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REPORT

CULTURAL INFLUENCES ON FAMILY PLANNING CHOICES

Focus Group Report

APRIL 2003

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MIC -Women's Health Services

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Executive Summary

With support from the Office of Population Affairs, MIC-Women's Health Services (MIC), in collaboration with the Research and Evaluation Unit of Medical and Health Research Association of New York City, Inc. (MHRA), conducted a research project from July to October 2002 to increase MIC's knowledge about four rapidly growing ethnic groups in our patient base. Specifically, we studied the influence that country of origin, associated cultural heritage, and recent immigration to New York City have on women's attitudes toward family planning and their choice and utilization of birth control methods. A series of eight focus groups was conducted with Mexican, Ecuadorian, Pakistani and Bangladeshi women at four MIC centers.

Recruitment and Participant Information

A new recruitment strategy was employed, in which bilingual consultants and staff social workers conducted waiting room and telephone recruitment, and most importantly, made two to three follow-up calls to confirm participation. The strategy was so successful that in five of the eight groups, more women arrived than could be accommodated, and all of the groups had from five to twelve participants. A $20 incentive was provided to each woman who arrived at the center.

A total of 78 women participated in the eight groups. They were all of reproductive age (18-45) and had been in the U.S. for varying lengths of time, ranging from less than one month to more than 10 years. They were predominantly MIC clients, and it is important to note that they may be a self-selected group more likely to use and have more positive attitudes toward contraception.

Important Findings

- These women are highly motivated to avoid pregnancy and limit childbearing after arriving in the United States.
- While all participants put the matter of family planning and contraceptive choices firmly within the purview of the couple, the Pakistani and Bangladeshi women described a much stronger role for their husbands than did the Mexican and Ecuadorian women.
- Method attributes, especially side effects, play a major role in the decision about whether to practice family planning.
- The participants reported real concerns and misinformation about method attributes, including side effects, efficacy, availability, and potential health consequences, and clearly expressed a need for further information.
- Health care providers are important sources of information and to a lesser extent, influence, particularly with respect to method choice.
- Religion does not play as large a role as expected in the decision making of these women.

This project was successful on several fronts. The success of the recruitment strategy provided process information that will be useful in conducting future research. The findings have implications for service delivery and health education and promotion at MIC. The motivation of the women and their evident desire for more information suggest that they would welcome any efforts by MIC to address these issues. MIC has always worked to ensure that the services it provides are linguistically and culturally appropriate; this study highlighted how vital those concepts are and suggested some additional steps that MIC might take as it begins to address the study's implications in the coming months.

MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY, Inc.

Cultural Influences on Family Planning Choices Focus Group Report

Introduction

MIC-Women's Health Services, a network of eight reproductive health centers located in low-income neighborhoods throughout New York City, is a service division of Medical and Health Research Association of New York City, Inc. (MHRA). The MIC network provides family planning services to about 19,000 women and prenatal and post-partum care to more than 8,000 women annually. MIC provides services primarily to women of color, many of whom are immigrants, residing in the City's poorest neighborhoods. In 2001, 70% of the women served reported having been born in a country other than the United States (including Puerto Rico). One of its most ethnically diverse centers, the MIC Center in Astoria, Queens, draws patients from over fifty countries.

All MIC centers are staffed with individuals who respect and attempt to understand the cultural, linguistic, and financial needs of the patients they serve; languages spoken by providers and ancillary staff include Spanish, Bengali, Chinese, Creole, English, French, Hindi, and Urdu. However, "cultural competency" is difficult to achieve in this city where ethnic diversity is unusually broad. The increase in patients newly emigrated from Mexico, Ecuador, and South Asia caused MIC staff to question their knowledge of the beliefs and attitudes of these patients about family planning and contraceptive methods. For these reasons, the agency embarked on a research project to increase knowledge about four rapidly growing ethnic groups in the patient population. A series of eight focus groups was conducted with Mexican, Ecuadorian, Pakistani and Bangladeshi women at four MIC centers.

The goal of the focus groups was to study the influence that country of origin, associated cultural heritage, and recent immigration to New York City have on Mexican, Ecuadorian, Bangladeshi and Pakistani women's attitudes toward family planning and their choice and utilization of birth control. The intent was to gain information that would allow MIC to further improve its health education messages and identify needed changes in the delivery of clinical services. This, in turn, would mean better service for current patients and more effective recruitment of additional patients in need of reproductive health services.

The participating ethnic groups were chosen for a variety of reasons. In 2001, 49% of all patients seen at MIC were born in a country where Spanish is spoken; Dominicans, Mexicans and Ecuadorians are the largest Latino groups, representing respectively 18%, 11% and 7% of all patients. Mexicans and Ecuadorians are less well known to the agency than Dominicans, due to the fact that only in recent years have their numbers been increasing dramatically. As such, they may possess quite different attitudes and beliefs about family planning than more established immigrant groups. In addition, shared language cannot be equated with shared cultural heritage;

it is necessary to understand where the experiences and beliefs of these populations converge and where they differ.

While South Asian women, including Bangladeshis, Pakistanis, and Indians, still constitute small numbers overall, they are rapidly growing populations at the Astoria MIC center. For example, the Pakistani population more than doubled after a Pakistani clerk was assigned to Astoria. However, despite the addition of some South Asian staff members, these groups are relatively unknown to the agency and very little is known about their beliefs and decision-making processes with regard to family planning. It is evident that the word is getting out about MIC's services among these groups, yet it remains unclear whether MIC is meeting patient needs for family planning in a culturally appropriate way.

Focus groups were conducted at four MIC centers; four groups with Pakistani and Bangladeshi women, as well as one with Ecuadorian women, were conducted at MIC's Astoria center. The remaining four groups were held at MIC's upper Manhattan center and at its Bushwick and Williamsburg centers, in Brooklyn, where large percentages of Mexican and Ecuadorian women seek services.

Methods

Focus groups as a research methodology allow an in depth examination of ideas and beliefs. Participants react to each other and their opinions can be informed by the discussion, allowing the moderator to elicit thoughts and ideas that otherwise may have remained hidden. This interaction and the agreement and disagreement that result can produce a fuller picture of the topic. The success of this method depends on the question guide developed, as well as the rapport both between the moderator and the participants and among the participants.

The focus group question guide for this study was developed by researchers at MHRA in conjunction with program staff from MIC. It grew out of an initial discussion about the influences on the decision to seek or not seek family planning services, as well as the influences on method choice. Thought was given to ensuring that the terminology used during the course of the discussions, the introduction of the topics, and the flow of the discussion would be comfortable for the women and induce them to share their thoughts. The guide was then reviewed by MIC center staff with input from MIC clients. The final guide was translated into Spanish, Urdu, and Bengali. (The English-language version of the guide is included in this report as Appendix A.)

To further ensure the success of the project, it was important that all those involved in running the groups be female and of similar cultural heritage to the participants so that they would be comfortable discussing family planning and more likely to share their true opinions and feelings. We identified a female moderator of Spanish descent to conduct the Mexican and Ecuadorian groups in Spanish. The moderators of the Pakistani and Bangladeshi groups were women of Pakistani and Bangladeshi descent and the groups were conducted in Urdu and Bengali, respectively. A bilingual female note taker/assistant moderator was identified for each session as well.

Recruitment of participants is also an important step in conducting successful focus groups. For this study, we recruited Mexican, Ecuadorian, Pakistani, and Bangladeshi immigrant women of reproductive age from the MIC client population. For the Mexican and Ecuadorian groups conducted in July/August 2002, two Spanish-speaking consultants known to the agency were hired as recruiters. The participants were recruited by the consultants or by Spanish-speaking staff social workers from the waiting room or via telephone call to patients whose country of origin was listed as Mexico or Ecuador. If recruited in the waiting room, the consultant made a follow-up call to confirm attendance and to ask if the woman would like to bring a friend or relative meeting the same criteria. If so, the consultant called that woman as well. In all cases, the women were called again if the focus group was more than five days away, as well as the night before the group as a final reminder. Thus, some women received three telephone calls from the recruiter. Due to previous difficulty recruiting for focus groups, we recruited approximately three times as many women as desired. This recruitment was extremely successful; in total, 46 women confirmed for the two Mexican groups, 36 came, and 23 participated. For the Ecuadorian groups, 66 confirmed, 37 came, and 22 participated. The women who were unable to participate, due to full groups, were nevertheless given the $20 incentive and a package of health education and MIC promotional materials, which all participants received.

A similar strategy was used for the Pakistani and Bangladeshi groups, all four of which were conducted at the Astoria MIC Center in October 2002. The Pakistani clerk at Astoria recruited women from the waiting room and telephoned patients using the master list of all Astoria patients with country of origin listed as Bangladesh or Pakistan. Then, the two focus group moderators, of Pakistani and Bangladeshi descent, telephoned the women recruited by the Astoria clerk. They called once to confirm attendance and to ask if the women would like to invite friends or family, and the second time the night before the group to remind the women. Therefore, the South Asian women received two calls on average. Given the extraordinary success of the recruitment for the previous groups, we attempted to recruit only slightly more than the maximum number that could be accommodated for each group. This strategy was also quite successful. For the Pakistani groups, 18 were recruited, 20 came (some joined from the waiting room), and 17 participated. For the Bangladeshi groups, 18 were recruited, 16 came and participated. Those women who were turned away, due to full groups, were given the $20 incentive and a bag of health education and MIC promotional materials, which all participants received.

The procedures and aims of the groups were explained and informed consent was obtained from the participants before the sessions began. The moderator led the discussion using the detailed focus group question guide. Although the same questions were asked of each group, the moderator had latitude to follow up on points that arose in each group; the same basic points were covered in each group, but the path each group took through the discussion was different. The session was audio recorded and the note taker/assistant moderator wrote a report based on the notes she took throughout the sessions, including quotes from the participants and summaries of the points discussed. The reports were written in English and the note takers were responsible for translating the quotes from the original language into English. The note takers had the audiotapes available to them as they prepared their reports. It should be noted, however, that complete transcripts were not made. The moderators also provided brief reports with their

impressions of the sessions, as well as their interpretation of the main points to come out of each session.

The content of the moderators' and note takers' reports were analyzed and the note taker reports were categorized by themes that emerged in the responses to the questions, particularly noting points that seemed to elicit general agreement. It is important to note that, because we did not have full transcripts, it was sometimes difficult to determine the level of agreement about certain points. This should be borne in mind when reading and interpreting this report. In general, we found high levels of agreement between the pair of focus groups for each ethnic group. After determining the main points for each ethnic group, we examined common themes and telling differences across ethnic groups.

In this report, we begin by looking at each ethnic group separately, giving a detailed description of how the women think and feel about family planning and how they make contraceptive decisions. The main topic areas are 1) attitudes and beliefs about family planning, 2) family planning in their country of origin and in their community in New York, 3) family planning decision making, and 4) need for information about family planning. Under each of these headings, we present the main points from each set of groups, illustrated by quotes. After the detailed accounts, we examine commonalities and notable differences among the groups, and then consider the implications of these findings for the provision of family planning services to immigrant women in New York City. We end by offering some recommendations for MIC.

Focus Groups with Mexican Women

Two focus groups were held with Mexican women, one, with 12 women, at the Williamsburg MIC Center in Brooklyn, and one, with 11 women, at the Manhattanville MIC Center in upper Manhattan. The participants were predominantly MIC clients, aged 19-36 years old, who had been in the United States from one year to over 10 years, though many had been in the U.S. less than five years.

Summary of Findings

Attitudes and beliefs about family planning

a. The range of responses to the question of what family planning means to these women encompassed determining the number and spacing of children and preventing pregnancy, as well as the methods used for that purpose.
    - "It is the number of kids we will decide to have."
    - "Control over not having children."
    - "Not have babies."
    - "Prevent pregnancy."
    - "Being able to give a better life to the babies we have."

   In one of the groups, there did not seem to be a clear differentiation between the terms "family planning" and "birth control" whereas in the other group, "birth control" was deemed

to refer more specifically to the methods used to prevent pregnancy. Both groups, however, decided to use the term "family planning" for the rest of the discussion.

b. Many of the women, especially in the Manhattanville group, were comfortable and not embarrassed talking about family planning. One mentioned talking to her 18-year-old son about condoms. Others thought it important to talk about family planning in order to learn more about it and methods available, to be better able to care for themselves.
   - "I feel comfortable talking about this…"
   - "It is a topic that should be spoken openly."
   - "I tell my friends, it is not shameful to talk about this."

   However, it should be noted that, although several women in the Williamsburg group agreed that it was not an embarrassing topic, many in the group did not appear comfortable and did not contribute greatly to the discussion.

Family planning in Mexico and in the Mexican community in New York

a. The women felt that in Mexico, there was considerably less comfort talking about family planning than in the U.S. They added that many people in Mexico are embarrassed to talk about it and to ask how to use it.
   - "…nobody talks to me about this in Mexico."
   - "In Mexico, it is shameful to talk about this."

   There is also less information available, less spoken on the topic, and a reduced sense of empowerment to make family planning decisions.
   - "In Mexico, parents don't tell you things."
   - "The information given by family members is antiquated."

   As a result, they find that having many children is more common in Mexico. Some people believe that births should not be controlled, that they should have "however many [children] come." Furthermore, some men are 'machistas,' disapproving of birth control. One woman noted that some husbands don't want to use family planning, that they make their wives have a lot of children. Others feel that, although there may be an element of this, the main reason for having many children is a lack of information.
   - "In Mexico, I think it's because of a lack of information, not really because of machismo…yes, there are machistas, but it's more about ignorance."
   - "It's because of a lack of information that people have so many children."

b. There is more information about family planning available in Mexico now than there was in the past. One participant noted that only in recent years is the topic really discussed in Mexico. Another agreed that now there are more clinics and doctors as well as more information and concluded that people take better care of themselves now.
   - "I think that now, there's more information; before, there wasn't a lot."

c. Poverty—both on an individual and a community level—and the size of the town, which in many ways, for these women, seems to be related to poverty, are factors in how much information about family planning is available. One participant noted that in small towns, there is a lot of poverty and suffering and that women have many children. The women also

felt that much more information is available in cities compared to small towns, though among small towns, more developed ones may have greater family planning resources.

- "There are small towns where there is not even a health clinic, where the problem is that there is a lot of ignorance. And there are more developed towns where there are clinics, hospital, school, and there is more information."
- "I think it really depends on how developed a town is."

In addition, even when available, many people may not have the personal resources to access family planning. One sentiment expressed by participants was that people in Mexico are poor and will only use birth control if it is free.

- "…when it's a public clinic, it's full…"
- "…there's no money, so for this reason people let themselves get pregnant, they don't take care of themselves."

d. In the Mexican community in New York, people are very motivated to limit their births. Most have come to the United States to work and make money, to try to better their position and that of their children. Having many children can be an impediment to these goals. Not only is it more difficult to work regularly with many children, but it is expensive to raise children in New York.

- "There is opportunity to give a better life to the children we have planned, that we wanted to have, but if we fill ourselves with children, we can't."
- "It is not easy to survive here with a lot of children."
- "Here you have to think about having children, here you don't eat if you don't work."

Family planning decision making among Mexican participants

Two related issues were discussed with regard to decision making—whether to use birth control or not and what method to use. The discussion of these two issues tended to blend together and the two are apparently not as separate as we originally thought. Availability and acceptability of various methods play a real role in the decision about whether to practice family planning.

a. When considering the influences on family planning decision making, we cannot underestimate the importance of the motivation not to have a large family in New York. As illustrated by the quotes in the previous section, these women are highly motivated to limit childbearing, which is likely to positively influence them to use birth control.

b. The role of the husband in family planning decision making is complicated. Most of the women felt that both partners should make such decisions together, and they strove to make that happen. However, the reality in some cases fails to live up to that ideal. A number of women felt that some men were not supportive and prevented their wives from using birth control because they want to have many children. These women felt that the responsibility for family planning generally fell to women. If need be, they would use contraception without their husbands' knowledge: "Hidden, but she does."

- "What influences me is between my spouse and me. We have to be in agreement about what method we will use."

- "I think that my husband and I have to take care of each other because I don't want to get infected with a sexually transmitted disease."
- "For me, my husband knows everything."
- "The spouses sometimes don't let the wife use a family planning method."
- "Mexican men just want to have kids."
- "It's the couple's decision."
- "It's the woman's decision."

Sometimes, contradictory feelings were in evidence in one woman.

- "My husband influences me; we are in agreement about family planning. After I recovered, I knew what to use. My husband doesn't want me to use anything. My child is very young. I made the decision myself. I use vaginal suppositories."

Despite the willingness to circumvent their husbands' wishes, it was clearly their preference that their husbands be involved. In addition, though they may consider information and advice from other sources (see the following points), at root, they felt the decision should belong to the couple.

- "But in all cases I think it is the couple's decision."

c. Side effects and other method attributes are of considerable concern to these Mexican women. They can be important not only in deciding which method to use, but may also influence whether women practice family planning at all. If women do not believe that the methods available are adequate or if they are concerned about the effects the methods may have on their well-being, they may decide not to use a method at all.
    - "One has to think about the side effects."
    - "What percentage of sureness a method has is important in making a decision."
    - "With Depo Provera, one worries if you will have your menstruation and if it will affect you in the future."
    - "If you don't have your menses, this will harm you."
    - "I'm afraid to use birth control, because all that has consequences. I've heard the news and it scares me to think…"

d. Medical providers are an important source of family planning information and influence. Women tend to value and trust information from this source. They perceived that health care providers can tell women generally about family planning and provide information about particular methods. The concern that women have about side effects indicates that information about methods can have a real effect on women's decision to use birth control as well as on what method to use. In fact, for many women, their first real knowledge about family planning comes from doctors or nurses after the birth of a child, often their first child.
    - "Here in the clinic, when I had my first baby, the nurse asked me what I wanted to use to prevent children, and she explained to me that there are different pills."
    - "I think that the clinic is where you get the most information, where you can ask about all the different methods with confidence. I feel confident here at the clinic about asking questions, because on the other hand, with friends and family, it's not the same, because a lot of times they can give you information on what they're using, but you don't know about all the others. So the clinic is where they explain it to you."
    - "The doctor influences in the decision."

- "They talked to me at the clinic about a family planning method and that helped me decide."
- "The doctor is the best person to inform me. I then discuss it with my spouse."

e. Family members may also wield some influence, though to a lesser extent than husbands or health care providers (doctors/nurses), and in some different ways. Their influence may come through example, sometimes by illustrating what women want to avoid, or sometimes in providing support for decisions. For example, one woman explained how the family can influence the choice to have few children when one grows up seeing the effects of having many children. In addition, family or friends may influence the choice of method by telling of their experiences with various methods.
   - "Not only does the doctor influence my opinion, but a sister does too."
   - "My mother supports me in the decision of having a child or not."
   - "My father had nine children. My sisters…don't have as many because they are always talking. When I talk to my sister, I tell her, take care of yourself, don't have so many children, because they suffer...I only have one [sister] here, but she doesn't have a lot of children, because the truth is we suffered a lot, all of us siblings."

f. Religion has some, but relatively less influence on family planning decision making than anticipated. The women recognize the influence religion, particularly Catholicism , has on some women, though most of the participants either remained silent or discounted the influence religion has on them personally, coming back to the fact that the decision rests with the couple.
   - "Some say, God said that we should have as many children as He gives us, and there are people who still carry that out; in other words, they have the children that they think God gives them, and they think that birth control methods are bad, that it is a sin, that they are not permitted by the religion."
   - "If God gives us kids, let Him give them to us."
   - "The Catholic religion influences a lot."

g. There were some reports of television and other media as sources of information, though it is up to the individual to "choose what to listen to or not."

Need for information about family planning

a. As a group, the Mexican participants were aware of various methods of contraception.

b. Although they generally felt that much more information is available to them in New York than in Mexico, they still expressed a strong interest in receiving additional information, for example, more detailed information about available methods and side effects, or information about other contraceptive methods such as Norplant or the patch.
   - "I would like much more information."
   - "It would be a good idea to have pamphlets available in the waiting area."
   - "But the pamphlets [given by MIC], they don't say that you can get cancer with pills and injections, I'd like to know more about that, because that scares me."

c. As noted in a previous point, many women received information about birth control at a hospital or clinic after giving birth. For many, this may have been their first exposure to this information, having never thought much about it previously.
    - "With the first child you don't know anything…you're not thinking about those things yet. Then after having the first child, you want more information."
    - "[At the hospital] they give you a piece of paper with all the methods."

d. There is not only a need for information, but a need that the information be imparted in a language they understand.
    - "I'm interested in pamphlets in Spanish because I don't know what they say in English."
    - "Speaking my language is very important."
    - "The Spanish language is important."
    - "I suffered a lot at [the hospital] because they did not understand me."

Focus Groups with Ecuadorian Women

Two focus groups were conducted with Ecuadorian women: one at the MIC center at Bushwick, Brooklyn, and the other at the MIC center at Astoria, Queens. The first group (Bushwick) consisted of 12 women of reproductive age, who had been in the United States for time periods ranging from less than one month to seven years; many were MIC patients. The second group (Astoria) had 10 participants ranging in age from 19-41 years old; all but one were MIC patients.

Summary of Findings

Attitudes and beliefs about family planning

a. For the most part, the participants agreed that family planning means planning how many children to have. They see birth control as basically the same thing, though they identify a slight distinction between preventing and planning children. They felt comfortable talking about these topics.
    - "There's no reason to be embarrassed; it's a natural thing."
    - "I think I would be embarrassed if I had a lot of kids and I couldn't educate them..I think that would embarrass me, not planning how many kids I should have in order to be able to give them a good future"

Family planning in Ecuador and in the Ecuadorian community in New York

a. The participants overwhelmingly felt that information about contraception was not readily available in Ecuador.
    - "There's very little [information]."
    - "There isn't a lot of diffusion, but yes, it exists. There are few ways to get information, and sometimes even the doctors are embarrassed."

- “There aren’t the same ways of disseminating information like here, such as the radio, television, pamphlets. There is little information because the economy is lacking.”
- “A lot of people don’t have knowledge about that.”

b. In Ecuador, the cost of doctor visits and of contraceptive methods themselves are prohibitive.
   - “…over there you have to pay the doctor who sees you, and if you don’t get checked you can become pregnant.”
   - “If you don’t have money, you can’t take care of yourself [use birth control].”

c. There is also much misinformation and there are many unanswered questions with regard to various methods.
   - “Also they’re scared, because they say that when you put in the copper T [IUD]…if you don’t get checked you can become pregnant.”
   - “We’re afraid it [the IUD] will give us cancer.”

d. Other participants discussed the culture of childbearing and sex education in Ecuador. Young girls do not receive sex education as they do in the U.S. Childbearing is a more natural process: women give birth at home, without any prenatal or hospital care, and get up afterwards and keep right on working.

e. Women are the ones who are responsible for birth control, but a woman who seeks birth control may be seen as promiscuous.

f. The participants overwhelmingly agreed that when Ecuadorians come to New York, they are extremely motivated to avoid numerous pregnancies. They come to this country to work and send money home, sometimes to children they left behind. Having children interferes with their ability to work, as the extended family support system is absent here, and thus, child care must be paid for. Even clothing a child is more difficult here, as the season changes require more clothing variety.
   - “Here everyone takes care of themselves [uses birth control] because they’re afraid of having kids…we left kids in Ecuador…they don’t want more kids because of work.”
   - “Here, you need money for everything. In Ecuador, there is more support from the family.”
   - “For example, if you have three children and you have to leave them with a babysitter to go to work, imagine, you are working only to pay the babysitter…it’s hard.”
   - “Things change a lot [upon immigrating to the U.S.].”
   - “It’s hard here…over there [Ecuador] people have houses, and you can have five, six children in the same house…here it’s very hard, you don’t have houses, you live in little apartments, you don’t have the same comforts, nor do you have someone to help you. Over there, there’s always your grandmother, your mother, your mother-in-law who can care for them…well I’m speaking for myself, if I don’t take care of my kids I don’t have anyone to care for them.”

g. Some men want to have as many children as God sends, or want to keep having children until a boy is born. There was disagreement about whether male attitudes toward family planning change upon coming to the U.S.
    - "The man is always a machista."
    - "Here they let women think. Women make their own decisions."

Family planning decision making among Ecuadorian participants

The participants were asked to identify what factors influenced their choice to use family planning and separately, their choice of contraceptive method. In fact, their answers indicated that there was not as much separation of the two issues as we originally thought.

a. Either alone or with their partner, the women weigh whether or not they desire a child, taking into account their ability to raise it, given their life situation. As stated above, these women are extremely motivated to avoid numerous pregnancies once they arrive in the U.S., which likely leads to a desire to use contraception.
    - "I think, 'If I don't take care of myself now and a child comes, what quality of life am I going to give him?'"

b. When asked whether a woman had to be married to seek birth control, the participant's opinions differed. While many answered that marital status was not important with regard to use of family planning, others explained that it is taboo for a single woman to seek birth control in Ecuador, and that buying condoms, for example, is extremely embarrassing there. A woman may be viewed as promiscuous if she seeks contraception. It was unclear whether they felt the context was different here in the U.S.
    - "…better to take care of yourself even more if you don't have a stable partner, because of AIDS and all the diseases."

c. Most of the focus group participants were married or with a steady partner, and most assumed that the decision to use birth control was made by women in a serious relationship. There was disagreement about the importance and influence of the husband/partner when it comes to deciding to use family planning. Those who said the husband played a role said that the decision rests with both partners.
    - "If they're married, it has to be both of their decision."
    - "It's [the family planning decision] something that concerns both [the man and the woman]."

   One woman explained that she shared family planning decisions with her husband, while another argued that not all men are that open. Many seemed to agree that the woman had the final say, since she was the one who bore and raised the children. They indicated that even if the man did not support family planning, it was permissible for the woman to use birth control without his knowledge. One woman, one of the most outspoken about women's independence, felt that a husband who refused to discuss family planning with his wife wasn't "worth much." (However, other women were quiet during this line of questioning and they may have felt uncomfortable vocalizing their disagreement.) One spoke of a friend who kept bearing children because her husband refused to use birth control.
    - "The last word always has to be the woman's; it's our body."

- "Yes, the responsibility is mostly the mother's...nine months of pregnancy, giving birth, raising the children."
- "Yes, I have a friend who has four children and I ask her, why don't you take care of yourself [use contraception] because the children are like one year apart and she says no because her husband won't permit her to use birth control—she'll have as many children as she gets, she doesn't work but I feel bad because she's very submissive…"
- "But some say that if they use it, he'll leave them."
- "Then that husband isn't worth much."

d. They also cite the influence of family and friends, who either recommend or show by example that the women should have small families. For example, a few participants cited coming from large families, and either their experiences growing up in those large families or direct advice from their mothers influenced them to have smaller families. Others agreed that family and friends played a large role. Another claimed she was all alone in this country and did not talk to women about such topics.
   - "My mother had 10 children, and she doesn't want me to have more."
   - "Yes, she [my mother] had 10 [children]. And she doesn't want me to keep having more children either."
   - "…here also friends at work tell you, you shouldn't have kids, and they give you advice about birth control methods."
   - "…it depends on the couple…because if you have five children, the family is not going to help you raise them."

e. Method side effects, as explained by the doctor/nurse or experienced by the women themselves, played a large role in the use of methods, and perhaps, use of family planning in general. The women mentioned concerns about side effects, efficacy, availability, and consequences, indicating that these issues were relevant not only for method choice, but also for the decision to use contraception to begin with. Some women suggested that there wasn't much of a choice, and that they only knew of two effective methods (oral contraceptives and Depo Provera).
   - "Every woman is different, and sometimes you use pills, and for some women it works well for them and for others it affects them. Same for the injection."
   - "Some use the copper T, for example, and they say you bleed a lot, so you're afraid to take care of yourself with that."
   - "It depends…every person has a different metabolism..."
   - "…then I started the injection which is every three months, but…I felt bad…I had a headache so I told the doctor that the injection doesn't work for me and she said, 'take the pill'…"

   They also explained that while the partner tended not to care which method she chose, he would intervene if there were drastic side effects, sometimes causing the couple to use no modern birth control method or just the condom.
   - "They [men] don't worry about that."
   - "So my husband told me 'that's enough. Throw away those pills and that's enough.' [after she had weight loss, rash, nausea while using the pill]

- "Because they say they're going to take care of themselves [with condoms]. And when they do, you get pregnant."

f. Health care providers, namely nurses and doctors, were named as important sources of information about birth control. Participants agreed that a woman often found out about birth control or started using a method after having her first child. Women seemed to trust information coming from this source.
    - "So the doctor asked, do you want to have more children, and I said no, and so you have to use family planning, and I said I don't know about that…"
    - "In my case, when I go to the hospital, I ask the doctor, what's the most convenient method, and so after my first child they told me, 'pills'..so then I stopped the pills and in a year I had my son..after my son I went and as times had changed, now there was Depo Provera, the injection, and they told me it was convenient, every three months, so I started it. And I think it depends on the doctor who attends you, or the nurse, because they know more than you and they give you advice."
    - "Trust in my doctor and in God."

g. The point was also made that immigration status affects the decision to seek family planning. A woman who is in the country illegally may be afraid to go to a doctor for a birth control method. Some women were unsure of MIC's policy toward immigration status, and were afraid to visit MIC at first.

h. The majority of participants felt that religion did not influence their decision making. The following quote helps to illustrate that point:
    - "Before, it was whatever God sends you. Not anymore. Necessity itself has changed that."

Need for information about family planning

a. The participants stated clearly that they lack knowledge and information about contraceptive methods, and that they are interested in learning more. They had many questions about various methods. For example, they wondered whether oral contraceptives or IUDs cause cancer, whether oral contraceptives lead to a loss of sexual appetite, and whether Depo Provera causes osteoporosis or weight gain. They are concerned about efficacy of methods such as the IUD and the condom. They are open to learning from various mediums, including health education sessions at the center, health-related videos shown at the center or a hospital, health-related magazines and brochures given to them by their doctor/nurse, radio, and television.
    - "I'm lacking a lot of knowledge."
    - "There should be more [information]; we should hear more about it."
    - "There should be more information so that women have more options."
    - "I didn't have much knowledge, I only have one child...and the doctor told me, here's a magazine to read that gives you information about using birth control."
    - "The doctor. Of course, the doctor, he/she should give us pamphlets."
    - "I really like listening to the Spanish radio, and doctors always come to talk."

b. The women expressed a desire that more Spanish-speaking providers (nurses/doctors) and for interpreters to be available. (However, one participant disagreed and said that the women should empower themselves by learning English.)

Focus Groups with Pakistani Women

Two focus groups were held with Pakistani women at the Astoria MIC Center in Queens, one with 12 women, and one with five women. The participants were predominantly MIC clients, aged 18-45 years old, who had been in the United States from nine months to 10 years.

Summary of Findings

Attitudes and beliefs about family planning

a. In both groups, the participants expressed a clear sense that family planning is about limiting the number of children they have. The main reason for this is to preserve the health of the mother and to ensure their ability to well provide for the children they have. It was eventually agreed that the ideal number of children was two to four.
   - "My idea is that a child's education, his food/drink, whatever work there is…whether two or three…you shouldn't have more than that. That's correct. If there are four to five kids, there will be difficulty for the parents."
   - "[One] should have few children."
   - "What you can easily afford."
   - "It's a good thing. Health stays good. If the mother's health is good, she can look after her children properly…if we have one child, then we want more, we think after some time we will make more…the child wants a brother or sister…but having a gap is necessary…one shouldn't have too many either."
   - "Having children year after year…this is not good at all…but after a gap of two, three, four years it's okay to have a child, if you want two or four…with more the mother's health won't stay good and she won't be able to take care of the other kids."

b. As the final two quotes (both from the second group) in the previous point illustrate, the women think of birth spacing as well as limiting when they think of family planning. In the first group, the thoughts about spacing came out in the discussion of birth control, and it initially seemed as though they were making a distinction between the two ideas: family planning referring to limiting the number of children and birth control referring to spacing between births. Spacing, as well as limiting, was seen to be beneficial for both the mother and the children.
   - "There should be some 'time' [a gap]…one child should get bigger…then the other should come; this makes things easier for the mother."
   - "As it is, taking care of two kids is hard."
   - "In psychology we say that it is good for there to be some time…for one to be older, the other younger…one child shows the other the way."

However, despite the initial apparent distinction between the terms in one group, in the end, it became clear that the women in both groups did not really recognize a distinction between family planning and birth control, that both terms defined the concept of limiting and spacing childbirth.

c. There was general consensus among the women that they were comfortable talking about family planning and some sense that beyond that, it is important to think and talk about it.
   - "We talk about it easily."
   - "It's something that is important to think about, that must be thought about."
   - "If we were embarrassed, we wouldn't be here."

Family planning in Pakistan and in the Pakistani community in New York

a. There are family planning information and services available in Pakistan and, in general, people are becoming more aware of and supportive of family planning.
   - "There is a lot for them [those who want to use family planning]."
   - "In villages where there are women who don't know [about family planning], there are social workers who go and tell them these things."
   - "Women there are getting the 'sense' that this family planning is good, it's right…there is a benefit for women…their health will remain, there will be a gap, it will be good for the children."

   However, there are still those, particularly among the older generations, who disagree, and this is often related to their interpretation of religious strictures. Furthermore, these are often influential people.
   - "They agree [with family planning], but for every 100 people there are two that don't agree."
   - "They don't want this, they say this is not allowed in our religion."
   - "The elders probably think it's bad, that family planning shouldn't be done…the way it is [right now] is good."
   - "The young people have to listen to the elders."

b. Knowledge about and acceptance of family planning in Pakistan vary based on where people live and how much education they have had. As is often the case then, although family planning is becoming more available in Pakistan, those who live outside the larger cities and those who are less educated are slower to adopt family planning.
   - "There is not much 'sense' [awareness] in villages."
   - "Those who are educated don't do this [think family planning is bad]."
   - "Those who are educated don't think this way; they say they will have only as many kids as they [their health] can handle."

c. Access to health care and family planning is better in the United States than in Pakistan. This is at least in part due to the locations of health centers in towns, not villages or the countryside. Cost and quality of care are issues as well. Private clinics may offer a higher standard of care, but their high costs put them out of reach for many people, who must then rely on poorly run public clinics. In addition, information is available more readily and in greater volumes in the U.S.

- "There is more care here. Things are explained. Things are explained over there too, but not as *much* as here."
- "People don't know that much about things over there. There *are* health centers, but they are in town."
- "People don't go to health centers over there."
- "There aren't as good medicines in Pakistan."
- "Private clinics are good, but only if you have money."
- "Government clinics are not good."

d. The motivation to use family planning is greater in the United States. Pakistani women in the U.S. lack the extended family support system that is available to them in Pakistan, where many family members help with childrearing. Because Pakistani women in the U.S. must bear much of the responsibility for child care themselves—and particularly for those who work this may be difficult—they may be more likely to want to limit their family size and thus, to see the benefits of family planning.
   - "There [in Pakistan] there is a family system that is not here."
   - "Here women are alone; it's harder to take care of a child. In Pakistan, there is the joint family…everyone helps out…you don't know who has had [given birth to] the child and who is raising the child."
   - "There you don't think about it…who will watch the child…but here you have to think about it."
   - "Who will take care of the child for those who have to work, to do a job?"
   - "There [in Pakistan], there is the grandmother…everyone…[here] the mother has to do it herself."

Family planning decision making among Pakistani participants

The influences on deciding whether to practice family planning and on deciding what contraceptive method to use are not that different. The strongest influence on decisions is the husband. In fact, these women hardly entertained the possibility of using contraception without his approval. However, other influences may feed into that discussion with the husband and the ensuing decision. Among these other influences, even method attributes, which would more naturally affect choice method, appear to play a role in the adoption of family planning.

a. For some of these women, the practice of, or at least the consideration of, family planning seems to be almost a given. This may help explain why the decision to practice family planning and the decision about what method to use tend to blend together. These women expressed the assumption that when sexually active, one would begin to think about family planning and would decide to use contraception when one did not want to have a child.
   - "You would decide that depending on whether or not you are having sex."
   - "This will happen when you think you shouldn't have a child."

b. The husband is by far the most important influence on a woman's decision. She may bring to the discussion information that she obtained elsewhere, but at root, the final decision is his.
   - "We listen to the husband the most."
   - "Whatever he says is what happens."

- "Everything will happen according our husband's opinion."

Using contraception without the husband's knowledge is not an option.

- "If we do, our home (household) would be ruined."
- "If he doesn't want it, what can you do?"

However, that said, many of the women agreed that family planning concerns the *couple* and, as such, is a matter for both husband and wife to discuss.

- "It's between the husband and wife."
- "The big decisions are made with the husband."
- "We will have a meeting—the two of us."

One woman even suggested that women should stand up for themselves and their desire to limit childbearing if out of accordance with their husbands. However, others immediately disputed that this would happen, noting that although the final decision belongs to the husband, disagreement is rare because the wife follows his opinion and he generally wants what is best for his wife.

- "If the wife wants it, but the husband wants to have more kids, the wife should do something…perhaps even put up a fight."
- "But this doesn't even happen."
- "This happens to a few [couples]…where there are misunderstandings…the husband wants what will benefit his wife."

In one of the groups, a couple of the participants expressed concern that Americans do not understand the Pakistani culture and the relationships within it between husband and wife. They believe that there is a large gap between the two cultures and fear that Americans will judge them based on that acceptance of their husbands' opinions and somehow use the information against them.

- "These questions you are asking to which we are giving answers, if any of that information gets out, then…who will be responsible?"
- "Like how we [Pakistani women] are more accepting of our men…these people don't…they don't believe [or accept]."
- "The people here…the white [American] people."
- "You ask us whose opinion matters…we think it is the husband's. If he doesn't want it, there is nothing we can do. This is what I am talking about. If this gets out, those people don't agree with this."

Still, although the decision about contraception may rest with the husband, the responsibility for the use of a contraceptive method still falls to the woman. And in this, they see less difference between the cultures.

- "Condoms…men never want to use these…so it's always up to the poor woman to do something. Here or in Pakistan—that is the same. Even women here [American women] are doing all this; men don't do birth control, women do."

c. Contraception before marriage is out of the question, mainly because sex before marriage is out of the question for these women. Even receiving information about family planning before marriage is questionable.

- "It's necessary to be married."
- "Without marriage, we cannot think about it."
- "After marriage."
- "It's embarrassing to talk about it before you are married."

d. Method attributes, particularly side effects, can play an important role in the decision. In one of the two groups this was one of the first things to come up once the topic of decision making was broached. It is a bit unclear whether the side effects are influencing the decision to use contraception or not, or perhaps, these women were starting with the assumption (as suggested in the first bullet point in this section) that family planning is beneficial and once sexually active, a couple is almost certainly going to practice it. This is belied somewhat by some of the comments about husbands preventing the practice of family planning. In the second group, side effects did not come up at all. In the group where it was discussed, there was concern about various side effects and the lack of methods without side effects and agreement that side effects could prevent one from using contraception. In addition, they expressed a desire for effective methods without side effects.
    - "They say they [birth control pills] cause depression; others say they lose their color or gain weight."
    - "Or IUDs, some women say their stomachs become bigger when they use these."
    - "The method that has no side effects, that is the one."
    - "Not 99%, but 100% [effective and lacking in side effects]."

e. Although religion does have a role in influencing opinions about family planning and how it might be practiced, it does not play as large a role as expected. The women acknowledged that they think and worry about the relationship between religion and family planning, but their belief that family planning, defined as spacing births, is not contrary to the tenets of Islam serves to reduce the effects of religion on deciding whether to use contraception. However, in this way, their religion can be considered to influence their choice of method, reducing the likelihood that they choose a permanent method, i.e., surgery.
    - "We are afraid of what Allah might think. When we think of family planning, we think, okay, let's do this, let's get an operation, so we don't have a child, this has become too much…If we talk to someone he (or she) says that this is not good for us…this is a crime…it's this, it's that…this makes us afraid…"
    - "We are influenced by religion for surgery."
    - Delaying children is okay [in Islam]…there should be a gap of three years, that is there…but totally stopping is not there…"

f. The extent to which other factors may influence decision making is unclear, though certainly no other factor seemed to be a strong influence. Health care providers (doctors/nurses) seem more a source of information about different methods than a source of influence over decisions. Some women cited the mother-in-law as a source of influence, but most maintained that family and friends have little influence on their decision to practice family planning. When choosing a method, some women turn to friends for advice or information, but again, the influence of friends is far outweighed by the influence of the husband.
    - "The mother-in-law is very powerful."
    - "This is something that is 'secret.' Not many people would tell their mother-in-laws."
    - "I am thinking about all this right now…and asking [a friend] what to do….Yes, I do ask her. But then I tell my husband what is good and bad and then what he says I do."

Several women mention television programs promoting family planning, but there was no real consensus that TV or radio has much influence, one participant noting that "we see and then forget." Similarly, although some women agreed that printed material can be important, there was little discussion of this as a strong influence, with some women clearly disputing that it has any influence: "we put papers in the garbage after leaving."

Need for information about family planning

a. The women in these groups were familiar with the array of methods available to them.

b. Although they recognized that information was available to them, they still found it lacking and expressed a desire for further information, particularly about methods.
   - "There is information, but not a lot."
   - "We should have more information."
   - "I think…[a method] that allows a two to four year gap between kids…if there is a method."
   - "If there is anything else [another method], tell us."

Focus Groups with Bangladeshi women

Two focus groups were held at the Astoria, Queens MIC Center with Bangladeshi women. The first group consisted of five women aged 20-35, all of whom were MIC patients. The second group consisted of eleven women, with ages from the 20s to the late 40s; most were MIC clients.

Summary of Findings

Attitudes and beliefs about family planning

a. The Bangladeshi participants seemed to associate family planning with population control, possibly due to the intensive family planning campaigns that have been carried out in Bangladesh. Thus, they felt that family planning meant "keeping the family small." For example:
   - "Too much population is not good."
   - "It's good to keep the family small for one's self and also for the country."

b. While some felt very comfortable talking about these topics, others were embarrassed.
   - "It does not feel good to me. I am shy."

Family planning in Bangladesh and in the Bangladeshi community in New York

The participants felt that the mentality toward family planning in the U.S. is different from that in Bangladesh.

a. According to the participants, family planning is a topic that causes laughter or embarrassment in Bangladesh. For the most part, older generations (such as the participants'

mothers) did not discuss, support, or practice family planning, but younger generations seem to be more interested in these "control processes." There were and still are many who believe in the following quote: "God gave children, so will he provide food."

b. Women of different classes and education levels act differently with regard to contraception. For example, participants stated that more educated women and women in the cities/towns are more likely to use birth control.
    - "Many more people are also educated. Every family has at least one or more people who are educated who understand the aim of the advertisement."

   For the average villager, however, contraception is financially unattainable, despite government outreach and marketing efforts. There was indication of some rather coercive methods, such as the provision of a monetary incentive or a free t-shirt for women who consent to undergo tubal ligation.

c. Bangladeshi immigrants in the U.S. are more motivated to limit childbearing than they are in their home country. Since the family structure they rely on in Bangladesh is absent here, there is no one to watch the children while they work. The participants felt that people in the U.S., including Bangladeshi immigrants living here, are more open about birth control. Everyone seems to want to follow "control processes," the hospitals and health care providers encourage small families, and there is financial assistance to use contraception. However, one participant who works as a social worker in New York pointed out that there are all sorts of people in the U.S., some of whom are comfortable with family planning and some of whom are not.

Family planning decision making among the Bangladeshi participants

a. The participants overwhelmingly agreed that their husbands played an important role in both deciding to practice family planning and choosing which method to use. They indicated that the decisions are made jointly with the husband.
    - "Because we live together with the husband, so of course he has to help first."
    - "First of all, the husband helps and then comes the medical centers."
    - "The husband mainly helps."

   However, when asked directly whether they would use a method without their husband's knowledge if it was against his wishes, they had conflicting replies.
    - "In general, we as Bangladeshi will not do anything without our husband's knowledge."
    - "I will take a decision without my husband's permission if I see that it is a benefit for my health."
    - "It's not that we can't go over our husbands' decisions. It is that the relation is between two people. So the decision has to come from both."
    - "I have seen many women whose decisions come from their husbands only." [social worker who works with this population]

b. The participants felt that a woman would not seek birth control without being married. According to them, there was no such thing as having relations with a man without being married.
    - "Before marriage nobody even knows about these things."
    - "We are Bengalis. We have to be married before we can think of birth control."
    - "As Muslims it is very important for us to be married."
    - "We don't have in our culture such things as having relations with men freely. After marriage the decision is on the husband; first having a baby and then birth control."
    - "Women most of the time don't even know about these things before marriage. They learn these things after marriage. This is also the religious way."

c. Family, and to a lesser extent friends, are also important influences. The women explained that when they are in Bangladesh, their in-laws and other relatives pressure them for large families or to keep trying until a son is born. In the U.S., the couple is more autonomous and less influenced by those around them, and the preference for a boy may not be as prevalent. Also, families back in Bangladesh may encourage the woman to limit childbearing because she is all alone in this country and will have sole responsibility for caring for the child. Friends, too, pass on advice about keeping the family small.
    - "Back home, sometimes couples have to make the father-in-laws or mother-in-laws happy, who wish to have a houseful of grandchildren."
    - "Also in our country a male child is a must in the family. So if there are two female children, then there has to be another attempt to have a male child. Here in this country, that idea is not pampered."

d. Participants had varying opinions about the influence of literature and media on both decisions. While some claimed to read on the subject, others stated that they did not read pamphlets or magazines. A few mentioned the influence of seeing small, seemingly happy families showcased on television. One participant had seen the contraceptive patch advertised on television. It is difficult to determine how much of an influence these media have, since they were mentioned only briefly.

e. There was also conflicting opinion on the influence of religion. One participant stated that birth control is not prohibited in Islam; others disagreed. The group concluded that there is a debate about religious permission to use contraception and that some people will base their decisions on their religious beliefs. In addition, some asserted that it is 'the religious way' to learn about family planning after marriage.
    - "Many people think that in our religion birth control is prohibited. That is not correct."
    - "In our religion, it is said that you can't control birth."
    - "Our religion says, one can control oneself, but can't have the pill or other things."
    - "Religion is not going to feed us."

f. While some women indicated that health care providers (doctors/nurses) encourage use of family planning, it seems from the comments, that hospital and clinic personnel play a larger

role in explaining method attributes, especially side effects, and helping the couple choose a method, once they have already decided to use contraception.

- "The husband and wife decide first and then go to the hospital. The nurse, the doctor help. They talk about all the side effects and then we make our decision."
- "Hospitals give the information and the decision is taken in the family."
- "Once one doctor told me that he is from Turkey. So he is also Muslim. I said to him that we don't have this birth control in my country (village). In my religion it is also not permitted. He talked to me about the importance of birth control."
- "'You are now 32 years old. You have five babies and so you have become old. If you had one or two babies, you would be young.'" [participant quoting a doctor]
- "Nurses always openly tell us about which method has what problem. Then we make our decision. The injection is not suggested now since my baby is young. Condoms are suggested for me and not the pill since I am breastfeeding."

In one group, there was a discussion of various attributes of the condom. A participant who worked in the field indicated that women prefer to use condoms because of fear of AIDS. Other women, however, claimed that condoms were uncomfortable. One participant was waiting to have an IUD inserted, and she was afraid she would get pregnant because her husband did not like using condoms.

- "I don't feel easy with the condom."

Need for information about family planning

While the participants listed most of the modern contraceptive methods, they had questions about various method attributes (i.e., how long the IUD can stay in) and side effects. A few had not heard of the female condom even when mentioned. Some claimed that they had enough information, while others wanted more. They admitted that young people in U.S. schools learn a lot about these topics, while their generation did not receive this kind of education. The participants suggested future classes conducted in their language, and requested that the moderator answer their questions right there.

- "I use the condom and do not know anything else."

Common Themes and Notable Differences

Common Themes

Despite the apparent differences between the cultures of the four ethnic groups who participated in these focus groups, particularly those that exist between the Latin American and South Asian cultures, we uncovered a number of commonalities with respect to attitudes and decision making about family planning.

Most of the women, across cultures, exhibited and expressed a reasonable level of comfort with the topic of family planning. However, there were some notable exceptions—the group of women in Williamsburg, for example, where many of the women *looked* uncomfortable (though it is not possible to determine the cause of their discomfort), and participated reluctantly. It is possible that a few women expressed comfort and the rest did not feel comfortable enough to speak up and dispute that. On the whole, though, most of the groups had a high level of

participation, an indication of their lack of embarrassment talking about the topic, at least among other women of their background. Even in the cases where women expressed some embarrassment about the topic, they clearly saw it as important and wanted to talk about it nonetheless.

Concerned that the women may be more familiar or comfortable with one term over another, we asked the women to define both family planning and birth control. There were differences in expression, but limiting and spacing births were common meanings and while some women tended to think of birth control as the *means* of practicing family planning, most of these women made no real distinction between family planning and birth control. That said, both groups of Bangladeshi women and one of the Ecuadorian groups chose to continue the discussion using the term “birth control,” whereas the rest of the groups chose to use the term “family planning.”

The women may have noted varying degrees of information, access, and openness with respect to family planning in their countries of origin—and even variations within that country—but they all agreed that, in the U.S., there is more information about and discussion of contraception, as well as greater access to methods and services. The groups were generally aware of a range of methods available to them, but misinformation and uncertainty about some of the methods were also apparent. In addition, they all agreed that, although there may be more information available in the U.S., they would like still more information, particularly about methods and side effects.

Some of the commonalities may have to do with their common status as immigrants to the United States and their experiences as immigrants in New York City. For example, these women are highly motivated to avoid pregnancy and limit childbearing. Many families have immigrated to the U.S. to work, earn money, and improve the lives of their children. Having many children makes this more difficult. It is expensive to raise children in New York (due to high costs of housing, childcare, clothing); additionally, these families do not have the same extended family support system in New York that they did in their home countries. While it is important to remember that most of these women are MIC clients, many of whom may have sought contraception, the impact that this high level of motivation to work, earn money and improve the lives of their children has on the decision to practice family planning should not be underestimated.

All in all, these women put the matter of family planning and contraceptive choices firmly within the purview of the couple—the husband and wife (in these groups, most were married and there was very little discussion of family planning outside of marriage). The different ethnic groups may bring information or advice from varying sources into the decision-making dyad and the partners may have varying degrees of influence within the dyad, but among all groups, decisions, ideally, rest with the couple.

Notable Differences

While these commonalities among the groups sketch a partial picture and provide information important to serving these women, it is also necessary to look at the points of divergence among these populations regarding family planning attitudes and decision making since these differences also provide insights into the best ways to serve these groups of women.

Although in all the groups, the final decision was perceived to lie with the couple, the respective roles of husband and wife within that relationship is one area where pronounced differences between the groups were discernible. The Pakistani and Bangladeshi women described a much stronger role for their husbands than did the Mexican and Ecuadorian women. Although the Mexican and Ecuadorian women preferred the involvement of their husbands in family planning decisions, they were willing to circumvent unsupportive husbands. By contrast, the Pakistani and Bangladeshi women seemed to assign to their husbands the role of primary decision-maker. This was especially true of the Pakistani women. For the Bangladeshi women, the husband was still a very powerful influence, probably the most important, but there was a stronger sense that the decision rested with the couple, rather than primarily the husband.

Perhaps as a result of the greater role of the husband, Pakistani and Bangladeshi women, particularly Pakistani women, seemed less influenced by other factors than were their Mexican and Ecuadorian counterparts. Whereas for all women, health care providers (doctors/nurses) were considered an important source of information about contraceptive methods, Mexican and Ecuadorian women expressed a great deal of trust in providers and, as such, their decision to practice family planning may be more likely to be influenced by providers.

Mexican and Ecuadorian women’s decisions to practice family planning may also be shaped by observing family and friends struggle with many children. Bangladeshi women, on the other hand, remarked on the impact of seeing friends and others around them happy and successful with small families. The Pakistani women seemed to be starting with the assumption that having a smaller family with larger spaces between births is beneficial to the health of the women and makes a higher standard of care possible for the children. It was unclear what shaped this opinion.

Given the importance of religion in these cultures-Catholicism in Mexico and Ecuador, Islam in Pakistan and Bangladesh-and the sometimes strong opinions on birth control expressed by religious leaders of these faiths, we expected that religion might be an important factor in family planning decision making. The reality is more complex. For most of these women, religion did not seem to inhibit their use of family planning, but for some it certainly flavored their thinking about family planning. In most of the groups, the discussion of the topic was limited and it is difficult to judge with certainty the women's feelings about the interplay of religion and family planning, though it ranged from being of very little import to the Ecuadorian women to being of considerable concern for the Pakistani women. Many across all the groups recognized that religion might influence some women's choices, even if not their own. However, the topic seemed to provoke the strongest emotion among the Pakistani women, some of whom confessed to feelings of guilt associated with using birth control, particularly permanent methods, against the perceived strictures of their religion.

One final difference, which has implications for the methods of transmitting information to women, was the enthusiasm expressed by the Mexican and Ecuadorian women for additional printed information in Spanish. On the whole, the Pakistani and Bangladeshi women were less enthused about the prospect of receiving information in this fashion; in fact, a number of them were dismissive of printed materials.

Implications

These findings bring to light a number of important points that have implications for the delivery of family planning services to Mexican, Ecuadorian, Pakistani, and Bangladeshi immigrant women in New York. These key points, to be discussed in this section, include the motivation to limit childbearing, the high level of interest in discussing and learning about family planning, the connectivity between deciding to practice family planning and choosing a method, the role of male partners, showing respect for cultural differences, sex outside of marriage, the role of religion as part of a cultural context, and immigration status.

Before discussing these implications, however, it is vital to note that there are some limitations to the interpretation of the findings of these focus groups. The first point is not so much a limitation as a characteristic of focus groups. These findings are based on the shared thoughts of a relatively small group of women and cannot be considered representative of a larger group. However, thoughts shared by one or two women can nevertheless provide insights that may be useful when planning services for that larger group of women. Although in the focus group format, precise calculations are not appropriate, we did attempt to get a sense of the level of agreement and importance attached to expressed ideas. This was rendered more difficult at times by the lack of a transcript. As such, the expressed extent of some of our interpretations should be viewed with caution. Furthermore, it is possible that some of the women may have been reluctant to speak freely: some had concerns about the audio-taping and some may have felt intimidated by more outspoken participants. As in most focus groups, not all women contributed equally; some were very quiet and others dominated. Finally, these groups were composed primarily of MIC clients, a self-selected group which may be predisposed to more positive attitudes about family planning.

Despite these limitations, this study produced some compelling findings. One key finding was that these populations of women are highly motivated to limit childbearing. The import of this cannot be underestimated when planning the delivery of quality family planning and contraceptive services to these populations. Some of the groundwork has already been laid; the audience is likely to be receptive. That said, it is important to remember, as noted above, that most of the women who participated in the focus groups are MIC clients (although some are prenatal patients rather than family planning clients) and they may be substantively different than other immigrant women from these cultures. For example, they were motivated enough to seek services and may be more motivated in other ways. However, their circumstances are likely to be similar to other immigrant women who may have similar desires to avoid pregnancy; outreach to these women could take advantage of this.

In addition to exhibiting a high level of motivation, these women expressed a real interest in discussing family planning and receiving further information, and it was evident that they trusted information coming from health care providers (doctors/nurses). It was also apparent that many women have received misinformation that needs to be countered. Information about methods available to them, including efficacy and especially side effects, would likely be well-received. Groups such as the ones we held—that is, in their native language with their peers, but *providing* information, may be an effective way to meet their needs. Other means of providing information

will need to be explored further; there was some evidence to suggest that the same methods may not work for all groups.

What did seem to be true of all groups was the blending of decision making about whether to practice family planning with the decision about what contraceptive method to use. Although we asked these questions separately, the responses tended to overlap and intertwine; they were clearly not distinct decisions to these women. Promotion of family planning services will need to take this into account and include information about method choices and method attributes, particularly side effects, which were of considerable concern to these women.

Furthermore, it is extremely important to involve and/or consider women's male partners in family planning activities. This involvement may take many forms. Although the current level of male involvement in family planning decision making varies across groups, all of the women clearly want their partners to be involved. This inclusion is likely to benefit all involved, improve contraceptive acceptance, and improve services. In some cases (e.g., the Pakistani population), it is necessary to involve the men and would be a disservice not to.

Related to the above point is the necessity of learning how to show respect for the culture and choices of these women, particularly the South Asian women who may choose to defer to their husbands as the primary decision-maker and spokesperson for the couple. In one of the Pakistani groups, the women expressed concern that providers try to impose "western" views on women's independence and marital relationships. If providers do not learn to work within the appropriate marital context, we may risk alienating these women and driving them away from services altogether.

In the South Asian groups, sex before or outside of marriage was considered unthinkable, obviating the need for family planning services for single women. However, based on anecdotal information from one of our moderators, the reality may be much more complex: a significant unmarried population in need of services may in fact exist. What is clear is that, whether or not women have sex outside of marriage, these women were not willing to talk about it. This means that attempting to promote or offer contraceptive services to unmarried women, especially in the Pakistani and Bangladeshi populations, will be difficult and require a great deal of finesse. Keeping in mind that these focus groups were composed of married women, not the ideal source for information on the needs of unmarried women (or adolescents), their views likely reflect the cultural context in which such services would need to be offered. While the Mexican and Ecuadorian women referred primarily to family planning decisions within the context of marriage, they were more open to the idea of premarital sex and allowed that it does happen. In order to understand the nuances, we need to do more research with a younger, unmarried population.

The cultural context within which these women operate is made up of a number of components, some of which were touched upon in the course of these group discussions. Religion, for example, can be an important part of a group's culture, and in some cases is so intertwined with culture as to make it difficult to disentangle the concepts. For example, as the note taker for the Pakistani groups observed, what the women think of as part of their religion, may not in fact be a tenet of Islam, but part of the cultural context in which Islam is practiced in their country.

Furthermore, while religion seemed to play a less direct role in decision making than we anticipated, it is part of the cultural context in which they are making their decisions and cannot be discounted altogether.

As it was only mentioned in one group, it is difficult to determine how much immigration status factors into the decision to seek care among these immigrant groups. Our past experience and literature provides evidence that this is indeed an issue. Since most of these women were already MIC clients, it is possible that they do not recall their early barriers to seeking care. In addition, we did not ask their immigration status, so the groups may have been made up of mostly legal immigrants (although a few women did mention that they are in the country illegally).

This study provides a glimpse of the richness and variety of the many cultures of the women served by MIC. One of the main things to remember when providing services to women of different cultures is to respect those cultures, and this includes respecting the decisions and the decision-making processes. While there are a number of commonalities here that can be used to direct services to all these groups of women, it is important not to gloss too quickly over the differences, even within the population of Latin American women or within the population of South Asian women. Only by understanding the subtle differences, can services be provided in a culturally competent manner that respects the cultures and choices of all our clients.

Recommendations

Education

- Increase education re: birth control methods among Latino and South Asian groups
- Explore the feasibility of providing education and information on contraceptive methods in smaller groups for Latino and South Asian patients
- Increase number of staff who speak South Asian languages
- Modify birth control education to be more specific re: side effects
- Recruit more Latino and South Asian clients to the Information and Education Committee and review birth control materials regularly with the committee
- Provide family planning and contraceptive education for males, especially for the South Asian populations
- Target enhanced outreach and education to those most recently arrived immigrant groups who are most at risk of lacking access to culturally competent reproductive health services

Service Delivery

- Increase providers' role in discussing the risks and benefits of all birth control methods with patients
- Further assess ways in which South Asian women would feel partner is "respected"
- Formalize procedure of inviting male partner of South Asian clients to participate in birth control discussion with provider and/or nurse
- Conduct cultural training workshops for staff, including providers. Stress the need to respect birth control choice and role of husband

Future Research

- Encourage a broader, more detailed research effort through a citywide collaboration of reproductive health providers who serve immigrants. Such research should be aimed at a further exploration of the factors that lead to women's contraceptive choices. Several points in particular suggest themselves for further research: the role of male partners (especially from the perspective of the men), and the attitudes of unmarried women, including adolescents, toward reproductive health care. Such a project should be designed to collect more detailed individual information that will allow a better understanding of the extent to which various factors influence different groups of women.

Appendix A

Focus Group Guide
(English Language Version)

English

Cultural Influences on Family Planning Choices
Focus Group Guide

Opening

Let's start by going around the room and introducing ourselves. Give your first name and how long you have lived in the U.S. I'll start…

Introductory

What do you think of when you hear the term family planning? What does family planning mean to you? What about the term birth control?

Before we go on, I want to define what *I* mean by family planning and birth control. Sometimes in this country, family planning and birth control are used to mean the same thing. As we talk here today, what I mean by "family planning" is planning when and if to have children. By "birth control" I mean preventing getting pregnant and having children. What we want to talk about for the rest of this discussion is delaying and preventing pregnancy. Just so that we are sure we are all talking about the same thing, I want to choose a term that means that for you. What term would you like to use? [moderator: reach a consensus with the group and insert that word into the brackets in the questions below.]

Transition

How do you feel about talking about [ ]?

PROBES: Is it difficult? Is it embarrassing?

Think about [ ] in [Mexico/Ecuador/Pakistan/Bangladesh].
What can you tell us about [ ] in [Mexico/Ecuador/Pakistan/Bangladesh]?

How do you think people feel about [ ] in [Mexico/Ecuador/Pakistan/Bangladesh]?

How is that different from how people you know in the [Mexican/Ecuadorian/Pakistani/Bangladeshi] community here in New York feel about [ ]?

Key

What if you were trying to decide whether or not to use a method to delay or prevent pregnancy, a method you would get from a clinic or a drug store. What kind of things would you think about? What or who would help you decide?

PROBES:

What about… whether you are married or not?
Your husband or partner…would his opinion make a difference?
Family… Would their opinion influence you? Who in particular?
Friends… Would their opinion influence you?
Whether you have been sexually active or not? Would you get a [ ] method before you have a partner or husband?

Religion…
Radio or TV…
Printed information (like in magazines or newspapers)
Your doctor or nurse
Does embarrassment about the topic effect your decision?
Do you feel that you have enough information about it?
What kinds of things would make you decide NOT to use [ ]?

Now let's talk about the actual methods to delay or prevent pregnancy. What are some methods that you know about?

Suppose you have decided to use a birth control method. How would you decide what method to use?

PROBES:
What about… your husband or partner…would his opinion make a difference? If he is opposed, would you choose one that you can use without him knowing?
family… Would their opinion influence you? Who in particular?
Friends… Would their opinion influence you?
Religion
Radio or TV
Printed information (like in magazines or newspapers)
Your doctor or nurse
Does embarrassment about the topic effect your decision?
Do you feel that you have enough information about it?

Ending

MIC wants to provide you with the best services possible. To conclude this discussion, I want to talk about what MIC could do to better provide [ ] services to you. Please share any ideas you have.

PROBES: For example, what might MIC do differently?
Does MIC provide you with all the methods you know about and want?
What would make your female friends and family more likely to come to MIC too?

Thank you for your participation.