

CONTRACEPTIVE USE DYNAMICS OF ASIAN WOMEN IN BRITAIN

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Summary. In-depth interviews were conducted with married Asian women from Indian, Pakistani and Bangladeshi backgrounds, to investigate patterns of contraceptive use and influences on contraceptive decision making. The results show two distinctively different contraceptive 'lifecycles'. Non-professional women typically have little knowledge about contraception until after their marriage or first birth. Their patterns of contraceptive behaviour show low levels of contraceptive use until after their first birth, when condom use is most prevalent. Non-professional women are influenced by their extended family, religion and cultural expectations on their fertility and family planning decisions. Professional women show an entirely different pattern of contraceptive behaviour. They are more likely to have knowledge about contraception before marriage, use some method of contraception throughout their childbearing years (typically the pill) and cite personal, practical or economic considerations in their fertility decisions rather than religious, cultural or extended family influences.

Introduction

Little detailed information is available on the contraceptive use dynamics of Asian women in Britain. Previous research on the contraceptive behaviour of Asian women (Beard, 1982; Rashid, 1983; Zaklama, 1984; Bunting, 1984; McAvoy & Raza, 1988; Sutton, 1990; Woolett, Dosanjh-Matwala & Hadlow, 1991a) has largely focused on the collection of quantitative data through the use of structured questionnaires and interviews. Most of these studies provide information for specific areas (e.g. Leicester, Bedford, East London), and are therefore likely to reflect the characteristics of their local Asian populations. The information gathered in these surveys has included data on current use and non-use of contraception, levels of knowledge and acceptance of family planning methods, and some reasons for method choice. These data are often examined at an aggregate level by age, religion and, to a lesser extent, English language fluency and number of years in the UK. Although these studies provide valuable information on the patterns of contraceptive use amongst Asian women and whether their use patterns differ from those of the general population, there is very little published information which looks in greater depth at the factors which underlie

contraceptive decisions: for example, the timing of first method use, the sources of first knowledge about contraception, and the changes in contraceptive use within an Asian woman's lifecycle. This type of detailed information is extremely informative for providers of family planning services and for the development and dissemination of family planning information to Asian women.

Only one study (Woolett *et al.*, 1991a) goes some way to provide this more detailed information. It used both quantitative (personally administered questionnaires) and qualitative (in-depth interviews) techniques to gather information from 100 Asian women attending three GP surgeries and a hospital antenatal clinic in East London. Woolett *et al.* also examine some aspects of the context within which Asian women make reproductive decisions, by using qualitative techniques to go into greater depth about Asian women's attitudes towards contraception, reasons for method choice and some of the factors which underlie their contraceptive decisions. Overall, this research offers greater depth in explaining some of the patterns of contraceptive use amongst Asian women than was possible with the quantitative techniques employed in other research.

It is often assumed that Asian women are a homogenous group who display similar behaviour and are influenced by similar factors in their health care decision making. This assumption may lead health professionals to anticipate that all Asian women will show the same behaviour and preferences regarding contraception. Although some studies identify differences within the Asian population (by religion, age, years in the UK) at an aggregate level, few studies have investigated behaviour differences at an individual level to identify the types of Asian women who show different patterns of contraceptive use and the factors which contribute to differential family planning behaviour.

The aim of this research is to provide detailed information on the contraceptive use dynamics of Asian women in the South and West Health Authority region. More specifically, this research aims to identify the context in which contraceptive decisions are made by Asian women and highlight their sources of knowledge about contraception, the timing of first method use and the influences on contraceptive use and decision making. It will also identify differences within the population of Asian women and how these differences impact on contraceptive behaviour. The target group for this research are married Asian women, from Indian, Pakistani and Bangladeshi backgrounds, aged between 18 and 55 years.

Methods

The research methodology used in this study differs from previous research on Asian women's use of contraception, in that respondents are drawn from the community rather than from lists of users of various family planning services. In-depth interviews are used to gather more detailed information about contraceptive behaviour than has been possible through previous questionnaire-based studies.

Respondent recruitment

All previous studies of contraceptive use amongst Asian women (Bunting, 1984; McAvoy & Raza, 1988; Sutton, 1990; Rashid, 1983; Woolett *et al.*, 1991a; Zaklama,

1984; Beard, 1982; Cartwright, 1987) acquired their samples of respondents from general practitioner (GP) registers, family planning clinic records, antenatal clinic attenders or domiciliary family planning service recipients. Therefore, the sample comprised only service users. Although this is a valid approach, it does not include those women who have no contact with these health services or who may be experiencing difficulties in using the services from which the samples were drawn; such as women who use condoms and have no contact with family planning services or those who are not using contraception before a first birth.

In contrast, the respondents for this study were drawn from the community. Access to the study population was carried out in two stages. Firstly, a range of community groups which were attended by Asian women were identified; these included social and activity groups, English language classes, adult education classes, computer classes, and an Asian mother's nursery school group. Aside from the more obvious advantage of providing a concentration of an otherwise difficult to reach target group, utilizing existing community networks can improve respondent participation in the research (Sills & Desai, 1996). Within the Asian population there exists a strong sense of 'community' in which community group organizers are well respected and trusted individuals. Working with community group organizers is crucial for establishing the trust of group members. If the group organizer is seen to support the research then it is more likely that women will be willing to participate in the study (Rai, 1996).

In utilizing community groups for identifying respondents, there exists a danger that respondents will be atypical of the target population and introduce bias into the study. This issue was recognized at the outset and it became clear that Asian women who attended these community groups were generally non-working, non-professional women. Although these women form an important part of the target population it was also important to include professional, working women in the study. Therefore, the second stage of respondent recruitment involved identifying Asian women who were working professionals. Professional women were defined as those who were currently employed in an occupation for which they required at least 2 years training or higher education. This definition sought to distinguish between women employed as retail assistants or in administrative roles from those such as accountants, lawyers, education or health professionals. These professional Asian women were identified through a process of purposive or *snowball* sampling, which involved initially identifying a number of women who meet the target criteria and seeking their assistance to identify others like them. In close-knit Asian communities this technique was very successful.

Community networking

Gaining acceptance is vital when working within community groups as it contributes to the generation of good quality data. Several months before data collection began an important process of community networking was initiated. This involved attending a variety of community meetings and events, giving brief presentations about the research, attending women's social and community groups and generally fostering an awareness about the research amongst key individuals in the Asian communities involved in the study. The process of community networking also aimed to generate an atmosphere whereby the researchers were accepted amongst the

Asian women who attended community groups, so that they were seen as familiar, non-threatening individuals. This period of 'trust building' was extremely valuable in improving rapport with Asian respondents and enabled researchers to obtain quality information during the interview (Rai, 1996).

In-depth interviews

In-depth interviews were conducted with Asian women. This involved a one-to-one interview between a respondent and the interviewer following a prepared question route. The prime advantage of in-depth interviewing of Asian women is the greater confidentiality it offers to participants, particularly when discussing personal issues such as contraception. The presence of an interviewer is valuable in encouraging and reassuring the respondent, particularly in view of the cultural taboos surrounding the discussion of contraception and sexuality in Asian cultures. It also allows the researcher to explore, in great detail, individual circumstances, decisions and influences surrounding the issues of contraception and family planning. One-to-one interviews allow communication problems to be dealt with individually by using a bi-lingual interviewer, which enables the respondent to communicate in the language in which they felt most confident.

Question route

The question route included questions on the background characteristics of respondents, including their family history, education, experiences of migration, marriage process and participation in social, cultural and religious activities. The main part of the question route was designed to allow discussion to flow chronologically from the time of marriage to the present, in order to explore each woman's childbirth and contraceptive use history. This strategy enables an identification of Asian women's first knowledge of contraception and how this knowledge is acquired; the circumstances surrounding their first use of contraception and first method chosen; any method changes during their childbearing years; and the influences on contraceptive use and choice during each woman's lifecycle. This information is valuable for family planning service providers as it indicates when the contraceptive lifecycle of an Asian woman is likely to begin, which methods are more likely to be selected at different periods in her reproductive lifecycle and the range of influences on use of contraception and method selection. The sources of knowledge about contraception and when women first learn about contraception also provide valuable indicators for family planning information provision and dissemination. Such information has not been collected in previous research amongst Asian women.

Interviewing techniques

A number of important interviewing issues were addressed prior to conducting fieldwork. It was important to use female interviewers when discussing contraception and family planning issues with Asian women due to cultural taboos which discourage discussion of sexual issues with males (Rai, 1996). In general, 'female gender matching of the interviewer and the research informant is widely regarded as "good" research practice for research amongst Asian communities' (Rai, 1996, p. 39). This is especially

important when discussing sensitive issues such as sexuality and contraception as the respondent may then feel less inhibited to discuss openly their views and experiences.

It was preferable for interviewers to be of non-Asian background and therefore not part of the respondent's community. This was to alleviate fears that personal information may be passed back into the Asian community, and because women may feel judged or threatened if they reveal, to another Asian person, behaviour or attitudes which may be contrary to their culture's popular beliefs. Some researchers believe that Asian respondents are more likely to express their views fully to a non-Asian interviewer than to one who is Asian (Rai, 1996). It was recognized that not all interviews would be conducted in English. A bi-lingual Asian interviewer was employed to conduct the interviews in community languages. It was also important that the bi-lingual interviewer was female, and not part of the local Asian community as women felt they would be inhibited in discussing personal matters with a member of their community and identified fears of confidentiality.

Conducting interviews at the community group location rather than in the women's homes provided women with a familiar and neutral environment where they could have more time to participate in an interview. It avoided the difficulties of interviewing women in their homes, such as the presence of males, interruptions, lack of privacy from family members and the fear of allowing unknown researchers into their homes.

In a community of women who are not accustomed to participating in social research and who are perhaps not at ease with the use of a tape recorder, respondents needed to be continually assured of the confidentiality of their responses to allay fears that the information would be used in radio or television broadcasts and that they may be recognized by other community members, or that male community members would hear the tape recording.

Fieldwork was carried out in the South and West Health Authority region, but primarily in Southampton and Portsmouth where there are the highest concentrations of the Asian population in the region. Twenty-nine in-depth interviews were completed with Asian women, 21 at community groups and eight through the snowball sample of professional working women. All interviews were tape recorded, translated (where necessary) and professionally transcribed. Data analysis was assisted by the use of *The Ethnograph*, a computer package designed to assist in the manipulation of qualitative data.

Results

This research shows that there are significant variations in Asian women's reproductive strategies. Variations are evident in knowledge about family planning methods, timing of a first birth and timing of first use of contraception, birth spacing and fertility. There are two distinctively different patterns of contraceptive use amongst Asian women in this study: those of professional women and non-professional women. The characteristics of women in both groups are detailed below.

Non-professional women

The first group of women are non-professional Asian women, who typically have never been employed or undergone any further education or training to pursue a career

or profession. Most non-professional women had been educated abroad (e.g. India, Pakistan) and left school before the age of 16 or had received no formal education. These women have variable levels of English language fluency and literacy; some are illiterate in both English and their mother tongue, while others have basic English language and literary skills. Although many non-professional women had resided in the UK for more than 10 years, one-third had lived in the UK for less than 10 years, some of whom were recent migrants having arrived as brides for British-Asian men. Most non-professional women reside in an extended family situation, usually living with their in-laws, and identified that their in-laws have some influence in their fertility decisions. Non-professional women in this study display low levels of personal autonomy in their decision making and in their mobility (i.e. drive a car, use public transport). They also show a strong level of dependence upon their husbands or other family members to access general community services.

First knowledge of contraception. Non-professional women show distinct patterns in their acquisition of knowledge about contraception, which has a direct influence on their family planning behaviour and childbearing outcomes. Eighty-five per cent (18/21) of non-professional women had no knowledge of contraception prior to their marriage and were not aware they were able to control their fertility. The few who did have some knowledge of contraception before marriage were educated in Britain and learnt about contraception in their sex education classes at school. One woman learnt about contraception before marriage through her employment in a rubber store in India which sold condoms; this indicates the haphazard acquisition of contraceptive knowledge amongst some women.

More than half (11/21) of non-professional women first learnt about contraception after their marriage through their husband. A further 33% (7/21) had no knowledge of contraception until after the birth of their first child, or in some cases the birth of subsequent children (see Table 1). These women first learnt about contraception through the hospital midwife or a health visitor who introduced them to contraceptive options. Therefore, for most non-professional women, gaining knowledge about contraception coincided with a major lifecycle event such as marriage or childbirth.

The main sources of first knowledge about contraception, aside from husbands, were medical sources such as hospital staff, midwives, health visitors or a GP. Non-professional women in this study did not identify informal sources of information such as friends, relatives, public media, literature or pamphlets. Every source of information about contraception subsequent to their first source of knowledge still reflects primarily medical sources and those related to child health, rather than community, public media or informal sources. There is little evidence to show different patterns between religions in acquiring knowledge of contraception.

First use of contraception. The fertility and contraceptive histories of non-professional Asian women, shown in Table 1, reveal distinct patterns in the timing of contraceptive use during their reproductive lifecycle, particularly in the use of contraception before and following their first birth and in the method used. Seventy-six per cent (16/21) of non-professional women used no method of contraception between their marriage and first birth. This pattern is particularly prevalent amongst Muslim (8/10) and Sikh (7/8) women. The number of Hindu respondents was too small to

Table 1. Fertility and contraceptive histories of non-professional Asian women

Religion	Marriage	Birth 1	Birth 2	Birth 3	Birth 4	Birth 5	Birth 6	Current method
Muslim	Knowledge None							None
Muslim	Knowledge None							None**
Muslim	None	Knowledge Pill	Pill	Pill				Pill
Muslim	Knowledge	Not specified	None					None*
Muslim	Knowledge None	Condom	Condom	Pill (Injection)	Condom	None		None**
Muslim	Knowledge None (Condom)	Pill	None (Cap)	Sterilization				Sterilization
Muslim	None	None	None	Knowledge None	Condom	Condom	Condom	Condom
Muslim	None	Knowledge None	None	None (Injection)	None	None	Condom	Sterilization
Muslim	None	None	Pill (Injection)					Pill
Muslim	Knowledge Condom	None	None	None	None	Condom		Condom
Sikh	Knowledge None	Knowledge None	None					None
Sikh	None	Knowledge IUD						IUD
Sikh	Knowledge Condom (Wdraw)	Condom	Condom (Wdraw)	Withdrawal				Withdrawal
Sikh	None	Knowledge Condom (Pill)	Condom (Wdraw)					Condom/Wdraw
Sikh	Knowledge Pill	Pill	(Pregnant)					None*
Sikh	Knowledge None	IUD (Condom)	None	None	None	None		None**
Sikh	None	Knowledge Condom (Pill)	Condom	Condom	Condom	IUD		IUD
Sikh	Knowledge None	Condom	Condom	Condom	None			Condom
Sikh	Knowledge None	None (Cap)	None	None	None	Knowledge Sterilization		Sterilization
Hindu	Knowledge None	None (Cap)	Vasectomy					Vasectomy
Hindu	Knowledge Douche/Condom	None	None	Sterilization				Sterilization

*Trying to conceive/pregnant. **Separated from husband and not sexually active.

Note: methods in parentheses denote minor method; where two methods are shown without parentheses both methods were used for equal duration or subsequent to each other.

indicate any similar pattern. Non-use of contraception after marriage leads to a short interval between marriage and first birth: 57% (10/18) of non-professional women had their first birth within 1 year of marriage. The reasons for not using contraception before the first birth was due to a desire to become pregnant, pressure from a husband or extended family to have a first child immediately, or religious reasons opposing contraceptive use. For example:

'Actually I want to wait for a couple of years time, but my husband want to have a baby,' (AW3 885–887).

'If God wants to give then . . . He does what a man does. We haven't talked about a child. If it happens I am not at work. My family will be happy, I will be happy but we don't use anything,' (AW20 298–308).

Woolett, Dosanjh-Matwala & Hadlow (1991b) point out that a short interval between marriage and first birth is viewed positively by Asian women's families and community, and those wanting to delay their first birth needed to have acceptable reasons for this desire. Having a child immediately after marriage is also beneficial in establishing a woman's position with in-laws (Woolett *et al.*, 1991a). However, one-third of non-professional women stated that the main reason they had not used contraception at this time was due to their lack of knowledge about contraception. The following quotations also suggest a demand for contraception to delay or space births which was constrained by inadequate knowledge about contraceptive methods.

' . . . at that time I don't know that people can do things. If I know I don't want so many children. I don't know. Nobody telling me . . . ' (AW5 824–829).

'I was thinking that you should have freedom for a few years, then you should decide if a baby, if you want one. But it wasn't really like that, I'd be pregnant that time . . . ' (AW15 358–364).

'He (husband) knows it, first night he get some Durex and I was scared and I won't let him use . . . (laughing) he tell me later on and then it was too late and we can't do anything,' (AW15 393–399).

'When I get married I don't know I getting soon pregnant. One month, second month, third month I get pregnant. I didn't use anything condom or anything, no use . . . But I don't know about it . . . After that baby I used condom,' (AW9 614–624).

Non-professional women who did use contraception before their first birth were most likely to have used a condom, perhaps reflecting that they first learnt about contraception (typically condoms) through their husband. These women gave personal or practical reasons for delaying their first birth. For example: *'Because my husband was not working he was studying . . . so we thought we'd have a child when the money comes in. (What did you do in the two years did you use anything?) (pause) after intercourse we had some, I don't know what you call that, with hot water and soap I had to clean,'* (AW2 467–481).

The most dramatic change in contraceptive use amongst non-professional women is seen after their first birth. While less than one-quarter (5/21) of non-professional women had used any form of contraception before their first birth, 61% (11/18) were using contraception after their first birth. Although there were still one-third (6/18) of women using no method after their first birth, it is more likely that Asian women will

use contraception after a first birth rather than before. Muslim women in this study were most likely to continue to use no method of contraception after a first birth while Sikh and Hindu women began to use contraception after the first birth, particularly a condom.

Although there are some cultural reasons for non-professional women not using contraception until after their first birth, the dramatic increase in contraceptive use after the first birth is also influenced by contact with hospital and community midwives, health visitors and other postnatal care staff who provide information on contraception. Midwives were identified as an important source of information about contraception for all Asian women during their childbearing years. However, for one-third of non-professional women their first ever knowledge of contraception came from hospital midwives, who are a vital source of contraceptive information for these women.

Midwives also represented an important additional source of information for those women who identified their husband as their first source of information, as midwives were able to inform women of the *range* of contraceptive options and the reliability and effectiveness of each method. It is crucial, therefore, that the contraceptive information provided by midwives is given in a manner which is suitable to the language, culture and literacy levels of these Asian women. Many women do not fully benefit from this source of information because of language difficulties. Most understood only a small fraction of the information passed on by midwives. Some women waited for their husbands to visit to enable them to translate for the midwives, while others accepted pamphlets which they asked others to read for them. However, these are short-term and haphazard solutions to communication difficulties with medical staff and provide little opportunity for women to question information or to discuss their concerns about particular methods fully and confidentially. It also reinforces a dependence upon family members to access personal information and relies on the skills of untrained individuals to communicate medical terminology. For example:

'I did understand sometime, at that time I can understand but I couldn't talk back. Then I tell my husband as well and he explained to me as well.' (AW15 460–464).

'She (midwife) talk about having family, family planning. The nurse she come and I said I can't understand much English and she tell me another time and she come when my husband come to visit me. So she talked to my husband.' (AW3 1053–1059).

'But that time I am not very good speaking English but I understand what she can tell, and when I came home I ask to come and she tell me and she check up everyday . . .' (AW9 636–640).

The current method of contraception used by non-professional women in this study is typically the condom or contraceptive sterilization. The prevalence of the condom amongst Asian women in general has been shown in other studies (Rashid, 1983; Zaklama, 1984; Sutton, 1990; Cartwright, 1987; Woolett *et al.*, 1991a). Some women changed from the condom to the pill, IUD, cap or Depo Provera injection for a short duration, but stated that they were not comfortable in using these methods. Women felt uncomfortable about the chemical or physical intrusion into their body, they did not understand how to use these methods effectively and were influenced by the negative experiences of other users.

Non-professional women in this study have higher fertility levels than Asian women who are working professionals. All professional women had fewer than three children, while 57% (12/21) of the non-professional women had three or more children; one-third (7/21) had between four and six children. This pattern of high fertility amongst non-professional women is still evident when considering fertility levels by age. Professional women aged over 35 years had no more than three children, while 71% (5/7) of non-professional women aged over 35 years had three or more children, and 55% (5/9) of non-professional women aged between 25 and 30 years had three or more children.

Professional women

The second group of Asian women are professional women whose characteristics are significantly different from those of non-professional women. All professional women in this study were employed in an occupation for which they had undergone at least 2 years training or further education. All women left school after the age of 16 and were educated in the UK or abroad (i.e. Pakistan, East Africa). Many professional women noted parental encouragement to complete their education and to pursue a career. Professional women have high levels of English language fluency and literacy. Most have been resident in the UK for more than 20 years, even though they may have been born or educated abroad. Professional women typically reside in nuclear families and stated that their in-laws or extended family have little influence over family matters, including family planning decisions. An important characteristic of professional women in this study is their well developed levels of independence and autonomy which they believe stems from participation in higher education and employment. This autonomy is expressed in their ability to make independent decisions, interact with health and other professionals, utilize community services and in their personal mobility. Professional women show a very different pattern of contraceptive knowledge and use to non-professional women.

First knowledge of contraception. Most professional women had been educated in the UK and therefore had significant knowledge of family planning and contraceptive options. Most professional women (5/8) acquired their first knowledge about contraception during school sex education classes in Britain (see Table 2). Those who were educated abroad indicated that they had first learnt about contraception through their husbands, or through pamphlets and written material. For all professional women in this study, subsequent sources of knowledge about contraception included a wide range of informal sources such as mothers, friends, relatives, public media and literature (books, pamphlets, magazines). Few women mentioned medical sources aside from a midwife.

'I almost can't remember not knowing in some ways 'cause I went to a very progressive, very good primary school . . . they showed a series of videos to all the students about sex education,' (AW28 533–540).

'Probably it would have been with friends at school, in my early teens . . . pamphlets that were around, perhaps in the doctor's surgery I might pick one up, put one in my pocket, have a look, things like that,' (AW32 514–522).

First use of contraception. Three-quarters (6/8) of professional women used a method of contraception directly after marriage to delay their first birth and generally

Table 2. Fertility and contraceptive histories of professional Asian women

Religion	Marriage	Birth 1	Birth 2	Birth 3	Current method
Muslim	Pill (None)	Pill	None	Sterilization	Sterilization
Muslim	Pill	Condom	Condom/Cap	Condom	None*
Muslim	None				None*
Sikh	Knowledge None/ Sterilization				Sterilization
Hindu	Knowledge Condom	Pill (Condom)	Pill (Condom)	Pill (Condom)	Condom
Hindu	Knowledge Pill	Pill (Condom)	IUD (Condom)		IUD
Hindu	Knowledge Condom	Pill/Sterilization			Sterilization
Hindu	Cap	Pill (Condom)	IUD/Sterilization		Sterilization

*Trying to conceive/pregnant. **Separated from husband and not sexually active.
 Note: methods in parentheses denote minor method; where two methods are shown without parentheses both methods were used for equal duration or subsequent to each other.

had a gap of 2–5 years between marriage and first birth. The first ever method used by professional women was most likely to be the pill and to a lesser extent the condom (see Table 2). Professional women had received sex education classes and were more likely than non-professionals to discuss contraception with friends and gain information from written media sources. They are therefore more aware of the effectiveness of different methods and the range of methods available, making it more likely that they select a medical method of contraception. Also GP contact to get a pill prescription posed no difficulties in terms of knowledge, access or language and GPs are more likely to provide pills than any other method (Cooper *et al.*, 1992). Professional women stated that the pill was often selected as their first method of contraception because of its convenience and effectiveness: '*I started about two and a half years ago, the pill, mainly for convenience and the fact that it's supposedly the most effective.*' (AW28 478–482). After a first birth there is little change in the contraceptive behaviour of professional women. They continue to use a method of contraception, although their method may change after childbirth. Some women switched to other methods such as the condom, cap or IUD. It was typical for these women to undergo contraceptive sterilization on completion of their families. Sterilization is the most common current method of contraception amongst professional women in this study. The pressures of religion, extended families and community expectations on fertility are not expressed by this group of women who are driven more by practical, economic and personal motives in their contraceptive and fertility decisions.

Influences on contraceptive use

All women are influenced by a complex range of inter-related factors in their contraceptive decisions and method selection. These factors may be a combination of personal preferences and beliefs or they may be external factors such as knowledge of contraception, cultural practices or community expectations which are encouraged by husbands, extended family or religious following. Although some of these influences have been identified in other research on Asian women (McAvoy & Raza, 1988; Bunting, 1984; Woolett *et al.*, 1991b), there is little indication of *how* these factors influence contraceptive behaviour and whether they have a different impact on professional and non-professional women. These issues will be examined below.

Knowledge and information have a powerful influence on contraceptive use. As shown earlier, professional Asian women are able to access and understand mass media messages regarding contraception which enable them to make informal family planning decisions. The contraceptive behaviour of non-professional women, however, is more likely to be influenced by a lack of knowledge about contraception or by misinformation or negative information about particular methods. For women with poor English language and literacy skills the influence of negative experiences and misinformation about a particular method is a strong deterrent. It is also difficult for these women to verify misinformation, given that they are unable to read leaflets; the topic of sexuality is generally not discussed with others and they do not have the confidence to seek a GP for such advice. This is particularly true in relation to the IUD, for example:

'No. I just don't (want to use the coil). Umm I heard in India like a long time ago, somebody had a problem with that so just too scared.' (AW15 431–434).

'They say put in coil. I say I'm frightened, I don't want that. One lady I listen to one lady and she got four kids and she got a coil and a ring, no more babies. She get pregnant, she come in, she got baby boy, born baby boy very ill . . . that's why I'm frightened,' (AW9 807–817).

Misinformation about particular methods also discouraged their use. For example, one woman believed Depo Provera injections had to be personally administered, '*. . . I have to do the injections myself, you know, I don't want that.*'; and another thought using the cap caused cancer. In a community where access to information about contraception poses many difficulties such misinformation leads to the low use of some methods.

Husband. The influence of a husband on contraceptive use and method choice is most pronounced amongst the non-professional women in this study. Non-professional women stated that their husbands often encouraged fertility rather than contraception and were particularly influential in encouraging a first birth immediately after marriage, subsequent births and, in some cases, continued childbearing to produce sons. The influence of a husband was also shown by Zaklama (1984). The influence of a husband often reflects cultural expectations of fertility after marriage and is compounded by similar influences from in-laws.

'And my husband wants a child because no baby in the house at that time,' (AW12 403–405).

'My husband actually he wanted one more son and I keep saying No, No . . . He says two sons would be nice,' (AW15 635–652).

Women who first learnt about contraception through their husband were most likely to use a condom. Some non-professional women indicated that their husbands accompanied them to the GP to arrange contraception. Family planning professionals confirmed the strong influence of husbands in selecting a method of contraception for their wives during family planning consultations. Husbands often acted as interpreters for their wives, and some selected contraceptive methods which family planning professionals felt the women themselves were not fully comfortable with or understood how to use correctly. In these instances the duration of method use was short or ineffective in preventing pregnancy.

Mother-in-law. The influence of a mother-in-law in encouraging fertility is well recognized amongst family planning professionals, who indicate that Asian women often make family planning decisions within the constraints of their mother-in-law's preferences. The influence of a mother-in-law over the family planning and fertility behaviour of non-professional women may not be altogether surprising given that most non-professional women live with their in-laws and have close daily contact with their mother-in-law. A mother-in-law may be instrumental in discouraging the use of contraception or persuading women not to use particular methods, especially the pill. Some women noted the constant expectations of newly married women to conceive their first child soon after marriage, pressure which is applied by a mother-in-law, extended families or by older community members. Some women therefore conceived soon after marriage as they felt this was expected of them and they had no acceptable reason not to begin childbearing immediately (e.g. employment). The strength of a

mother-in-law's influence should not be underestimated; a dominant mother-in-law may exert considerable pressure on women for early childbearing or continued fertility until a son is born, as shown in the extracts below.

'Yes, I knew about the pill but my mother-in-law will not let me have it. It didn't suit me my mother-in-law said I should not use anything,' (AW7 326, 426).

'My mother-in-law wanted us to have children as her husband and her did not have many. Then it started one after another,' (AW7 293–296).

'She's old type lady. She just tell you to have kids. She always tell me to have another child. All the time. When he's born and after one year and she tell me to have another child and I say I'm not, I don't feel like having another child now, still she's after me to have another child . . .' (AW3 1149–1158).

'First thing she's happy she's got grandchild. Second time I had a daughter she feels a bit nervous cause she wants to have a boy,' (AW3 1273–1276).

In contrast, few professional women identified that their mother-in-law or other extended family members had any similar influence over their fertility decisions or contraceptive use. Professional women explained that they largely escaped such pressures due to their separate living arrangements and work commitments, and therefore there were different expectations of them in terms of fertility.

'Yeah I think there is a difference because the women who are not working and are staying at home, they say well you're not doing anything else why don't you have your family now and bring them up, do this, whereas the professional woman says well yes I want to have a couple of children, two or three children that's it and I would like to continue with my career . . .' (AW22 1336–1363).

'I think there are those attitudes, she's a doctor or she works in the community . . . she works full time and doesn't have time . . . it's different. It's like that woman at home why hasn't she had a baby, why isn't she bulging, is she pregnant, isn't she pregnant . . .' (AW32 1109–1119).

Religion. Opinions vary on the extent to which religion influences fertility and contraceptive use amongst Asian women. Studies which analyse data by religion, at an aggregate level, indicate some influence of religion on contraceptive behaviour. However, it is individual level data which provide a clearer understanding of the variation amongst Asian women regarding the influence of religion on contraceptive use. A significant pattern is evident if women's opinions about the influence of religion are placed on a continuum whereby religion states that contraceptive use is: *forbidden, discouraged or acceptable*. This pattern is most strongly influenced by religious group (e.g. Muslim, Sikh, Hindu) and whether women are professional or non-professional.

Non-professional Muslim women typically believe that contraceptive use is *forbidden* according to Islam, that fertility is 'up to God' and women should not use contraceptive devices unless their health or the health of future babies is at risk. For example: *'My religion says No. Not allowed to use anything . . . My religion says you don't have to use nothing. I don't know what to say. No, you are absolutely not allowed to use anything. No,'* (AW1 837–851) (Muslim, aged 39). To a large extent this belief is reflected in the contraceptive behaviour of non-professional women, whereby non-use of contraception is particularly prominent.

Professional Muslim women, however, believe that contraceptive use is *discouraged* in Islam, but that this does not necessarily influence their contraceptive behaviour. They feel that economic, practical and personal considerations have a greater bearing on their contraceptive behaviour than religion. This attitude is in keeping with the pattern of contraceptive use demonstrated by professional women whereby most use some form of contraception throughout their childbearing years. For example: '*As far as I am aware my religion says that any type of sexual activity should really be for the reproduction of children, but obviously people don't stick to that anymore in this modern day. So that's actually what it says but people don't stick to that anymore, cause you can't it's not practical really,*' (AW25 568–577) (Muslim, aged 25).

All Hindu and Sikh women, both professional and non-professional, stated that contraceptive use was *acceptable*, that their religion had no bearing on their decision to use contraception and that it is a woman's choice whether or not to control her fertility. For example:

'My religion says nothing. If you want using some contraception, you can. If you don't want to don't. My religion say nothing. I'm free (laughing),' (AW3 1039–1043) (Sikh, aged 27).

'Well I just think it's important to be in control of you life irrespective of what people may say about their religious calling or their religion and we shouldn't be interfering with nature . . . If you've got the means and the tools to be able to prevent overpopulation . . . you've got to look at the social and economic situation . . .' (AW27 922–935) (Hindu, aged 46).

Sex preference. In traditional Asian society the birth of boys is highly desirable (Bunting, 1984; Thornton, 1980; Woollett *et al.*, 1991b). It is expected that a son and his family will remain living with his parents, and it is typically a son's responsibility to support his parents financially and the role of his wife to care for their well-being. Family property and land was traditionally only inherited by sons and a son ensured the perpetuation of the family name into future generations. Daughters were seen as a financial drain on the family as they had to be provided with a dowry when they left the family for marriage. Many Hindus also believe that it is the duty of a son to perform the funeral rites to enable a man's soul to go to heaven (Bunting, 1994). For these reasons sons were important to Asian families as they were a means of financial and social support in societies which did not have a social welfare system. Daughters left the family once married and bore children for another family line and were therefore seen as less desirable.

There was a considerable mixture of opinion amongst respondents about whether women's fertility patterns are influenced by the desire for sons. Although there is strong evidence that this behaviour still exists, it appears to be more evident amongst women over 35 years and non-professional women whose attitudes and behaviour, in this respect, may be similar to women in Asia. For example: '*Boy very nice, very nice caring with us. Paying bill, my bills you know because my husband doesn't work, they pay, they come along every weekend and they look after us, they doing shopping for us and everything they can afford, they help,*' (AW5 1002–1009) (Non-professional, Sikh, aged 55). Although younger women did not necessarily conform to this view they were influenced by older relatives and community members who expressed the importance of producing sons. Most professional women in this study declared that the sex of children did not have an impact on their fertility or contraceptive behaviour: '*The type*

of family they come from you know, if it's a traditional family, uneducated, they still feel that's important . . . I know women who get depressed and suicidal if they keep having girls and don't have any boys, whereas if there's a boy they automatically see them as a great asset to the family . . .' (AW33 671–680) (professional, Muslim, aged 25).

Although son preference may exist amongst older, non-professional Asian women and may influence their fertility, there are also examples of women who have no sex preference of children, and equally, examples of women for whom the desire for a daughter was strong enough to continue childbearing. One notable example is: *'Second time I'm pregnant I thought it maybe girl this time, but it was a boy, third time I'm pregnant I thought maybe this time girl, no not a girl, a boy, four times I wait, wait, wait, fifth time she was come along I'm so happy,'* (AW5 990–996) (non-professional, Sikh, aged 55).

Discussion

Non-professional women in this study show distinct patterns in their contraceptive behaviour. The most notable patterns involve non-use of contraception before a first birth and then a dramatic increase in contraceptive use after this time. Non-use of contraception before a first birth is shown to result from: pressure from husbands and the extended family to conceive soon after marriage, a lack of knowledge about contraception, difficulties in communicating with health professionals and religious beliefs discouraging birth control. Muslim women in this study showed a greater tendency not to use contraception throughout their childbearing years than Sikh or Hindu respondents. However, there is evidence to suggest that some non-professional women would have preferred to delay their first pregnancy if they had adequate knowledge of contraception. Lack of knowledge about contraception also contributed to short birth intervals and to high fertility amongst this group of women. Knowledge about contraception is significantly increased after their first birth due to contact with health professionals related to childbirth and postnatal care, such as midwives, health visitors or a GP. Midwives, in particular, have been shown to be a very important source of contraceptive information for non-professional women. These women have low levels of English language competency, literacy and awareness of family planning services. This puts them at a significant disadvantage in utilizing mainstream channels of information and services to broaden their knowledge about contraceptive options and compounds their reliance on hospital staff for information about contraception.

The importance of midwives and health visitors in information dissemination needs to be given greater recognition and support to enable adequate information to be given to these Asian women to allow them to make informed family planning decisions. Perhaps midwives and health visitors need to become more aware of the patterns of contraceptive behaviour of Asian women in order to recognize their important role in the dissemination of family planning information to non-professional Asian women, in particular. Increasing the awareness amongst health professionals of the context in which non-professional women make reproductive decisions and the complex range of influences on their family planning behaviour may also contribute to a greater understanding of the pressures and preferences of non-professional women in their contraceptive behaviour and enable the delivery of appropriate family planning

information and advice. Such issues as allowing sufficient time to explain contraceptive methods to non-professional Asian women, some of whom may have no prior knowledge of contraception, and providing linguistic support to midwives to assist in their communication with these women need to be given greater consideration.

In the provision of family planning services to non-professional Asian women, consideration needs to be given to the context in which their family planning decisions are made. Family planning information should not only be directed at women of childbearing age; it is equally important to ensure that such information is also received by those who are most influential in the family planning decisions of non-professional women. In particular, a mother-in-law, husband or extended family members who may exert considerable pressure on family planning behaviour. In closely knit Asian communities the values and traditions of older generations are well respected and influence the younger women in the community. In this type of situation it is only a half measure to provide information to women of childbearing age. The development of programmes whereby mothers-in-law and older community members are also exposed to information which shows the beneficial aspects of contraception to mother and child health by spacing births is likely to have greater effectiveness. Such a programme may initiate a dialogue between generations and enable women to assert their preferences on a more informed basis and to a more understanding audience. Broader strategies of information dissemination are likely to be more effective for non-professional Asian women.

'I think it's also teaching the family as well, especially if they've got a mother-in-law because . . . my mother still fits into this, "Oh no no, you must carry on having children" . . . as far as they were concerned they didn't use contraception . . . I think the in-laws, particularly the mothers-in-laws need to be aware of [contraception] as well, so it's not just for women who are reproducing but also women they have contacts with,' (AW22 1296–1325).

' . . . it's very important to have the mothers and the grandmothers there as well . . . when you just have the young women there they go home and they say "Don't be stupid, we've been doing this for generations and its not affected us, why change now" But it's very important that you get a cross range of people, ages, so that they can exchange information, you could answer their questions and look at their point of view and their fears or whatever,' (AW22 1564–1579).

Professional Asian women in this study show an entirely different pattern of contraceptive behaviour and are motivated by different criteria in their contraceptive choice than non-professional women. They are more likely to have knowledge of contraceptive options before marriage, use contraception before their first birth and continue to use contraception throughout their childbearing years. The most common method used was the pill and some form of contraception was used throughout their childbearing years to enable spacing of 2–5 years between births and to enable their fertility to remain below three births. These women therefore have significant knowledge about contraceptive options before marriage and are able to make informed choices on their contraceptive needs. They are less likely to be influenced by religion, family and community expectations on fertility, and more likely to cite personal, practical and economic considerations on their fertility decisions and timing of

childbearing, which are similar to women in the general population. Their method choice reflects greater knowledge of contraceptive options and an ease in gaining assistance from health professionals. Professional women therefore show an altogether different pattern of contraceptive knowledge and use and are influenced by a different set of factors in their contraceptive behaviour. There are few service delivery implications for professional Asian women. They display sufficient knowledge about contraceptive options, have the independence to access and utilize family planning services and are able to meet their contraceptive needs with existing services. They appear to be little different in their contraceptive behaviour to women in the general population.

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