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Are 'low socioeconomic status' and 'religiousness' barriers to minority women's use of contraception? A qualitative exploration and critique of a common argument in reproductive health research

Jonna Arousell[a,*], Aje Carlbom[b], Sara Johnsdotter[b], Birgitta Essén[a]

[a] Department of Women's and Children's Health (IMCH), Uppsala University, 751 85 Uppsala, Sweden
[b] Faculty of Health and Society, Malmö University, 205 06 Malmö, Sweden

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ABSTRACT

Objective: 'Low socioeconomic status' and 'religiousness' appear to have gained status as nearly universal explanatory models for why women in minority groups are less likely to use contraception than other women in the Scandinavian countries. Through interviews with pious Muslim women with immigrant background, living in Denmark and Sweden, we wanted to gain empirical insights that could inform a discussion about what 'low socioeconomic status' and 'religiousness' might mean with regard to women's reproductive decisions.

Design: Semi-structured interviews were conducted in Denmark and Sweden between 2013 and 2016.

Findings: We found that a low level of education and a low income were not necessarily obstacles for women's use of contraception; rather, these were strong imperatives for women to wait to have children until their life circumstances become more stable. Arguments grounded in Islamic dictates on contraception became powerful tools for women to substantiate how it is religiously appropriate to postpone having children, particularly when their financial and emotional resources were not yet established.

Conclusion: We have shown that the dominant theory that 'low socioeconomic status' and 'religiousness' are paramount barriers to women's use of contraception must be problematized. When formulating suggestions for how to provide contraceptive counseling to women in ethnic and religious minority groups in Denmark and Sweden, one must also take into account that factors such as low financial security as well as religious convictions can be strong imperatives for women to use contraception.

Implications for practice: This study can help inform a critical discussion about the difficulties of using broad group-categorizations for understanding individuals' health-related behavior, as well as the validity of targeted interventions towards large heterogeneous minority groups in Scandinavian contraceptive counseling.

Introduction

One problem that continues to occupy many academic scholars in the field of reproductive health is that women in ethnic and religious minority groups in a variety of countries are less likely to use contraception than the majority of women in the population. Accordingly, many studies have sought to find explanations for this divergence. Two arguments repeatedly emerge in the literature. First, scholars have proposed that a 'general socioeconomic vulnerability' among women in minority groups explains why these women are less likely than others to use contraception. This argument is presented in studies from the U.S., Canada, and France (Cyrus et al., 2016; Poncet et al., 2013; Wiebe, 2013), as well as from the Scandinavian countries. Helström and colleagues have, in two studies, indicated several factors, presented under the umbrella term 'low socioeconomic status', that are believed to cause immigrant women's suboptimal contraceptive practices in Sweden (Helström et al., 2003; 2006). It is argued that women's often "low education, weak social network, poverty, unemployment, and being outside common pathways to healthcare" (Helström et al., 2003 p. 405) are likely factors that contribute to their contraceptive neglect. The low level of knowledge of contraception has also been presented as a possible explanation behind migrants' and second-generation migrants' low proportion of contraceptive

* Corresponding author.
E-mail address: jonna.arousell@kbh.uu.se (J. Arousell).

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use (Emtell Iwarsson et al., 2019). Similarly, in a Danish context, Rasch et al. (2007) have claimed that the high rate of abortion (which is considered a proxy for contraceptive neglect) "among non-Westerners is caused by the composition of non-Westerners more often being unemployed, having a low income and having two or more children" (p. 146), as compared to Danish-born women.

The second argument is that 'religious barriers' tend to prevent women of minority groups in various geographical contexts from using contraception. Muslim women in Ethiopia, possibly more than women of other faiths, are thought to be less likely than non-Muslims to use contraception (Walelign et al., 2014). The arguments about *why* women's religiousness risks being an obstacle to their use of contraception appears, nevertheless, to vary. Musa et al. (2016), in their Ethiopian study, speculate that Muslims' low levels of contraceptive use may be due to the fact that the Muslim community in Ethiopia considers family planning to be prohibited in the Qur'an. Others suggest that a high level of piety and involvement in religious organizations seems to be correlated with a low level of 'protective behavior', as was the case in a French study (Moreau et al., 2013). Gifford's exploration of Islamists' role in family planning programs in Senegal has given support to the argument that 'religion' can have a limiting effect on women's access to contraceptives. Gifford became aware that Islamic jurists lobbied engagingly for the view that family planning is just another 'Western invention', with one jurist proposing that: "There is nothing worse for a fertile married woman than to renounce motherhood" (Gifford, 2016 p. 706). Also, Sargent (2006), in her study about Malian Muslim immigrants in France, has shown that husbands, as the main interpreters of religious doctrine in many spousal relationships, could use religious interpretations to limit women's decisions on whether to use contraceptives (Sargent, 2006). In Denmark and Sweden, the two countries to which our exploration relates, evidence about how religious dictates influence Muslim minority women's contraceptive decisions is scarce. Worth noting, however, is that the current lack of evidence has not refrained scholars from speculating that 'religious barriers' may explain why Muslim women in Scandinavia are less likely than others to use contraception (see also Omland et al., 2014). Larsson and colleagues refer to study results obtained among African-Americans and Caucasians in South-Eastern USA to give bearing to the argument that culture and religion often have a "significant impact" on women's decisions relating to contraceptives (Larsson et al., 2016). The impact of "culture and religion" upon immigrant women's contraceptive practices is also an aspect that Kolak et al. (2017) suggest that midwives in Swedish contraceptive counselling should have knowledge about. The assumption that religious convictions are barriers to contraceptive use tend to be easy to accept and readily on hand for researchers to make use of, and are also applied when they attempt to understand why women in minority groups in Scandinavia are less likely than most women to use contraception.

It appears that 'low socioeconomic status' and 'religious barriers' have gained status as nearly universal explanatory models for why women in minority groups are less likely to use contraception than others. These perspectives, which together seem to nurture a widely accepted and taken-for-granted view of minority women's vulnerability and disadvantageous position with regard to their health, have commonly been generated through statistical analyses of large sets of data. In the field of medicine and public health this is a good sign, because such methods are often thought of as trustful predictors about how the world works (Hacking, 1991). But recently, scholars have cautioned against the tendency to rely solely on this type of 'objective' explanatory models — such as socioeconomic status and religiousness as causes of contraceptive neglect — when trying to understand why people make certain reproductive decisions (Olivier and Wodon, 2015). Critics claim that the current desire in medical and public health research to statistically capture the complex social contexts in which people are embedded may obscure a more thorough understanding of individual experiences (Aronowitz et al., 2015). Often terms such as 'socioeconomic status' or 'religiousness' are too vague and unspecific to provide much detailed information (see Baehr and Gordon, 2018). The concern is also that statistical surveys operating with "broad native and migrant categorizations" (Mulinari et al., 2015 p. 916) are ascribed too high an importance in the formulation of health policies and clinical recommendations, consequently increasing the risk of exposing individuals to unjustified clinical interventions (Krasnik, 2015).

Drawing on this recent critique, in this qualitative study we aimed to obtain a better understanding of how pious Muslim women with immigrant background reflect on contraception and contraceptive use. We wanted to gain empirical insights that could generate an analytically rich exploration of what the seldom-problematized ideas of 'low socioeconomic status' and 'religiousness' might mean with regard to women's reproductive decisions. We asked: In what ways did Muslim women with immigrant backgrounds reason about their decisions to use, or not to use, contraception, and what aspects did they take into consideration when making their choice? In our exploration of how religious norms intersect with women's ideas on contraception, we draw on Asad's (2009) understanding of Islam as a 'discursive tradition'. 'Islam' is not a static set of norms that people subordinate themselves to, but rather a discourse that reflects many norms and ideas that are negotiated, contested, reasoned about, and argued for and against (Asad, 2009). At the end of the article we will discuss how the results can inform a debate about special interventions towards women with immigrant backgrounds in Danish and Swedish contraceptive counseling.

Methods

Study setting and participants

The study was conducted in Denmark and Sweden: two similar Scandinavian countries in which researchers — just as in other parts of the world — have raised concerns about socioeconomic and religious barriers to the use of contraception by women of minority groups. Qualitative interviews were conducted with twenty women and took place between 2013 and 2016. The informants in this study all self-identified as being pious Muslims. They were all children to parents born in countries with a Muslim majority population, most of them located in the Middle East or Northern Africa region. Some of the informants were born abroad and had migrated to Denmark or Sweden, whereas some of them were born in Denmark or Sweden. None had lived in Scandinavia for less than seven years when the interviews took place. Many of them were enrolled in study programs or had taken supplementary courses to improve their grades in order to apply for admission to university, whereas others had already studied at university level. Some women were currently unemployed, whereas others were employed; some as assistant nurses or shop assistants, and others in highly skilled and qualified employment, such as medicine. Others were running their own small-scale businesses. The women were aged between 19 and 38 years, and most, but not all, were married.

Informants were included in the study based on their self-identification as being active in practicing Islam and/or engaging in religious reflections around everyday matters. They were recruited through Muslim youth organizations, in mosques, through three different organizations working for women's integration, and through a subsequent snowballing technique.

Procedure

Semi-structured interviews, lasting between one and two hours each, were conducted in Swedish or Danish, respective to the two country settings, by the first author. Informants were asked to reflect upon their evaluations of Islamic doctrine in relation to contraceptive use, the source from which they acquired this Islamic guidance, what authority they assigned to their various answers, and to describe their personal experiences of using or not using contraception. Four women were interviewed several times. Interviews were conducted at a location of their own choice, usually in their homes or in cafés. Most interviews, but not all, were audio-recorded. If interviews were not recorded, detailed notes were taken during the interview. Most of the audio-recordings were transcribed from the beginning to the end, whereas for a few audio-recordings, only selected parts were transcribed. All informants have been given pseudonyms in the presentation of the findings in this article.

The study was approved by the Uppsala Regional Ethics Board (Registration number 2013/346).

Data analysis

Data analysis began with repeated readings of the transcripts, as well as repeated listening to the audio recordings, in order to identify latent themes in the informants' narratives (Braun and Clarke, 2006). After a few interviews had been conducted and we had a general idea of recurrent patterns, the interviews continued in order to follow up and to explore specific dimensions of interest in depth. Given the way the collection of data developed, the research process had similarities with what Lincoln and Guba have defined as 'naturalistic inquiry', in which important understandings of a certain phenomenon grow as a result of subsequent data collection (Lincoln and Guba, 1985). A number of overarching themes were identified. The themes were: *Financial stability and education: imperatives for contraceptive use, "I wanted to have more children!" Building a family as an adaptive route, Constructing religious legitimacy regarding contraceptive use,* and *Islamic doctrine as liberalization strategy.* These themes were included and elaborated upon because they were considered to add new dimensions to the existing research in the field. The assumption underpinning this stance towards themes in qualitative research is that findings do not exist as natural phenomena. Neither can they be 'found' by a researcher's skillful use of adequate methods (see Bacchi, 2009). Instead, the themes came into being through an interpretative process in which various dimensions of the interview material were compared and weighted against others, as well as to the knowledge that already exists on immigrant women's use of contraception (Lincoln and Guba, 1985). This mode of qualitative analysis implies that the findings must be interpreted and contextualized by the researcher, in order to inform a broader understanding of their importance (Bernard, 1996).

Results

Financial stability and education: imperatives for contraceptive use

While researchers in the field have argued that 'low socioeconomic status', such as unemployment, a weak social network, and knowledge deficits, are important barriers to immigrant women's optimal use of contraception, our data reveal aspects that in part contrast this prevailing idea. For several of the women we interviewed, living under financially and socially insecure conditions were not *obstacles* for using contraception, but instead were strong *imperatives* for using contraception. One informant, Heba (married, three children), recalled that she and her husband decided to postpone having children until her husband, who had worked for many years in Saudi Arabia, had settled well in Sweden. She explained:

> We had a very unstable life in the beginning, we didn't have any permanent employment contract, and we … like … We had to struggle hard to get money for rent. Yes, so it was a little bit up and down. And of course, we had to make sure in some ways that we did not get pregnant.

Also, Fatma, another informant in her late twenties, explained that she now, just after having had her second child, wanted to engage in her job as a nursing assistant in a home for elderly people. Her parents still lived in her home country. Having lived in Sweden for seven years, she only had her husband and her husband's family as kin who lived geographically nearby. She had been home with her children continuously since she migrated and had very limited contact with people and social institutions in Sweden. Lately, Fatma had begun taking Swedish courses at SFI (Swedish for Immigrants). In order to start her own career and become more financially independent in relation to her family, she explained, she had been keen to find an appropriate contraceptive method that would prevent her from getting pregnant and instead be able to work.

Not only Heba and Fatma, but also other women we interviewed, wanted to use contraception and did so. Given their engagement in their studies or in the labor market, many informants said that they wanted to thoroughly plan when to have children and how many to have, in order to create a balance between work, education, and the other things they wanted to have time to do.

I wanted to have more children! Building a family as an adaptive route

Sarah, another woman in her late thirties with a family background in Syria, presented an alternative story about what her 'low socioeconomic status' — in terms of her low level of education, low income, and lack of current occupation — meant for her family planning decisions. Sarah's desire was to *have* many children and she was not particularly interested in obtaining an education to thereby be able to join the Swedish labor force. Consequently, before getting pregnant with all of her five children, she had removed the intrauterine device (IUD) without her husband's knowledge. Her husband expected her to make use of the extensive opportunities in Sweden with regard to education and employment, but Sarah did not agree with him and therefore decided to manage the situation in her own way:

Sarah: I removed the IUD without his knowing about it [laughs]. And I thought for myself: 'No, I don't tell him anything, he doesn't want kids.' He had great expectations of me, that I should study, become something good, like that. I didn't want that! [laughs]. I wanted to have more children, be like other women.

Researcher: So what did he say when he got to know that you were pregnant?

Sarah: Yeah, like every time we spoke and discussed that I wanted children, he just said no […]. And every time I saw a woman with a stroller, I got so sad and [asked myself] why am I not allowed? What is the difference between her and me? So when I got pregnant, for three months, he didn't know anything. And then when I told him I thought: 'It is a bomb that will explode!' But no. He was so happy.

In many statistical surveys, women like Sarah would be categorized as immigrant women with a low level of education, no job, and low income, and as those who do not use contraception. Objectively spoken, this is a fully adequate observation. But once we know about Sarah's priorities and strategies, the proposal that so-

cioeconomic status is a *risk factor* for her non-use of contraception does not appropriately capture her own concerns. With no education, no job, a low income, and with relatively low ambitions to make a career in the labor market, giving birth to several children was, for Sarah, both an adaptive and logical route to take. But she was also firm that her religious convictions, or 'Islam', did not have anything to do with her choice not to use contraception:

> Yes, one is allowed to use contraception [according to the religion]. Some say that they don't want to use it, "no, it can harm…". But what is best: to use contraception or to get children that you cannot support or raise? Child rearing is very important for society. You are a role model for them and they can become a role model for others, so this is worth considering.

Constructing religious legitimacy regarding contraceptive use

As Sarah's narrative above suggests, 'religiousness' for her was not a serious obstacle for her use of contraception. In fact, our overall results disrupted the common argument that 'religious barriers' prevent women's use of contraception. Many of the women in our study instead used Islamic doctrine to motivate the religious legitimacy of using contraception. By discussing this issue with Muslim friends and by consuming a variety of Islamic sources dealing with the topic, most informants came to argue that using contraception was part of being a 'good Muslim' who was taking care of planning the family size in a responsible way.

Maryam, a woman in her mid-twenties with parents from the Northern Africa region, unmarried and with no children and now living in Sweden, said that she could not find any arguments for why she should not use contraception in the future. Recalling a discussion she had heard in the mosque that she usually visits, she gave a reflective account of what contraceptive use meant for her from an Islamic point of view:

> It was one story that I've heard about the Prophet [Mohammad] when he was in the mosque and was playing with his grandchildren. And then it was a man who approached the Prophet and said that it was strange that he played with them and said, "I have ten children and I don't even know their names." The Prophet answered: "It is not my fault that God took away the mercy from your heart. You have got ten children and you say you don't even remember their names, I actually feel sorry for you because this is nothing you should feel proud of." So this quite clearly shows that it is not as easy as just getting a lot of children – one should also be able to give them enough love, attention, give them the food they need, clothes on their bodies, roof over their heads. So therefore it is more common now that people plan their family. To plan your life, actually, just as one should do.

Taken together, the women argued that: (1) using contraceptives was imperative as long as they could not ensure adequate financial support for the children who are already born as well as for future children; and (2) parents needed to have enough emotional resources and adequate time to give all of the children in the family sufficient love and attention.

Islamic doctrine as liberalization strategy

Notably, this position — motivated through an Islamic discourse — was shown to correlate well with many women's own desires to obtain an education and become established in the Danish and Swedish labor market before having family and children. Several women described how they had experienced attempts by family members, such as mothers and mothers-in-law, to persuade them not to use contraception. They also described how older family members had the idea that hormonal contraceptives could cause infertility and that women should take responsibility for the family's procreation. However, many of the women we interviewed often rejected such views as reflecting the traditional beliefs originating from their parents' home countries, and perceived that they did not correspond well with either medical facts or religious dictates from Islamic jurists. It appeared, thus, as if women's references to Islamic sources and interpretations helped them to become more independent in relation to their family members' ideas about their reproductive practices. By extension, it also seemed to provide women with resources to move away from family members' sometimes disadvantaged socioeconomic situation and create their own opportunities in the Scandinavian labor market. Two empirical examples can illustrate the tendency that women's religious convictions enabled a break from parental expectations and, in some cases, from gendered expectation on women's reproductive obligations:

One woman in her mid-twenties (married, two children, living in Sweden), here referred to as Layla, recalled that she had previously believed that contraceptives were prohibited. She had frequently heard from family and friends that they should not be used before the first child is born, because they could cause infertility. But later Layla's life changed, and so did her view on contraception. Layla's change of opinion was a result of her marrying into a much more religiously devout family. Once married, she explained, she became engaged in the local mosque, began to read about Islam, and soon became aware that using contraception is greatly encouraged in Islamic doctrine. Now, she said:

> For me, it is allowed. I always have that Qur'an verse in my head: "God never gives you a greater burden than you can manage." And it should really be a great burden to have a new child every year. So I usually try to think logically about it […]. One has to give the child love and one also needs to raise them, it is not only about having many children.

In other words, Layla's intensified religious commitment opened up for a more permitting attitude to the use of contraception, which gave her the strength to persist against other family members' divergent opinions by using legitimate arguments. Religious norms did not limit her access or willingness to use contraceptives. It was rather the other way around: the more religious she became the more she came to realize that the practices that she previously had deemed as religiously 'impure' could, in fact, be viewed as being religiously encouraged.

Another woman, Mariah, living in Denmark, described how she one day was approached by her mother-in-law who wanted to confirm that Mariah and her husband used appropriate contraception. The reason was that the mother-in-law wanted to ensure that Mariah did not pressure her son into an early family-life: according to the mother-in-law, it was crucial that her son was given the possibility to finish his university degree and enter the Danish labor market before taking responsibility for children. Mariah was surprised by her mother-in-law's frankness and told her husband what had happened. Consequently, as Mariah described, her husband had sharply but politely told his own mother to stay out of their family planning matters and contraceptive use, because "Islam says that such decisions are to be taken between husband and wife only". By grounding the arguments in an Islamic discourse, Mariah speculated that her religious mother-in-law was more easily convinced that her husband was correct. The mother-in-law refrained from any further discussion with Mariah about her choice of contraception.

Discussion

The aim of this study was to provide an in-depth exploration of how pious Muslim women with immigrant background reflected on contraception and contraceptive use. We wanted to gain

empirical insights that have the potential to deepen the understanding of how 'low socioeconomic status' as well as 'religiousness' relate to Muslim women's decisions to use, or not to use, contraception. We found that a low level of education and a low income were not necessarily obstacles for women's use of contraception, but instead were strong imperatives for women to delay having children until their life circumstances became more stable. Arguments grounded in Islamic dictates on contraception seemed to become powerful tools for women to substantiate how it is religiously appropriate to postpone having children, particularly when the necessary financial and emotional resources were not yet established.

The positive effect of positioning arguments in favor of contraceptive use within an Islamic discourse seemed to be even more prominent for women who had a low level of education, a low income, and who were under pressure from family members to organize their reproductive life in a 'traditional way', but who *wanted to* postpone having children. By arguing that giving birth to children is only religiously encouraged when children can be ensured a stable financial and emotional environment, women in our study could argue for the benefits of first studying, working, and securing an income. This tendency indicates an interesting dimension with regard to the relationship between 'socioeconomic status' and 'religiosity' that has not yet been emphasized in research: namely, that women's exercising of Islamic doctrine can be a resource in moving away from a disadvantaged socio-economic position in society.

Religious subordination, cultural change, or both?

There are various ways in which the informants' religious reasoning in relation to their reproductive choices can be understood. One interpretation is that the women's attitudes to contraception is a result of their willingness to succumb under the religious dictates that they found to be most appropriate. From the ethnographer Saba Mahmood's perspective, the women's religious reasoning about contraceptive use exemplifies how they aimed to "transform[ing] themselves into the willing subjects of a particular moral discourse" (Mahmood, 2005 p. 28). From this perspective, the women's foremost interest would be to educate themselves about ethical standards in Islam and thereby obtain sufficient guidance on how to practice the religion in the best way possible. This is also what Hughes Rinker (2015) found to be the case in her Moroccan study on pious Muslim women's reproductive practices. When the women took responsibility for their reproductive practices, Hughes Rinker argued, this was not because of the liberal contraceptive rhetoric that was enforced by medical policies or healthcare providers in Moroccan society. Rather, the women acted upon "what they saw Islam as saying about fertility and motherhood" (p. 2) — regardless of whether it fitted well with their own sexual and reproductive (Hughes Rinker, 2015). In Agrama's (2010) study on religious counseling provided to Muslim couples at the Fatwa Council of the Al-Azhar mosque in Cairo, this is also what he observed: when couples received a *fatwa* (i.e., a response to how to live in a religiously appropriate way), they "tended to follow it although it caused them difficulty or some unhappiness" (p. 4). The view of what 'Islam is saying' on contraception would, from this perspective, be difficult to navigate away from and the power of God's words and Islamic jurists' legal interpretations would have an important influence on women's final reproductive decisions — regardless of the social norms and reproductive politics in the society where they live.

A perhaps more reasonable interpretation is, however, that the informants' positive attitude to contraception had been shaped in an interplay between liberal politics on contraception in Denmark and Sweden, and their reading of religious doctrine. Both Denmark and Sweden have well-institutionalized structures that ensure women's extensive access to contraceptives as well as rights to obtain higher education and enter the labor force. It does not appear to be odd that the women in our study wanted to do what most other women in Scandinavia are doing, i.e., study, work, earn money, and raise children under relatively secure financial and emotional circumstances (Ekstrand et al., 2005; Rasch et al., 2002; Sköld and Larsson, 2012). The findings in our study support the hypothesis that people often tend to absorb the values adopted among the majority population after having lived in the new country for a period of time (Norris and Inglehart, 2012). For instance, many informants described that they had a far more progressive attitude to contraception than their older family members, or that they had become more positive to contraception as the years went by. Noteworthy, however, is that the women's liberal stance to contraception did not involve an abandonment of their religious convictions in favor of secular, progressive ideas. While it is probably true that some women changed their attitudes towards contraception after spending some years in Sweden, religious norms did not seem to prevent this development from taking place: rather, through their readings of Muslim jurists' edicts, many of the informants came to argue that using contraceptives was considered a desired and pious endeavor.

Special interventions in contraceptive counseling? A current discussion in reproductive health research and policy

The understanding of how women's contraceptive practices are influenced by their financial situation as well as by religious convictions is of relevance in relation to the current discussion about healthcare interventions towards women in minority groups in Scandinavian contraceptive counseling. The question that continues to trouble researchers in the field is: how should healthcare providers best support vulnerable and disadvantaged minority groups of women in order to make them more likely to use contraception? The answer has, in most cases, been that midwives and doctors should be "better equipped in their encounters with immigrant women […], especially when it comes to contraceptive counseling" (Larsson et al., 2016 p. 18), to take seriously the "paramount importance that immigrant women are reached by culturally sensitive information campaigns" (Rasch et al., 2007 p. 1325), and to be aware "that immigrant women in Sweden constitute a group that needs to be specifically targeted for support and interventions" (Helström et al., 2003 p. 410). A common hypothesis used to justify such interventions is, as we have discussed in this article, that women's 'low socioeconomic status' and 'religiousness' are barriers to their use of contraception, and that women in minority groups therefore need healthcare providers' assistance to make well-balanced reproductive decisions.

What happens when policy-makers and healthcare providers organize the provision of care solely from the presumption that low levels of contraceptive use among women in ethnic and religious minority groups is a serious problem that should be solved through targeted group interventions? A first consequence is that women might categorically become singled out for a different type of contraceptive counseling because they fall into providers' broad categories of what a socioeconomically and religiously 'vulnerable' woman is and is not (Mulinari et al., 2015). Because the content of the special interventions in contraceptive counseling, in most cases, remains undefined in research and policy, it is not possible for providers to know exactly what to do or how the interventions' effectiveness can be evaluated. Thus, although such 'special interventions' are most likely proposed and implemented with the best intentions (i.e., to improve women's reproductive health and to reduce inequalities in health outcomes), at the same time they risk legitimizing the exclusion of many women from standard and evidence-based procedures for contraceptive counseling. Some

women might thus receive a separate type of care, whose quality is not known, simply because they belong to a certain ethnic or religious minority group. While this is an institutional structure that in other situations could be classified as ethnic and/or religious discrimination (see Article 14 of the European Convention on Human Rights), it is, in the case of the contraceptive practices of women belonging to minority groups, often suggested to be a fully acceptable solution. In the worst case, this exemplifies a broadly established structure in Scandinavian contraceptive counseling in light of which some women risk receiving a suboptimal care that is unsuited to their individual needs.

A second consequence is that adopting a one-dimensional view of women's difficulties in making deliberate and autonomous decisions on contraception inhibits a critical discussion and understanding of alternative discourses. It cannot be excluded that some women, due to factors that have to do with their socioeconomic status or religious convictions, may benefit from extra education, information, and support from healthcare providers in contraceptive counseling regarding their contraceptive use. It is also true, however, that other women — such as Heba, Fatma, and Layla in our study — are probably fully capable of embracing the 'standard' content of contraceptive counseling without any extra support from midwives or doctors. What healthcare providers in reality are set to manage, is thus a balance between two different perspectives: i.e., between providing extra support and interventions to some women of minority groups on the one hand, and providing others with nothing else but the standard version of contraceptive counseling on the other.

In a time when the migration to Scandinavia has reached historically unprecedented numbers, questions about how to integrate newcomers into Scandinavian societies have become particularly relevant (Bendixsen et al., 2018). Should healthcare providers strive to learn about 'cultural beliefs' and incorporate this knowledge in clinical encounters (i.e., in the name of 'cultural competency'), or should they adapt a more person-centered approach where each individual's concerns are allowed to unfold in the clinical encounter? At its core, this is a question of how modern welfare states such as Denmark and Sweden can safeguard everyone's access to adequate counseling and contraception, without inappropriately targeting individuals who are at *no risk* of suboptimal contraceptive use (see e.g., Krasnik, 2015).

Methodological considerations

This study was initiated with the aim of making a qualitative exploration of an area that previously has been studied mostly through quantitative methods. While quantitative methods manage to capture general patterns in large population groups, they are unfit to shed light on people's way of reasoning; how they end up reaching conclusions; how people change their minds and why; and the often-fluid processes in which people develop arguments as individuals and in relation to others. Qualitative methods do not aim at generating statistically generalizable results. Rather, with qualitative methods, the researchers are able to use specific examples from people's everyday life in order to understand larger social phenomena (Thorne et al., 2009). This refers to what some researchers call 'analytical generalizability' (Polit and Beck, 2010), i.e., when interpretations are authentically described to the reader, they "can reflect valid descriptions of sufficient richness and depth that their products warrant a degree of generalizability in relation to a field of understanding" (Thorne et al., 2009 p. 1385).

In other words: the findings presented in this article are not representative of all pious Muslim women with immigrant background living in Sweden and Denmark. Yet, it was clear that none of the women that we interviewed experienced any barriers in accessing or using contraceptives; all of the women in our study that wanted to use contraceptives also did so. This strong tendency was considered to add substantial theoretical value to a discussion about targeted interventions towards groups of immigrant women in contraceptive counseling. We also believe that it is likely that the dilemma illustrated in this article — i.e., regarding the transferability of large-scale tendencies at group level into face-to-face encounters with individual patients — can be found in other areas of medicine and public health research as well.

Conclusion

We can conclude that the empirical evidence regarding the contraceptive practices of women of ethnic and religious minority groups is more nuanced than they appear at first glance. We have shown that the dominant theory that 'low socioeconomic status' and 'religiousness' are paramount barriers to these women's use of contraception must be problematized. When formulating suggestions for how to provide contraceptive counseling to women of minority groups in Denmark and Sweden, one must also take into account that factors such as low financial security as well as religious convictions can be strong imperatives for women to use contraception and thereby postpone having children. In other words, group-level data is not always useful in encounters with individual patients (Olivier and Wodon, 2015). In summary, the findings in this study can help to inform a critical discussion about the difficulties associated with using broad group-categorizations for understanding individuals' health-related behavior (see Brubaker, 2013; Nielsen et al., 2013), as well as the validity of 'targeted interventions' for large heterogeneous minority groups in Scandinavian contraceptive counseling (Mulinari et al., 2015).

Conflict of interest

The Authors declare that there is no conflict of interest.

Ethical approval

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