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Caught in the middle? How women deal with conflicting pregnancy-advice from health professionals and their social networks

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ABSTRACT

Objective: to investigate how pregnant women deal with conflicting advice from their social networks and their caregivers and how this influenced their pregnancy-related behaviours.
Design and methods: a qualitative study based on face-to-face interviews and focus-groups. We applied an inductive analysis technique closely following the 'Gioia method'.
Setting: impoverished neighbourhoods in Rotterdam, the Netherlands.
Participants: 40 women who were pregnant, or had given birth within the last 12 months. 12 women were Native Dutch, 16 had a Moroccan background, and 12 had a Turkish background.
Findings: all women faced a misalignment of advice by health professionals and social networks. For the native Dutch respondents, this misalignment did not seem to present a challenge. They had a strongly articulated preference for the advice of health professionals, and did not fear any social consequences for openly following their advice. For the women with a Turkish/Moroccan background, however, this discrepancy in advice presented a dilemma. Following one piece of advice seemed to exclude also following the other one, which would possibly entail social consequences. These women employed one of the three strategies to deal with this dilemma: a) avoiding the dilemma (secretly not following the advice of one side), b) embracing the dilemma (combining conflicting advice), and c) resolving the dilemma (communicating between both sides).
Key conclusions and implications for practice: we argue that the currently popular interventions geared towards increasing the health literacy of non-Western ethnic minority pregnant women and improving communication between ethnic minority clients and caregivers are not sufficient, and might even exacerbate the dilemma some pregnant women face. As an alternative, we recommend involving not only caregivers but also women's social network in intervention efforts. Interventions could aim to increase the negotiation capacity of the target group, but also to increase the health literacy of the members of their social network to enable the circulation of 'new' information within a rather homogeneous, tight-knit network.

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Introduction

Pregnancy-related health behaviours such as late initiation of antenatal care or consumption of alcohol, tobacco and drugs are major predictors of negative birth outcomes (Rowe et al., 2008; Timmermans et al., 2011). Most studies trying to understand which factors influence pregnancy-related behaviour mainly consider intrapersonal (i.e. individual-level) factors, such as health literacy or socio-economic status (Mohangoo et al., 2008; Mook-Kanamori et al., 2010). This is in line with the mainstream public health approach to understanding health behaviours, which is largely informed by traditional social psychological theories. These theories focus on intrapersonal characteristics that influence behaviour and only pay limited attention to environmental influences (Burke et al., 2009).

More recently, however, research suggests that variations in pregnancy-related behaviour cannot solely be explained by

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individual-level factors but are also influenced by environmental factors, such as neighbourhood social cohesion (Masi et al., 2007; Pickett and Wilkinson, 2008; Schölmerich et al., 2014). Public health studies emphasising environmental influences are often based on social-ecological theory. This theory stresses how human behaviour is not only shaped by individual factors, but also by a plethora of environmental influences such as accessibility of local health care or cultural norms (Bronfenbrenner, 1977; McLeroy et al., 1988).

A few studies established that pregnant women's social networks influence their pregnancy-related health behaviour (Büchi et al., 2006; Brar et al., 2009; Boerleider et al., 2013). These studies tend to categorize social networks as a negative influence. For example, two studies found that pregnant women followed the advice of their family/friends to enter antenatal care later and visit their antenatal caregiver less frequently than recommended (Büchi et al., 2006; Brar et al., 2009). This could have a negative impact on their birth outcomes (Boerleider et al., 2013).

In this study we aim to expand the current understanding of the influence of social networks on pregnancy-related behaviour of women living in Rotterdam, the Netherlands. Gaining a better understanding of the experiences of women living in Rotterdam could be valuable, as this city shows the highest recorded disparities in perinatal mortality in any developed country (Poeran et al., 2013). Perinatal mortality (deaths from 22 weeks of gestation until seven days post partum) ranges from 2 to 34 per 1000 births across more or less affluent neighbourhoods (De Graaf et al., 2010; Poeran et al., 2013). In this study, we investigate whether pregnant women living in impoverished Rotterdam neighbourhoods received advice from their social networks that contradicted biomedical advice from health professionals, how they dealt with this, and how this influenced their pregnancy-related behaviours. With biomedical advice, we refer to guidelines and protocols on healthy behaviours (e.g. refraining from eating raw meat during pregnancy) that are based on empirical evidence and commonly accepted within mainstream health care.

Methods

Respondents

This study investigated the experiences of women during their pregnancy. We spoke to women who were pregnant, or had given birth within the last 12 months, and the interviews took place during February 2012 – June 2013. The respondents of this study had a low socio-economic background and lived in the most impoverished neighbourhoods (http://www.rotterdam.nl/socialeindex2011) in Rotterdam.

During the recruitment of women for this study, we made use of purposive sampling. This means that we attempted to interview women reflecting important socio-demographic segments in these diverse neighbourhoods (see Table 1 for an overview of their characteristics). We included women of Moroccan and Turkish backgrounds, as they belong to the largest non-Western minority groups in the Netherlands. Moreover, we included women who varied in terms of the following criteria: a) living situation (living with in-laws or not), b) employment status, c) ethnic minority status (1st or 2nd generation), d) number of children and e) age (between 20 and 45). We have excluded women younger than 20 and older than 45 as well as women undergoing IVF treatment. This is because we expect that such pregnancies represent a different set of experiences and challenges. The criteria outlined above were developed on the basis of discussions with our seven key informants, who were community health workers active in promoting reproductive health in our targeted neighbourhoods. They had extensive contacts in these neighbourhoods and worked there on a daily basis. As further outlined below, our key informants were involved in the recruitment phase of this project, provided many informal interviews and were also consulted during the data analysis phase.

Recruitment strategy

We employed three main strategies for recruiting respondents. For one, the researchers involved (see below for more information) visited meeting places commonly frequented by our target groups: a) pre-schools and elementary schools (during parent–teacher meetings), b) mosques, c) neighbourhood community centers and d) Turkish and Moroccan women's associations. Next to this, one of our research assistants was able to recruit several native Dutch women in her indirect network via social media. We then used the snowballing method (Saunders et al., 2011) by asking the already recruited respondents to provide contact details of other possibly interested women.

Interviews

We conducted semi-structured interviews with 12 women with a Turkish background, 16 women with a Moroccan background and 12 native Dutch women. The interviews lasted between 40 and 60 minutes. At the beginning of each interview, we explained to the respondents that we were interested in their experiences surrounding their pregnancy. With the permission of the respondents, all interviews were tape-recorded. These were then subsequently transcribed, and included interviewer's notes on non-verbal communication, moments of silences during the conversation and general impressions of the respondents. Afterwards, the audiotapes were deleted. We also informed the respondents that any identifying information from the interview (such as their names or addresses) would not be transcribed. In this article, all of the names of the respondents have been changed to protect their anonymity. This study was exempt from an ethical approval in the Netherlands as it did not require respondents to take any specific actions (such as taking blood tests). For more information, please see the Dutch CCMO (Dutch Central Committee on Research Involving Human Subjects) website: http://www.ccmo.nl/nl/uw-onderzoek-wmo-plichtig-of-niet nl.

The first author and four research assistants conducted the interviews. All of the interviewers were social scientists. One of the research assistants who interviewed women of Moroccan

Table 1
Overview of the respondent's characteristics.

Respondents	Nr of respondents	Nr of respondents living with in laws	Nr of employed respondents	Migration history (first/second generation)	Nr of children (range)	Age (range)	Nr of single women
Women with a Turkish background	12	4	4	6 women 1st generation, 6 women 2nd generation	0 (pregnant)–5	23–39	0
Women with a Moroccan background	16	3	5	9 women 1 generation, 7 women 2nd generation	0 (pregnant)–4	20–40	0
Native Dutch women	12	0	6	N/A	0 (pregnant)–2	22–40	0

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