should try to somehow pick the more vulnerable, teenagers, or the people who are from different ethnic backgrounds, or from, who are foreign and don't speak English but that's counterintuitive on a busy day. We'll go for the easiest people to speak to but that's just anecdotal."* [Junior doctor]

Three women not fluent in English stated their husbands interpreted for them during PNC discussions. When asked if they were happy with this, two women answered in relation to potential embarrassment for their husband. They did not question his role as interpreter as they saw it as involving him in the decision.

DISCUSSION

Identifying how Pakistani women wish to approach discussions around PNC can enable maternity staff to provide relevant and accessible information to these women to support their choices. Previous research around contraceptive use by Pakistani women is limited, particularly in relation to PNC.

None of the women interviewed objected to midwives discussing PNC with them during the antenatal period, suggesting acceptance of antenatal contraceptive counselling. However, their preferences

for how this information is provided and some of the wider cultural influences affecting their decision-making are important to recognise. There was a range of views expressed regarding potential side effects and influential factors such as family, friends and religion. Some of these did not differ significantly from influences affecting women of any ethnicity in relation to contraceptive choice. Some myths and misconceptions were noted regarding the return of fertility after childbirth.

Research around social and cultural influences on Pakistani women in the UK accessing contraception highlights differences between 'modern' and 'traditional'[13] women or professional or non-professional status.[6] Information on professional status was not collected in our study; however, women did refer to Pakistan-born women as 'traditional'. Some maternity staff in our study perceived Pakistan-born women as more likely to experience challenges with contraceptive choice, sometimes due to low English language competence. There was a noted potential for misinformation, with or without the presence of an external interpreter, further compounded by the perceived 'sensitive' nature of the topic of contraception. Maternity staff also identified practical difficulties in relation to additional time and perceived effort involved in contraceptive discussions involving an interpreter.

The cultural expectation of starting a family soon after marriage was recognised. For some women, the antenatal period may be the first time contraception will be discussed in any detail, thus reflecting the findings of other research.[6] As such it presents an important opportunity to ensure reliable information about fertility after childbirth, postpartum contraceptive options, and how and when these can be initiated. This may reduce myths and misconceptions about contraception.

This antenatal discussion is particularly important if Pakistani women are to be able to avail themselves of the opportunity to receive their preferred method of contraception following delivery. This includes immediate postpartum intrauterine contraception at elective caesarean section or vaginal birth, shown to be a popular and well-received service by women in the study region.[19 20]

This is the first study to explore the views and experience within this population around PNC. Key strengths were the involvement of a bilingual researcher to capture the views of women who might otherwise have been difficult to recruit, and facilitation of access to the community by a link worker. The inclusion of both women and maternity staff sought to gain a comprehensive overview of current experience and assist in aligning future priorities and inclusive service delivery. However, as the study only involved women from one part of the UK, it may not be entirely representative of other regions. There is also scope for further research to explore the differing influences and experiences of those from other ethnic minority backgrounds with regard to contraception.

CONCLUSIONS

It is clear that Pakistani women value antenatal discussion about PNC and that a range of factors affect their decision-making regarding method selection and timing, whether immediately after childbirth or later. Maternity staff should feel confident in introducing the topic of contraception into antenatal and postnatal care. They have an important role in providing accurate information and dispelling myths. Translation services can assist in facilitating these discussions, but specific challenges are recognised. This can be further supported by the development of resources in a range of formats and languages to minimise inequalities in the ability to access reliable information. Most importantly, staff should adopt a tailored approach to identify the individual woman's needs and preferences.

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Contributors AG, SC, MC, JS, SG and RI designed the research question and study approach. AG, SC, MC, JS, TI, SG and RI contributed to the design of data collection resources. AG, MC and JS carried out data collection from maternity staff and TI carried out data collection from the women with support from RI. AG carried out the data analysis with input from TI, SC and MC. AG, SC, MC and TI wrote the first draft of the manuscript and read and revised subsequent drafts. AG, SC, MC and TI all approved the final draft of the manuscript for publication and accept responsibility for the article as published.

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