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Healthcare providers' perceptions of the challenges and opportunities to engage Chinese migrant women in contraceptive counselling: a qualitative interview study

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Abstract. ***Background*:** In Australia, there are many culturally and linguistically diverse communities and Chinese migrants make up one of the largest. Yet, little is known about healthcare providers' (HCPs) unique experiences in providing contraceptive care for Chinese migrant women. There is minimal research into the HCPs' perceptions of challenges or opportunities in engaging Chinese migrant women in informed and shared decision-making processes during contraceptive counselling. The aim of this study is to explore HCPs' experiences of providing contraceptive care for Chinese migrant women, their perceptions of women's care needs when choosing contraceptive methods, as well as their own needs in supporting women's decision-making. ***Methods*:** Semi-structured interviews were conducted with 20 HCPs in Sydney, Australia who had substantial experience in providing contraceptive services to Chinese women who were recent migrants. Transcribed audio-recorded data were analysed using thematic analysis. ***Results*:** Four main themes were identified, including: 'Are you using contraception?': the case for being proactive and opportunistic; 'Getting the message across': barriers to communication; 'Hormones are unnatural?': women favouring non-hormonal methods; and 'Word of mouth': social influence on contraceptive method choice. ***Conclusions*:** In order to facilitate informed choice and shared decision-making with Chinese migrant women during contraceptive counselling, broader health system and community-level strategies are needed. Such strategies could include improving HCPs' cultural competency in assessing and communicating women's contraceptive needs; providing professional interpreting services and translated materials; and improving women's health literacy, including their contraceptive knowledge and health system awareness.

Additional keywords: contraception, migrant and mobile populations.

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Introduction

Australia has a large migrant population and is home to many culturally and linguistically diverse (CALD) communities. Over one-quarter of the Australian population are born overseas, and another quarter have at least one parent who was born overseas.[1] Nearly one in five residents in Australia speak a language other than English at home.[1] Ethnic Chinese people are the second largest overseas-born group in Australia, making up over 2.2% of the total Australian population.[2] Despite being one of the largest migrant groups, Chinese

residents and their sexual and reproductive health (SRH) needs are understudied. Although Chinese participants were included in some studies that explored migrant and refugee women's SRH needs,[3–9] with the exception of a recent survey study conducted among Chinese-speaking international students,[9] their accounts were often subsumed within homogenous, collective patterns in CALD women's unmet needs.

Empirically, much of the research into migrant and refugee women's SRH needs explored women's perspectives on difficulties and barriers and made recommendations for healthcare providers (HCPs) to respond to such needs accordingly.[10,11] Findings from such research often point to complex language, social, cultural, religious and system barriers that women face in accessing and utilising SRH services.[3,4,11–13] Only few studies in Australia had specifically looked at the challenges that HCPs themselves encounter when engaging with migrant and refugee women.[10,14–16] For example, in one study, HCPs reported lack of SRH knowledge among migrant and refugee women, which required prolonged and repeated consultations.[10] HCPs also reported challenges in assessing migrant and refugee women's contraceptive needs, especially when their husbands were present, as they felt women were not able to freely discuss their needs and preferences.[10] However, it is unknown whether such findings are equally transferrable across different heterogenous cultural groups, including Chinese migrants.

Sexual and reproductive health knowledge, behaviours and health-seeking experiences among migrants and refugees can be influenced by experiences in their country of origin.[10] In China, the traditional sexual norms are deeply influenced by the Confucian concepts and these maintain that the purpose of sex is to procreate within a married relationship rather than to seek 'pleasure'.[17] However, gradual changes are occurring in China and sex is less likely to be confined to within a marriage.[17] Also, Chinese migrants in Western countries tend to experience greater sexual freedom due to having a greater sense of autonomy and privacy.[17–19] One recent Australian study found that Chinese-speaking international students mostly held liberal attitudes towards sex.[9] More than half reported having had experienced at least one form of sexual behaviour (i.e. genital touching, oral, vaginal or anal sex) and over 80% perceived premarital sex or cohabitation to be acceptable.[9] However, one-third of students reported not receiving any sex education when in China and only 10% of them had ever discussed SRH or contraception with a HCP in Australia.[9] Taken together, Chinese migrants, especially the younger generation, may tend to have liberal attitudes to sex compared with some other CALD groups.[9,13,20] However, their lack of SRH knowledge and limited familiarity with the health system may still pose challenges to addressing their unmet needs.[7,9]

Choosing a method among available contraceptives is a complex process for women and men, which is influenced by many intersecting biological, psychological, cultural and social factors.[21,22] For HCPs, the best practice for contraceptive counselling advocates for patient-centredness and informed and shared decision-making (SDM) in assisting patients to choose medically safe methods that are aligned with their preferences, values and goals.[23] Recent research shows that women who reported SDM during their consultations are more likely to be satisfied with their chosen contraceptive methods than those who made autonomous decisions or those whose healthcare practitioners directed a preferred method.[24] Research also shows that SDM is likely to help reduce health inequality experienced by socially disadvantaged groups, such as ethnic minorities and people with low health literacy.[25] Yet, it can be challenging for HCPs to adhere to a SDM approach, with time pressures, personal bias or preference for certain methods, established directive counselling styles and the intimate and sensitive nature of contraception-related topics being cited as common reasons.[26] Although SDM during medical encounters is becoming more established in policy and practice in Australia, there is a need to explore the challenges and opportunities to implement SDM with vulnerable population groups, including migrants and refugess.[27]

In Australia, there are many culturally and linguistically diverse communities and Chinese migrants make up one of the largest. Yet, little is known about HCPs' unique experiences in providing contraceptive care for Chinese migrant women. There is a lack of research into the challenges or opportunities that HCPs face in engaging Chinese migrant women in informed choice and SDM processes during contraceptive counselling. Understanding HCPs' perspectives, alongside Chinese migrant women's own perspectives on contraceptive care experiences and challenges, is likely to help address women's unique needs in choosing contraceptive methods. Therefore, in this study, we sought to explore HCPs' experiences with providing contraceptive services to Chinese migrant women, their perceptions of Chinese migrant women's information, communication and support needs, as well their own needs in supporting Chinese women's decision-making.

Methods

This study was part of a larger project that aimed to adapt decision-support strategies and tools in contraceptive decision-making for Chinese migrant women. As part of the project, both the Chinese migrant women (reported elsewhere) and HCPs were interviewed. The Australian Bureau of Statistics defines a 'migrant' as a 'person who was born overseas whose usual residence is Australia'.[28] The term 'Chinese migrant women' has been used to label the patient population of interest, which are Chinese women who were born in Asian countries and had been living in Australia as either temporary or permanent residents for no more than 10 years.

Theoretical framework

The design of this study was informed by the Ottawa Decision Support Framework (ODSF), which has been predominately used to guide the development of SDM interventions and tools.[29–31] There are three key steps in the ODSF: assessing the decisional needs; providing decision support; and evaluating the decision quality.[29] Decisional needs assessment aims to determine the needs of both the patients and HCPs in collaboratively making healthcare decisions that

are informed, values-based and most likely to be acted upon.[29] For this study, the research questions, the initial interview guide and codes generated from the deductive analysis of data closely reflect the key domains of the decisional needs, as outlined in the ODSF.

Data collection

We used semi-structured in-depth interviews for data collection. We targeted our recruitment strategy towards HCPs whose usual workplaces were located in areas with a high density of Chinese migrant population and who self-identify as having substantial experiences in providing contraceptive services to Chinese migrant women. We sent invitation emails, with details about the nature of the study, to potential participants through professional networks of the research team, a state-wide, non-profit network of family planning clinics and a private SRH clinic in metropolitan Sydney. We posted a recruitment advertisement on the website of a local primary healthcare network, which covers suburbs with large Chinese population. We provided HCPs who contacted the research team expressing their interest in the study with participant information statements and consent forms. If they confirmed to proceed, we agreed on a mutually suitable time and venue (if face-to-face) for interviews. We obtained written consent forms from all participants. HD conducted all interviews in English from July 2018 to December 2018. In accordance with the conditions of the state-wide, non-profit network of family planning clinics, HCP participants recruited from that organisation received no reimbursement for their participation. Other participants received A$120 for their time and participation.

Two research topics were explored during the same interviews. During the first part of the interviews, HCPs were interviewed about their perceptions of Chinese migrant women's knowledge, values, decisional conflict and support needs in terms of choosing contraceptive methods and their own needs in supporting them. The interview guide was adapted from the ODSF workbook[29] and was modified iteratively throughout the data collection period (File S1, available as Supplementary Material to this paper). For second part of the interviews, HCPs were shown an eight-page contraceptive-choice decision aid package and were asked about their perceptions of it. For this paper, we analysed and presented data from the first part of the interviews only.

Data analysis

All interviews were audio-recorded with consent from the participants. A professional transcription company transcribed the audio-recordings verbatim and HD checked them for accuracy. A six-step thematic analysis method proposed by Braun and Clarke was followed.[32] First, HD read all the transcripts while other authors read different subsets of transcripts each to familiarise themselves with the data. Second, HD coded all transcripts using Nvivo 12 software (version 12.6.0, QSR International Pty Ltd, Melbourne, Vic., Australia), while others coded or searched for key themes in participant accounts in given transcripts. We coded data at the semantic level, where codes and themes reflect the explicit surface meaning of participant narratives, rather than capturing the deeper level of underlying assumptions or structures.[32] We coded data deductively when the explicit meaning of the text segments in the transcripts were mapped onto the key domains of the ODSF. We coded data inductively when explicit meaning reflected new and interesting perspectives, for which the domains for the ODSF were too broad or insufficient to capture the essence of. Third, codes were clustered and collated in an iterative manner to identify patterns and initial themes. Fourth, a team meeting was held where members reviewed initial themes and checked that the candidate themes reflected useful and important aspects of the research topic. A thematic map was used for exploring the relationships and distinctions between themes (Fig. 1). Fifth, names, focus and scopes of each candidate themes were refined. Sixth, themes were presented along with selected supporting data.

Ethical approval and consent to participate

Ethics approvals were obtained from the University of Sydney human research ethics committee (ref: 2018/159) and Family Planning NSW Project Ethical Risk Team (PERT) (ref: PERT 25). All participants read the participant information statement and consented to participate. Participants were informed within the participant information sheet that the data collected during the interviews would be published. They then signed a consent form indicating that they had read the information sheet and that they understood 'it will not be possible to identify me from any publications'.

Results

A total of 20 HCPs took part in the interviews. Among them, there were 10 general practitioners, six specialised SRH doctors, one gynaecologist and three specialised SRH nurses. All, but two, participants were female. Seven HCPs spoke both English and Chinese. Interviews lasted from 21 min to 64 min. Most interviews were conducted face-to-face, with only two completed over the phone. The phone interviews lasted for 30 min and 59 min each, and both were comparable to the face-to-face interviews in terms of length and richness of data. The HCPs estimated the proportion of their patients from Chinese backgrounds and this ranged from 5% to 95%. Five broad themes were identified based on the responses of HCPs.

Theme 1. 'Are you using contraception?': the case for being proactive and opportunistic

This theme describes circumstances in which contraception was discussed during the healthcare encounters with Chinese migrant women. There were some differences between the experiences of HCPs working in general practice settings and specialised SRH clinics. The recurrent theme in general practitioners' (GPs) accounts was that it was uncommon for Chinese migrant women to specifically attend for

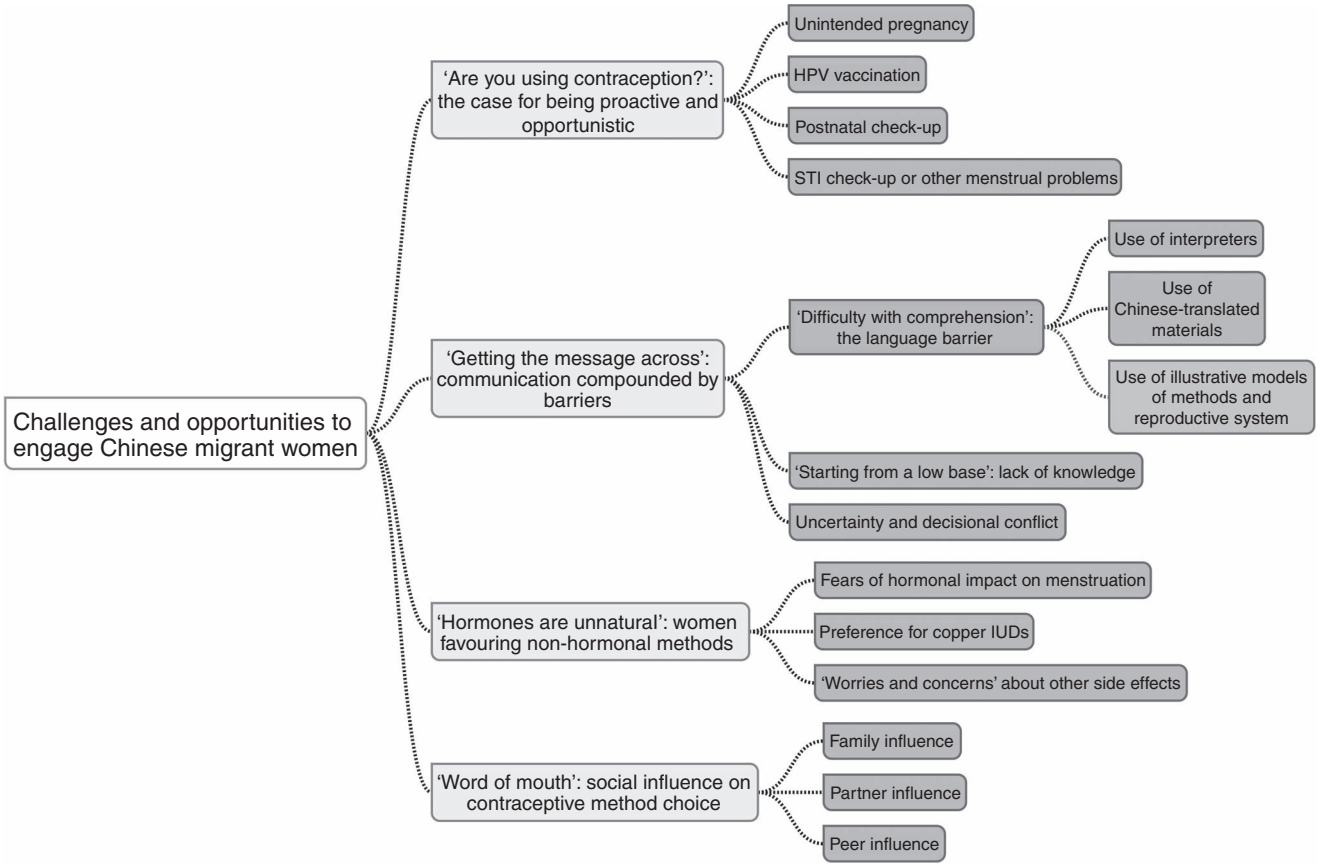

Fig. 1. A thematic map exploring the relationships and distinctions between themes.

contraceptive advice and the contraceptive counselling was often opportunistic. Discussion about contraception was usually initiated or prompted by HCPs after women presented for reasons such as human papillomavirus (HPV) vaccination, sexually transmissible infection check-ups, menstrual abnormalities, postnatal routine visits or after an unintended pregnancy. As one bilingual GP described:

> '*I think presenting – actively asking for contraception is very uncommon. Doesn't mean I don't discuss it, but they coming in to ask about it is I think hardly ever in the immigrant Chinese female... I guess we talk about it at the postnatal check. I try to... they come in with problems with their period or anything like that, anything to do with genital urinary tract stuff. One of the questions I'll ask is, 'Are you sexually active? Are you using contraception?' So, I'll bring it up then.*' (Participant 16, female, GP, bilingual)

In general practice settings within close proximity to educational institutions, one of the common occasions when contraception was raised was when Chinese international students specifically came in asking for HPV vaccines. HCPs perceived that there was an increased uptake of HPV vaccines among Chinese students, possibly due to such vaccines not being available in China. For them, such encounters often created opportunities for assessing students' contraceptive needs. As one GP put it:

> '*...every consultation for the HPV vaccine, we talk about contraceptive, sexual health, those kinds of things. So, we establish if they're sexually active or not, what kind of contraceptive they're using, and give them other options about contraceptives as well.*' (Participant 3, female, GP)

Unlike GPs, for specialised SRH providers, '*contraception was covered in some form or another*' for most of their consultations. However, they considered the main reasons for presentation for Chinese women was for intrauterine device (IUD) fitting or removal, cervical cancer screening or unintended pregnancies. On those occasions, discussion about a range of contraceptive methods were often brought into discussion or a follow-up consultation was made specifically for contraception or alternative methods.

There was a common concern among both the GPs and specialised SRH providers that young Chinese international students can be especially vulnerable to unintended pregnancies due to their lack of SRH knowledge and lack of support around them. They felt that often the first time contraception was

brought up was when women visit them after having concerns about pregnancy following an unprotected sex or when they had experienced an unintended pregnancy. Such situations were considered consistent with unmet contraceptive needs and an important time to provide contraceptive counselling. As one specialised SRH provider explained:

> '*There's definitely a lot of unplanned pregnancies and I really make a point of trying to sort of counsel them as much about contraception as I can because that's a really good time to intervene, because they've had a failure of contraception essentially*.' (Participant 19, female, specialised SRH provider, bilingual)

Although HCPs' accounts indicated that they proactively took opportunities to counsel women about contraception, engaging them in such conversations was not without challenges. Some HCPs felt that some women may not feel ready to talk about contraception when they raise the topic and there can be a level of discomfort talking about sex-related topics. They further explained a view that those who are older or recently arrived in Australia can be especially '*shy*' or '*not very prepared*' to talk about sex-related topics. Regardless, HCPs described that they often provide some information on contraception and risks of unprotected sex and '*opportunistically try to get them think about it a bit more*'.

> '*I usually ask them about it. They're not always ready to talk about it in the same consultation. We always try to give them information, let them go away and think about it and get them to come back*.' (Participant 14, female, GP, bilingual)

Overall, the experiences of HCPs in providing contraceptive care for women were characterised as being '*opportunistic*' and '*proactive*', in that they provided information either verbally or in printed format for women whenever there was an opportunity to do so.

Theme 2. 'Getting the message across': communication compounded by barriers

This theme describes HCPs' perceived barriers to effective communication with Chinese migrant women during clinical encounters.

Sub-theme 2.1. 'Difficulty with comprehension': the language barrier

Language was one of the most frequently mentioned barriers to communication by both the bilingual and English-speaking-only HCPs. Bilingual HCPs often felt the linguistic challenges when communicating sexual health-related concepts with women in spoken Chinese, due to their own limited Chinese-language skills and unfamiliarity with Chinese equivalent expressions of SRH and contraception. Whereas, for English-speaking-only HCPs as well as some bilingual HCPs, the language barrier was perceived to be dependent on the women's level of English proficiency.

> '*I think there definitely is some difficulty with comprehension. And I guess part of it is also because I'm doing a consult in Chinese, and obviously, I've done all my medical education in English. So, there is a – especially for sexual health, there's a little bit of a difficulty in me communicating certain things to them*.' (Participant 19, female, GP, bilingual)

When the consultation was likely to be impeded by a language barrier, both English-speaking-only and bilingual HCPs described turning to face-to-face or phone interpreting services to '*getting the message across*'. However, some HCPs were concerned about the accuracy and completeness of the translation and felt sometimes information was lost in translation or they were excluded from the conversations between the patients and interpreters. The flow of the conversation felt not as smooth. Time was also a concern to some, where longer or multiple consultations were necessary in order not to '*rush through*' the consultations.

> '*Sometimes I say something very simple and it ends up being this long, sort of almost a discussion between the interpreter and the patient that you miss out, and so, I'm not really sure exactly sometimes what's communicated*.' (Participant 10, female, specialised SRH provider)

Some specialised SRH providers described using models of the female reproductive system, contraceptive devices and pills to demonstrate how contraceptives methods work to help enhance women's comprehension of the information. HCPs also reported printing out Chinese-translated materials from family planning organisational websites for women to read or take home.

Sub-theme 2.2. 'Starting from a low base': lack of knowledge

Many HCPs felt that, compared with women who grew up in Australia, women who grew up in China tend to have limited knowledge or '*health literacy*' around SRH. They perceived that, generally, women's awareness of contraceptive methods was limited around condoms, non-hormonal IUDs and in some cases, pills. As one HCP put it, women '*come with personal experience in condom use, in IUD use, but tend to be less interested or aware of hormonally based methods*'. The lack of knowledge was considered as a major challenge, where HCPs needed to spend extra time and effort in explaining the basics of reproductive health and contraception.

> '*Some of the young girls don't know very much and so, you're starting from a very low base explaining how a contraceptive works and why certain things like withdrawal don't work*.' (Participant 9, female, specialised SRH provider)

Sub-theme 2.3. Uncertainty and decisional conflict

There was a viewpoint among HCPs that when some women were presented with many options to choose from, especially those that are not known to them or methods that involve hormones, deciding on which method to choose can be overwhelming or take a longer time. HCPs attributed this perceived hesitancy among women to conflicting advice and information they might receive from different sources (see

Theme 4). Some HCPs also felt that there was some level of uncertainty or lack of confidence in decision-making in women, especially young women, with some deferring the decision to HCPs, their partners or others around them.

Overall, Theme 2 pointed to the communication challenges stemming from not only the language, but also the lack of '*health literacy*' of women in terms of SRH. Here, health literacy encompassed women's SRH knowledge and self-efficacy in seeking, appraising and communicating information in making informed decisions.[33] These communication challenges added to the earlier mentioned challenges in proactively initiating contraceptive conversations with Chinese migrant women.

Theme 3. 'Hormones are unnatural?': women favouring non-hormonal methods

Many HCPs expressed that there is a strong preference for non-hormonal methods, such as condoms, copper IUD, withdrawal or fertility awareness-based methods, among Chinese migrant women. They described such disfavour/aversion towards hormonal methods could be due to several factors, which are elaborated on below.

Sub-theme 3.1. Fears of hormonal effect on menstruation

One of the common perceptions among HCPs was that Chinese women believe not having regular menstrual bleeding, which can be a side-effect for hormonal methods, is '*unnatural*'. They reported having been told by Chinese women that having monthly menstruation is a '*procedure for cleaning the body*' and having '*poison-blood build up inside*' the body is harmful. Some women were worried that hormonal methods are irreversible and, for instance, taking contraceptive pills over a period of time or having '*unnatural*' hormones in their body might cause infertility.

> '*. . .when I talk to them about the fact that with a hormonal IUD, for example, their period might stop all together, they're not happy about that. They want to feel like they're cleaning, and they do say that word like, 'I'm cleaning out my body every month.*'' (Participant 13, female, specialised SRH provider)

Sub-theme 3.2. Preference for copper IUDs

Healthcare practitioners, especially specialised SRH providers, perceived that there was a preference for copper IUDs over hormonal IUDs among Chinese migrant women. Although not wanting to have '*unnatural hormones in their body*' was perceived as one reason, they felt it could also be due to non-hormonal IUDs being more commonly known and used in China. SRH providers described often seeing women presenting for '*Chinese ring*' removal. Chinese rings were made of inert metal and inserted after a first birth as part of the one child policy with the intention that they would never be removed.[34] Women booking for IUD insertions were reported to often have a specific request about having a copper IUD fitted.

> '*In China obviously, most women have been offered up until recently the copper IUD. So many women will come with their contraceptive methods, wanting to change and they like the copper one or actually the Chinese ring, steel ring, which has been around for long time, they're kind of comfortable* [with copper IUD].' (Participant 5, female, specialised SRH provider)

Sub-theme 3.3. 'Worries and concerns' about other side-effects

Healthcare practitioners perceived that women also worry about other side-effects, such as weight gain, acne, mood change and cancer. Such concerns were not unique to Chinese women, as HCPs stated, but these concerns might be placed '*over how effective their contraception is*'. Overall, HCPs' accounts signalled a general pattern in Chinese women's contraceptive method preferences, with hormonal methods generally being avoided. Even when younger women do consider or choose hormonal oral contraceptive pills that are short-term and '*most reversible*', HCPs commented that '*continuation rates aren't great*' due to the perceived impact of side-effects.

Theme 4. 'Word of mouth': social influence on contraceptive method choice

Healthcare practitioners' perceptions on the social influence on Chinese women's contraceptive method choice was often discussed in light of family, partner and peer influences.

Sub-theme 4.1. Family influence

Healthcare practitioners' views on Chinese parents and other family members' influence on women's contraceptive method choice were two-fold. Some HCPs perceived that Chinese parents, or more broadly Asian parents, tend not to talk openly about SRH with their children, except to discourage sex outside of marriage. However, despite these assumptions about parental communication, HCPs felt that women's mothers or other family members might advise women against using hormonal methods. Also, women might be more familiar and comfortable with non-hormonal IUDs if their mother or other older women in their family have had used them in the past. As one HCP noted:

> '*I think it's just part of growing up in a Chinese community and wanting to avoid – trying to have your medicine as natural as possible and trying not to put hormones in you. I think the other reason is because generations before them, like their mother or their grandmother, typically those women would have had a copper IUD put in post-natal with the one-child policy. So, they're comfortable with copper IUDs in general and they're also comfortable with condom use as well.*' (Participant 1, female, GP, bilingual)

Sub-theme 4.2. Partner influence

Similarly, HCPs had varied views on the relative influence of partners on Chinese women's choice of contraceptive methods. Some HCPs recounted being told by middle-age or married women that they '*would want to consult their partners*' or '*the partner said to her not to take anything*

because it's not good for the body'. However, generally, HCPs perceived that contraception was often seen as '*women's business*'. They felt that, '*as opposed to other cultural groups where men are very heavily involved in decision making*', Chinese women seem to have more autonomy and were less likely to experience having a partner '*interfere*' with the preferred method choice. Although such autonomy and non-interference can be seen in a positive light, HCPs' accounts also shed light on the potential negativity of it; for example, HCPs perceived that some '*boyfriends*' think that '*it's the girl's responsibility to not get pregnancy*' and '*won't use condoms and then it depends on how determined the girl is to avoid pregnancy*'.

> '*. . .my feeling is that as opposed to other cultural groups where men are very heavily involved in decision making, . . .this is something that* [Chinese] *women do, that they do* [it] *by themselves*.' (Participant 8, female, specialised SRH provider)

Sub-theme 4.3. Peer influence

Healthcare practitioners viewed peers as a significant source of information and influence for Chinese women's contraceptive method choice. They perceived that young Chinese women often rely on recommendations or information they get from friends. Sometimes, such information was not accurate, and '*misinformation*' was perceived common.

> '*Other friends who are on contraception, other friends who love their contraception or hate their contraception, I'm sure that all plays a part*.' (Participant 14, female, GP, bilingual)

Overall, HCPs' accounts suggested that women's contraception decisions and attitudes of different methods can be influenced by not only their own knowledge and preferences, but also the advice, recommendations and influence from peers, family and partners.

Discussion

We set out to explore HCPs' perspectives on challenges and opportunities to engage Chinese migrant women in informed and shared decisions during contraceptive counselling. We found that, as HCPs perceived, Chinese women were unlikely to make their contraception needs known unless specifically probed or opportunistically counselled about such needs. Discomfort towards discussing sex-related topics, language barriers, lack of SRH knowledge and high-level of distrust towards hormonal methods were perceived by HCPs as challenges to engage Chinese migrant women in contraceptive discussions and provide decision support.

These study findings are consistent with several earlier studies examining HCPs' perspectives on CALD women's engagement with SRH services in Australia.[10,15] In all those studies, HCPs perceived women's lack of SRH knowledge and awareness of available services, and language barriers as hurdles to communication.[10,15] The finding that HCPs reported frequently raising the issue of contraception opportunistically with Chinese women also corroborates findings from a previous study, which found that women who spoke a language other than English were less likely to present for contraceptive consultations in Australian general practice settings.[35] Internationally, prior studies from other countries have explored Chinese migrant women's perspectives on contraceptive method choice.[36–38] Common themes reflected in those studies included negative attitudes towards hormonal methods, concerns about reduced or altered menstrual bleeding patterns and friends being a main source of information.[36–38] Such beliefs and behaviours were also perceived by HCPs in our study.

The unique finding of this study compared with previous literature is that HCPs observed a low level of involvement or interference from the Chinese migrant women's partners in contraceptive decision-making and a view that contraception is '*women's business*'. Previous studies among CALD women in Australia often highlighted the lack of decision-making autonomy and patriarchal gender norms as barriers for women in making SRH decisions and utilising services.[12,20] This study finding highlights the heterogenous nature of SRH needs and decision-making power dynamics among CALD groups and cautions against treating them as homogenous. Another unique finding is the communication barriers expressed by bilingual HCPs. It highlights that given the sensitive nature of SRH and importance of appropriate use of words to describe sensitive concepts, communication challenges may still exist even when there is language concordance between the patient and the HCPs.

Implications for policy, practice and research

The findings from this study have several implications for future policy, practice and research. The opportunistic nature of contraceptive consultations with Chinese migrant women, along with communication and knowledge barriers, can create challenges for the implementation of SDM during clinical encounters. This highlights a need for a broader health system and community-level approaches to addressing Chinese migrant women's contraceptive care needs, in addition to providing decision support during direct clinical encounters.

At the health system level, improving the cultural competency of the healthcare system by providing appropriate and professional health translation and interpreting services is likely to help address language barriers between HCPs and Chinese migrant women. Chinese women may feel discomfort or embarrassed when contraception is discussed or brought up by HCPs; therefore, providing HCPs with a culturally sensitive communication guide and training in engaging Chinese migrant women in conversations using either English or Chinese language are likely to assist HCPs in assessing and responding to women's contraceptive needs proactively. At the community level, providing translated, easy-to-read and culturally appropriate contraception-related health education materials that are easily accessible by Chinese women is likely to improve their SRH knowledge. Through community organisations, migrant resource centres as well educational institutions, developing materials and interventions to improve Chinese

migrant women's health literacy is likely to help break down some of the access and communication barriers. Such materials and interventions can incorporate information and training about the Australian health system and available SRH services, and provide contextual information about the nature, process, individual rights in healthcare encounters and prompts to communicate contraceptive needs. During clinical encounters, on the basis of supporting Chinese migrant women's preferences for contraceptive methods and autonomy in decision-making, providing comprehensive information on available options, efficacy, their risks and benefits (such as effect on menstrual bleeding patterns, future fertility and skin changes), is likely to foster informed choice.[23] A step further from informed choice is SDM. Use of decision support materials and tools, such as illustrative reproductive system diagrams, real examples of contraceptive tools and methods or decision aids, is likely to assist the SDM process. The current research is exploratory in nature given little is known about the topic being explored. Future research can be guided by the findings of this research and focus on implementing and evaluating the health education and promotion interventions on SRH and contraception among Chinese migrant women.

Strengths and limitations

The key strength of this study is that HCP participants had diverse clinical backgrounds and insights into providing contraceptive services to Chinese migrant women in different clinical settings. One of the limitations of the study is that only HCPs from a large metropolitan city of Australia were interviewed, and it is unclear whether the findings would be representative of HCPs' perceptions and experiences in other geographic settings. We were not able to triangulate the data source by collecting data from the HCPs' actual patients and confirming the validity of HCP's reports. Although we interviewed Chinese migrant women as part of our larger project, a majority of women who were interviewed had no experiences in consulting HCPs for contraceptive advice. Therefore, the HCPs' perceptions presented in this study were based on their interactions with a small sub-sample of Chinese migrant women who were counselled about contraception in clinical settings. Despite such limitations, HCPs' perceptions may be valuable for designing and disseminating interventions, as they likely affect the perceived acceptability/value of the interventions.

Conclusion

Addressing the particular contraceptive care needs of Chinese migrant women may require broader health system and community-level approaches that incorporate improving cultural competency in contraceptive care provision and enhancing SRH knowledge and health literacy of the Chinese migrant community. Such approaches are likely to help foster informed choice and SDM during patient–provider encounters.

Conflicts of interest

DB has been supported to attend educational events by Bayer Healthcare and Merck Sharp & Dohme Corp., both are manufacturers of contraceptives, and has attended advisory committee meetings for these companies as part of her role at Family Planning New South Wales. RT has received research funding to study shared decision-making and shared decision-making interventions, including contraceptive care; she receives royalties from the sale of a book on shared decision-making and owns copyright in several decision aids, including a decision aid on contraception. All other authors declare that they have no conflicts of interest.

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