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Hear Our Voices: Experiences of Family Planning Services by Tongan Women in South Auckland, New Zealand

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Abstract

Access to family planning services have been widely accepted worldwide as a basic human right. However, findings from a study that involved 12 Tongan females in South Auckland, New Zealand reported that Pacific women were less likely to use available family planning services due to cultural taboo and sensitive reasons. This becomes a breach of basic human rights especially as Pacific women (including Tongan) have one of the highest rates of unplanned pregnancy in New Zealand. The purpose of this article is to present the key findings from a study that was undertaken in 2015 as part of the primary author's Masters in Public Health degree from the University of Auckland. The key findings from the study indicated the complex and multifaceted barriers to accessing family planning due to cultural and social factors including embarrassment, stigma, taboo subjects, anga faka Tonga and inter-generational conflict. Differences in cultural views and expectations regarding pre-marital sex and abstinence between the West and anga faka Tonga points towards the need for improved awareness of family planning services irrespective of marital status. Improving communication between daughters and their mothers (or trusted female figures within the family) and providing culturally safe services were identified as key strategies to improving access to family planning services.

Keywords: Tongan women; Family planning; Fertility; Primary health care

Introduction

With a growing population and dwindle resources, unplanned pregnancy becomes an increasing global and national problem [1]. The high number of unplanned pregnancies that occur within two years of a previous birth can be averted with family planning. In the United States an estimated 3.2 million unplanned pregnancies have resulted in abortion [2]. However, there is a lack of equitable access to family planning services at a global and national level. It is estimated that over 200 million women worldwide who desire family planning lack access [3]. This indicates an unmet need that requires immediate attention at an international and national level.

The role of family planning thus becomes vital in the primary prevention of unplanned pregnancies and abortion [1]. Access to family planning services have been widely accepted as a basic human right [4]. Findings from the study by Paterson et al. (2004) [5] reported that Pacific women are less likely to access available contraceptive services. Family planning services are less accessible to Pacific women who want to space and limit their births. Factors that can reduce access include how services are delivered and provided and other social, cultural and economic factors [4-7].

Methodology

Two methodological approaches were used to inform the study, the Kakala framework [8] and the Constructivist

Grounded Theory (CGT) [9]. Regarding the later, CGT enables the creation of a theoretical perspective that is grounded in the data signifying the role of the researcher in its construction. The four elements of the CGT namely purposive sampling, initial coding, focus coding and theoretical saturation were used in the study [9]. The Kakala framework based on the metaphor of making a garland were premised on three main processes; toli- identifying and selecting the appropriate flowers (see study design, data collection), tui-weaving of flowers together in an aesthetically patterned fashion (see data analysis) and luva-the meaningful and purposeful gifting of the garland (dissemination). The research methodology and research design has been described elsewhere [10].

Ethical approval for the study was granted on November 2014 from the University of Auckland Human Participants Ethics Committee (UAHPEC).

Study Design

Toli (data collection)

Purposive sampling [11] was utilised in the study. The eligibility criteria determined that participants needed to be:

- Female
- Self-identified as Tongan
- Between 16-45 years old
- Reside in South Auckland
- New Zealand/Tongan born

Recruitment

A selective method of indirect snowball sampling [12] was used to recruit participants for the study. Details of the research were disseminated to numerous Tongan community groups to ensure that a diverse group of Tongan women were reached. Church groups were also consulted with, in which a few faifekau (church minister) wives agreed to participate in the study. These community groups also suggested potential eligible participants to participate in the study.

Face-to-face in-depth interviews were carried out over a three-week period. Before each interview commenced, the investigator verbally explained what the research was about to ensure participants understood the conditions of the study. A consent form was than given and signed at the commencement of the interviews.

Tui (Data Analysis)

The interviews were transcribed verbatim and were then loaded onto the Nvivo software programme which enabled for a more rapid analysis of the interviews. Data was analysed using three main processes in CGT, 1) initial coding, 2) focused coding and 3) theoretical coding [9]. During each coding phase constant-comparisons were made within the same data (interview transcript) and between different data. Details of the data analysis method have been published elsewhere [13]. Data collection (toli-to pick or collect data) and data analysis (tui-to weave or analyse) occurred simultaneously, meaning, as interviews were carried out, initial phases of data analysis was undertaken during the collection of data. The interviewer made sense of the interviews by making notes, also known as memo notes to make sense of the information that was shared by the women at the time of the interview. This initial form of data analysis is an important element unique to the CGT approach. In this essence toli and tui were not followed as a step by step process per se. Rather the process was executed in a cyclical manner that allowed 'going in and out' of each phase. This allowed for important themes to be extracted and probed in subsequent interviews. The identity of the women who took part in the study was kept confidential hence pseudonym was used.

Results

Demographics

Altogether there were 12 Tongan females who took part in the study. Half of the participants (6) were born in Tonga and the remaining half (6) were New Zealand-born. The majority of the women lived in high deprivation areas, mirroring the demographics of Pacific peoples living in New Zealand [14]. Participants attended different Christian denominations including Free Church of Tonga, Methodist, Presbyterian, Jehovah Witness and Latter-Day Saints. Of the women 7 were married and the remaining 4 were in a domestic relationship or single.

The main barriers to accessing family planning services that were discussed by the women were embarrassment, taboo, cultural conflict, belief systems, husbands' objection and perceived side effects. Also discussed were various strategies to improve access as perceived by the women who took part in the study?

Embarrassment

Feelings of embarrassment were the most common barrier discussed. The sense of embarrassment felt by the participants was often made in reference to sharing intimate details, self-consciousness of body image and the perceived stigma related to sexual activity and promiscuity. The latter was mostly described by females who were not married. As shared by Teisa:

"Having that shame does prevent you from accessing the service…they (Tongan people) perceive the service as a clinic

for woman who are either married or are sexually active (out-of-wedlock)" (Teisa).

Taboo

The conservative view held by most Tongan communities is the belief that young Tongan women should keep their virginity until they are married. This was a notion that was weaved throughout the discussions with the women. Conversations relating to sex or sexual health within the family unit (father, mother and children) was considered tapu or taboo and strictly forbidden. Similarly, any conversation that concerned contraception, dating and sex was considered taboo and inappropriate within the Tongan culture. Such conversation topics spoken within the family context was considered disrespectful, immature and naïve. As shared by the women:

"Talking about sex is something that you don't talk about. To be faka'apa'apa (respectful) you wouldn't talk about it especially if your father is present" (Teisa)

"My mom, even my aunties or cousins wouldn't talk to us about sex… it's too taboo. The subject was too sacred. If you go and ask about it (sex) they will think you're hoha'a mo manako tangata (naive and fond of boys)" (Hina)

Cultural Conflict

Discussions deemed cultural conflict between the conservative anga faka Tonga and the liberal West. Most of the discussions often referred to comparing life in Tonga to life in New Zealand. The example below was discussed by a married woman who talked about whether it was 'right' to use contraception due to the ethical and cultural conflict between the "Tongan way" and the "New Zealand (NZ) way". As stated by Mele:

"Because I've experienced both worlds, the NZ way and the Tongan way; there is a conflict between what to do and what is right…its almost considered taboo (prohibited) to use contraception (in Tonga). It's a struggle because you want to please both worlds. The last thing you want to do is to cause conflict in your family" (Mele)

In the case above there seemed to be a conflict between "what to do" and "what is right" with reference to the "New Zealand way" compared to the "Tongan way". The more liberal western view towards contraception by some women seems to be more open to the idea of contraception-use for both married and un-married women. Whereas for unmarried Tongan women contraception-use is usually frowned upon due to conflict with conservative ideals. Such conservative views were linked to some of the womens' religious beliefs.

Belief Systems

Some of the participants discussed the conflict between their decision to use contraception and their belief system that strictly negated contraception use. Their religious belief of controlling conception and birth was strongly communicated across by some of the participants. Likewise, the ethical issue of the right to preserve life was also discussed. Despite this there was some consensus on the purpose of contraception. As shared by the women:

"There was a conflict with my mom. She said you don't have a right to stop having kids! 'E ta'ofi faka e 'Otua pe ia (God will stop you from having kids). I thought to myself who am I to ta'ofi 'ae tapuaki (stop the blessing-the ability to have children) God has given me? But than a part of me thought: God won't want me to keep on having kids' knowing that I have birth complications [so I used contraception] it was a hard decision" (Hina)

"It's that question: are you playing God? Do I believe in contraception? It makes sense to use contraception to space out your pregnancies especially if you don't have the means to provide for them. God has given us, a sound mind to make sound decisions. But then sometimes I feel like I might be going against God…it depends on the situation" (Valu)

Husbands' Objection

Married women who took part in the study discussed the issue of consensus between themselves and their partner on the matter of contraception-use. A husbands' objection towards contraception-use was mainly due to wanting "to have more" children from their part alone. Consequently, one woman stated she had to hide her contraception-use from her husband. In this case, her husband wanted to have more children despite his awareness of birth complications if they were to have more children. The different preferences of childbearing and contraception-use between the spouses question the place of a woman's agency in a relationship and respecting a woman's choice to use contraception if and when she wants to. As told by Nima:

"It's a barrier because I have to hide my implant from him and if he finds out he will make me stop…He wants me to have more kids even though he knows I have complications during birth" (Nima)

Perceived Side Effects

The perceived side effects of contraception such as weight gain and skin pigmentation was also discussed as a barrier to using contraption. Some participants identified that the perceived side effects could also be a barrier to

accessing the service. As shared by Fifita:

"The side effects such as getting fat or getting dark (skin) create that fear and stop women from using contraception" (Fifita)

Strategies to Improve Access

Many of the women stated the need for improved awareness of family planning services. The women suggested different avenues of how to raise awareness ranging from incorporating churches, schools, culturally safe service provision and raising children well.

Church Setting

Participants stated that the church will provide an effective avenue to 'catch' a lot of Tongan people. As discussed by Mele:

"The church is good because that's where you can catch a lot of Tongan people and the youth as well. It's very important, whether it's going to church and putting aside females and their mothers aside for a session…its culturally sensitive" (Mele)

Earlier Education within School Curriculum

Some participants identified the need to initiate education about family planning at an earlier stage within the school curriculum. This was specified to be initiated within intermediate rather than high school. This was also discussed in the form of educating parents and other education institutions about the different contraceptive methods available. As discussed by Tina:

"It's more than just education to prevent unwanted pregnancies it's also preventing abortions and leaving school early. In this generation, intermediate is the best stage to introduce contraception" (Tina)

Another participant also described how the family planning message ought to be framed in order to have buy-in from parents and school staff. As stated by Teisa:

"Overall it's how the message is framed and delivered that's important. To educate school staff and parents so they understand and become more accepting of the importance of family planning. And to co-create the curriculum with the parents and have them on board from the beginning-in the planning stage" (Teisa)

Improved communication with daughters: A few of the participants identified the importance of talking to their daughter(s) about sexual relationships or sexual issues. Having the ability to share with family members intimate personal details was seen as a way to help reduce any uncertainties they may have about their daughter(s). This was discussed as a learning curve to pass on to their children. As shared by the women:

"I would definitely go about this differently with my daughter or anyone close to me, and what best person to hear from than your mother. The best people to get advice or insight are your parents…if I have a daughter; I would want to tell her to know what I went through" (Mele)

"I don't want to keep information about sexual relationships from my daughter because I wouldn't want her to get information else-where, I want to be the one to tell her" (Hina)

Culturally safe service provision: The second most discussed improvement strategy was linked to the provision of health care providers (HCPs) within the family planning clinic. Participants discussed the importance of having culturally appropriate HCPs who acknowledge the cultural differences between Tongan and non-Tongan women. Also described were ethnic specific (and non-ethnic specific) HCPs that will be beneficial for different groups of people. For example, ethnic-specific HCPs were seen as favourable for elderly women with limited English language, whereas mainstream HCPs were more favourable for teenagers and women who felt less comfortable with ethnic specific HCPs. One woman in particular stated she preferred a "New Zealand-born Tongan" nurse compared to a Tongan born nurse, due to perceived trust, confidentiality and respected privacy. As shared by Nima:

"It depends, if she is a NZ Tongan it will be alright. And not from my church…that's something that can stop me from accessing because I have to be able to trust them to keep my privacy" (Nima)

Other participants implied the need for mainstream HCPs to be culturally appropriate. Being culturally appropriate was referred to being aware of the issues and struggles Tongan females face and understanding the associated stigma. As discussed by the women:

"Mainstream HCPs need to be aware of the stigma that's involved (pre-marital sex) and the struggles Tongan females may have because of the stigma…to understand where you're coming from so that they're aware of the issues" (Valu)

"We need more HCPs learning how to speak a different language, even if it's just a little bit...that will make a big difference for our people, it makes them happier. They will feel that you want them to be there and make them come back"

(Nima)

Furthermore, stigma experienced within the healthcare setting was expressed as an important matter to prevent within the family planning clinic. Perceived and experienced discrimination within family planning services was strongly viewed as a barrier in accessing the service. As discussed by Tina:

"With past experience going to the doctors I don't like it when they judge me or force me to take some form of contraception. Health providers should just consult and give me advice but not attack me for not doing this and that because you're this and that. This should not happen in a family planning clinic!" (Tina)

Raising children well: How a child is raised was viewed as an important aspect of children making the 'right choices' later in life. Raising children in a Godly manner and being more open minded (towards the issues of teenage pregnancy) were a couple of examples of how to raise children well were deemed important to reduce unwanted pregnancy among children. For example, as shared by Valu:

"If you raise your kids in Gods way to pray and do the right thing then they will turn out right. But that depends on the child to make those decisions. If they have good values to start with than that will teach them to try and make the right choices. If there are too many gaps in their life, then they are more likely to go off their own way" (Valu)

Discussion

The findings associated with embarrassment in the study is supported with findings from Tonga that reported the stigma and embarrassment associated with accessing services among women, in particular unmarried women [15]. The fakama associated with pregnancy out of wedlock or perceived promiscuity was a barrier in accessing family planning services. Tongan females who became pregnant out of wedlock were less likely to access family planning services in Tonga because of the associated stigma and embarrassment [15]. The Government of Tonga & UNICEF's [16] report states that there is reluctance among government facilities to provide contraception to unmarried youth in Tonga. The conservative attitudes held by the public health sector in Tonga make it difficult for youth to access family planning services when needed the most. The findings from this research indicated similar experiences and views held by Tongan women in New Zealand. Aspects of the anga faka Tonga which often dictates how Tongan females are ought to behave may have influenced such views.

According to anga faka Tonga Tongan females are expected to keep their virginity before marriage [7]. Like other studies the findings in this research indicated a double standard of how a Tongan female is stereotyped if she negates from the social norm [7]. Shame is brought upon a family if their daughter becomes pregnant prior to marriage and is referred by the family as finemotu'a vale or stupid old woman because she has put herself in that situation [7]. However, if a son has illegitimate children, he is not given the same ridicule, rather in a comical notion [7]. In this notion, it seems that unmarried Tongan females are highly valued for their purity and innocence where they are kept under great watch by their mothers to ensure their chastity is kept [6,7]. Associated with such views is the Christian belief of purity.

Keeping ones' virginity and abstinence can act as a protective factor against unwanted pregnancy among unmarried women. The unmarried women in the study expressed a preference to be married first. This provides an avenue for service providers to address the complex issues Tongan women face when deciding when to use contraception and hence access family planning. Such conservatives however can be diluted among Tongan born women who migrate and live in New Zealand for period of time. For example, inter-generational conflict between most migrant parents who uphold the anga faka Tonga and their children navigate between the West and the Tongan culture in New Zealand. As Tongan females lose the value of anga faka Tonga and adapt to the Western culture the increased likelihood for young Tongan females to engage in pre-marital sex is likely. Here, the need for improved access to family planning services becomes vital. Overall, the study recognises the importance of encouraging anga faka Tonga values within community health services and sex education in schools as a protective factor against unwanted or unplanned pregnancy.

Consequentially, health policy makers should be aware of the issues of cultural conflict between anga fakatonga and the West and how that can hinder access to family planning services among Tongan females. Creating culturally safe spaces [17] within the health care system is deemed important so Tongan females can navigate their cultural values and feel free to voice any issues within the health care system at all levels without feeling undermined by health care professionals. Creating a culturally safe space within the health care system usually requires health professionals to have undertaken a process of contemplation of how their own cultural identity informs their own biases and health practices and to have learned to practise in a way that asserts the culture of their clients and health professionals [17]. With a growing Tongan population in New Zealand, the number of Tongan females that will be exposed to sexual health decisions will increase and hence will require access to culturally safe family planning services. The participants in the study agreed that family planning services should be

made aware to all women irrespective of sexual activity or marital status.

The perceived side effects of contraception were also deemed a barrier. The provision of accurate information of the potential side effects of modern contraception methods is important to improve health literacy and informed decision making of its utilisation. This is supported by a similar study in Tonga that indicated the need for improved communication of the side effects of contraception methods [18].

Reproductive education has shown to improve abstinence rather than promote sexual activity [16]. However, within a Tongan home, conservative views inhibit any discussion related to sex and contraception. Consequentially, sexual health education within schools may be the only avenue in which young Tongan women are introduced to family planning and sexual health information. Some of the participants agreed that there was a need to introduce family planning earlier within the school curriculum, for example, as early as primary (year 6) or intermediate level (years 7 and 8).

However, even if reproductive education is implemented earlier within the curriculum, there is no guarantee that the quality of reproductive education programs will meet the diverse needs of Pacific students. The recent comprehensive approach to reproductive education requires evaluation to assess whether the strategies are carried out in practice. In the past, reproductive education programs in schools appeared to be passive in their approach in meeting the demands of Pacific students. Based on the findings from the study, the incorporation of anga fakatonga values within the sexual health curriculum may strengthen cultural values to prevent unwanted pregnancy. This was strongly supported by literature that indicates the success of incorporating indigenous values within health initiatives. Not only may this help improve safe sexual and reproductive decisions among Tongan youth but may also encourage students to learn more about their culture and have a secure cultural identity, which is deemed important for improved mental wellbeing. This proposed initiative is one avenue that can help prevent unwanted pregnancy among Tongan youth.

Findings that support the issue of poor awareness of family planning services was indicated by another study that was carried out with iTaukei women in New Zealand which found that the lack of awareness of family planning services was a key barrier to accessing and using family planning [19].

Most of the improvement strategies discussed was related to increasing awareness of the availability of family planning services. The most frequently discussed improvement strategy was to increase awareness within the church setting. Interestingly, this differs to the mentioned barriers related to cultural, taboo and religious beliefs that can pose as a barrier to providing family planning initiatives within a church setting. The participants acknowledged the challenges of implementing a family planning initiative within a church because of the taboo associated with discussions concerning sex and contraception and stigma attached to sexual activity and pregnancy out-of-wedlock. A critical question of how family planning initiatives can be best framed and adapted to be culturally appropriate for a church audience warrants further exploration. Past health promotion initiatives implemented within the church setting have been deemed successful [20,21]. The sheer number of people that can be reached within the church setting can be promising due to the majority of Pacific (including Tongan people) who live in Auckland and are affiliated with a religion or denomination of some sought [22]. Likewise, using the church setting will allow for the male counterparts to be aware of the benefits of family planning.

Strengths and Limitations

There have been seldom studies that investigate the perceptions of Tongan women (or men) towards family planning services in New Zealand. Therefore, the findings from the study provide new insight into an area for further exploration. The strengths of the study were related to the methodological underpinnings of the study and the research methods that were utilised to capture the views of Tongan women. The two methodological approaches that informed the method of enquiry, the Constructivist grounded theory and Kakala framework added depth to the research and the reassurance of the findings to be representative of the views of the participants who took part in the study. The use of in-depth interviews enabled the collection of rich and in-depth information from the participants. Overall research processes including interviews and data analysis were executed in a culturally appropriate manner to ensure non-discriminatory framing or victim-blaming.

Although the study had some unique findings and understandings in the realm of fertility and family planning among Tongan females, this research is without its limitations. While the study was premised on the perspectives of 12 Tongan women who lived in South Auckland, the findings may not be generalizable for all Tongan in New Zealand or for Pacific women more broadly. However, in-depth information of the barriers towards accessing family planning services among Tongan women living in South Auckland were shared that may be similar for other Pacific women who experience similar barriers. Further, although the interviews were conducted in both the English and Tongan language, interviews that were translated into

English for the purpose of analysis may have resulted in a loss of cultural understanding because of the English terms used in translation. Furthermore, this study was limited to the voices of Tongan females; their male counterparts were not included in this study. Future research could explore the perspectives of both sexes using culturally appropriate data collection methods due to the sensitivity of the topic.

Recommendations

The following points provide key strategies that target both a health systems and community approach to help improve access to family planning services and reduce unwanted and unplanned pregnancy among Tongan women in New Zealand.

- Develop policies that address discrimination within the health care system and socio-cultural issues (such as embarrassment) that prevent Tongan women from accessing family planning services.
- Promote the creation of culturally safe spaces within health care setting and the Tongan community to enable reproductive and sexual health topics to be discussed more openly and culturally appropriate.
- Utilise anga faka Tonga protocols to inform culturally safe initiatives that address the issue of teenage pregnancy, unwanted and unplanned pregnancy within a Tongan community or church setting.
- Incorporate culturally appropriate knowledge and protocols within family planning services and education institutions. For example, the importance of abstinence and virginity within the anga faka Tonga context.
- Reorient services to improve the provision of reproductive healthcare services with clear accountability lines between institutions and service providers in order to provide culturally safe quality services for Tongan women in New Zealand.

Conclusion

This article explored the barriers experienced by Tongan women aged 16 years to 45 years, regarding family planning and fertility in South Auckland, New Zealand. The main barriers identified included embarrassment, taboo, cultural conflict, beliefs systems, husband's objection and perceived side effects. Such barriers prevented contraception-use and access family planning services among Tongan women. The main strategies to improve access as perceived by the women in the study included improving awareness of family planning, increase communication between family members, between mothers and their daughters, improve intergenerational understanding of both cultures the anga faka Tonga and West, raising children well through God and provide culturally safe services that are non-discriminatory. Lastly, initiatives that de-stigmatise the notion of 'who' could access family planning services among the Tongan community was perceived as useful to prevent unplanned and unwanted pregnancy among Tongan women in New Zealand.

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