General practitioner experiences in delivering early medical abortion services to women from culturally and linguistically diverse backgrounds

A qualitative–descriptive study

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Background and objectives
General practitioners (GPs) are ideally placed to deliver early medical abortion (EMA), yet little is known about how GPs deliver this care to women from culturally and linguistically diverse (CALD) backgrounds. We explored GP experiences in providing EMA to women from CALD backgrounds and their recommendations for service improvements.

Methods
This was a qualitative study involving telephone interviews with 18 Australian GPs who provide EMA to women from CALD backgrounds. Data were thematically analysed using the Capability, Opportunity and Motivation Behaviour model.

Results
GPs experienced challenges in communication and cultural competency when delivering EMA to women from CALD backgrounds due to insufficient training, lack of multilingual resources and difficulties accessing interpreters. In addition, the stigma surrounding abortion and concerns around reproductive coercion made engaging these women challenging.

Discussion
Upskilling GPs in culturally competent care, improving access to multilingual resources and enabling efficient interpreter use can optimise EMA delivery to women from CALD backgrounds.

AUSTRALIA is one of the most culturally diverse nations globally, with over one-quarter (29.7%) of the population born overseas[1] and more than one-fifth (21%) speaking a language other than English at home.[2] Yet, women from culturally and linguistically diverse (CALD) backgrounds (defined in this paper as those born overseas or who have a parent born overseas and whose first language is not English[3]) experience poorer sexual and reproductive health (SRH) outcomes than Australian-born women,[4] including higher rates of unintended pregnancy.[5] International literature also suggest that migrant women have higher rates of abortion[6] and present to abortion clinics at later gestational ages than non-immigrant women.[7]

These disparities may be attributed, in part, to lower utilisation and access to SRH services by culturally diverse communities.[8,9] Reasons for underutilisation include unfamiliarity with the Australian health system, poor health literacy, financial constraints, language barriers and confidentiality concerns.[4,10,11] SRH provision to women from CALD backgrounds may also be complex due to the sensitivity of SRH in some cultures,[10,11] which, coupled with a lack of cultural safety in the Australian healthcare system,[12,13] can make the provision of culturally appropriate services challenging. Consequently, the *National women's health strategy 2020–2030* has identified women from CALD backgrounds as a priority population for improving access to SRH services, including early medical abortion (EMA).[14]

General practitioners (GPs) have the potential to improve access to EMA services because they are usually the first point of contact for pregnancy-related issues.[15] GPs are particularly critical for improving access to EMA for women in rural and regional areas who are often geographically isolated from private abortion services.[16] Despite this, there are limited qualitative or quantitative data on EMA delivery to women from CALD backgrounds in the general practice setting. Specifically, literature regarding GP perceptions on EMA delivery to women from CALD backgrounds is lacking. Examining GP perspectives

on EMA delivery to women from CALD backgrounds is necessary to identify gaps in service provision and improve access to EMA services for this priority group. Therefore, the aims of the present study were to: explore GP experiences in providing EMA services to women from CALD backgrounds; and describe GP perspectives on improving EMA care to this priority population in the Australian general practice setting.

Methods

Study design

A qualitative–descriptive approach was chosen to enable an in-depth exploration of GPs' experiences in delivering EMA to women from CALD backgrounds. The study design was guided by the Capability, Opportunity and Motivation Behaviour (COM-B) model.[17] The COM-B model postulates that behaviour is the result of an interaction between three components: capability, opportunity and motivation. This model was used to link GPs' experiences to a specific component of behaviour, which would facilitate the selection of intervention and policy strategies that are most likely to be effective in addressing the barriers to EMA delivery to women from CALD backgrounds.

Researcher characteristics and reflexivity

The interviewer and lead author (RS) is a young, female, medical student from a CALD background. Her cultural background and the conduct of a literature review before data collection may have led her to come into the project with preconceived perceptions. Participants were aware of her status as a medical student. A reflexivity journal, which recorded methodological decisions and reflections from interviews, was maintained throughout the research process to identify and counteract sources of bias. RS and LM both received interview and qualitative research training from experienced qualitative researchers at the Department of General Practice, Monash University. The other authors (AKS, DM and MS) are experienced qualitative researchers and DM is also a GP.

Sample and recruitment

GPs who provide EMA to women from CALD backgrounds in the Australian general practice setting were recruited nationally between June and August 2021 using purposive and snowballing sampling methods. Three strategies were used: email invitations were sent to practices with a GP EMA provider listed on Victoria's 1800 My Options website[18] or Queensland's Children by Choice website[19] (SRH service directories that direct women to local abortion service providers); social media advertisements were posted on a private Australian medical abortion providers special interest Facebook group; and recruited GPs were asked to pass on the study details to other GP EMA providers. Interested GPs emailed the lead author (RS). Written consent was obtained and interview times were subsequently arranged. There were no pre-existing relationships between the researcher and any participants.

Data collection

Semi-structured, audio recorded telephone interviews were conducted (by RS) between June and August 2021. Sampling continued to 18 participants to confirm data saturation. The COM-B model[17] and literature review that was completed before data collection underpinned the semi-structured interview guide. Four pilot interviews with GPs were conducted to further refine the interview guide (pilot interviews were not included in the final data set). The final interview guide (Appendix 1; available online only) explored GPs' experiences in delivering EMA to women from CALD backgrounds. All participants were reimbursed with a $150 gift card as acknowledgement for their time.

Data processing and analysis

Interviews were transcribed verbatim and subsequently deidentified. Data were stored and managed in NVivo (QSR International, Denver, CO, USA), and access was only granted to researchers who were involved in the project. Braun and Clarke's six-phase theoretical framework guided the reflexive thematic analysis process.[20] Initial codes were generated by two researchers (RS and LM) from review and independent line-by-line coding of five transcripts. Coding discrepancies were discussed and reviewed to create a final common coding scheme. RS then used this coding scheme to code the remaining transcripts and group the codes into themes. Following this, consensus of findings and themes occurred between all researchers, which increased the qualitative rigour and reliability of the analysis.

Results

Participant demographics

Eighteen GPs were interviewed (Table 1). Fourteen GPs were female and four were male. GPs ranged in age from 30 to 55 years; 61% spoke a language other than English and most practised in metropolitan clinics. Interviews ranged in duration from 22 to 54 minutes.

From the data analysed, the following three themes emerged: provider preparedness, sociocultural influences and the GP's important role in the community.

Provider preparedness

Cultural capability is not included in EMA training for GPs

Most GPs felt they had insufficient formal training in providing EMA to women from CALD backgrounds, and that this reduced their confidence in service provision to this patient group. Many expressed a willingness to undertake training on culturally responsive communication and EMA care to further build competency in managing challenging situations, such as responding to indications of reproductive coercion. In particular, GPs noted they would appreciate training when first initiating the service to gain skills and confidence in providing EMA to this priority group:

> *I think having some specific training would be really useful to think about what other things might be going on for women and to better tailor your service.* (GP1, female, Vic)

> (Cultural-specific training) *would have given me confidence … at least to make* (me) *start the service without worrying about it.* (GP2, male, Qld)

Table 1. Participant demographics (n=18)

Characteristic	No. participants
Sex	
Female	14
Male	4
Age (years)	
30–39	14
40–49	3
≥50	1
CALD status (self-reported[A])	
Non-CALD background	8
CALD background	10
State of practice	
Victoria	12
Queensland	4
Tasmania	1
Western Australia	1
Remoteness of practice[B]	
Metropolitan (RA1)	16
Inner regional (RA2)	1
Outer regional (RA3)	1
Clinic billing type	
Private	7
Bulkbilling	6
Mixed	5
Years providing EMA	
<1	1
1 to <2	5
2 to <3	4
3 to <4	3
4 to <5	2
≥5	3
No. EMAs provided to women from CALD backgrounds per month	
<1	3
1–2	4
3–4	3
≥4	8

[A]General practitioners self-reported as coming from a culturally and linguistically diverse (CALD) background (ie they were born in a non-English speaking country and/or spoke a language other than English at home).

[B]The remoteness of practice was determined from the Health Workforce Locator Map, using the Australian Statistical Geography Standard – Remoteness Area (ASGS-RA) 2016 classification.[21]

CALD, culturally and linguistically diverse; EMA, early medical abortion.

However, one GP noted that extra training on cultural capability may deter GPs from becoming providers because they already undergo additional training and recertification every three years to provide EMA:

> *I think we all get a bit of training burnout … a lot of people don't provide it because there's the perceived hassle of doing the training.* (GP3, female, Vic)

GPs who had not received formal cultural-specific EMA training described their capability to provide this service as closely tied to experience. With more experience, GPs reported increased knowledge and skills on setting up their service, communicating with women and managing complications. Interestingly, GPs who had experience working with women from CALD backgrounds for other healthcare consultations indicated that cultural capability is an integral part of service provision and experience is transferable across services:

> *I'm quite used to doing medical consults* (with CALD women) *in other settings … those skills have been able to be transferred into providing medical terminations to CALD people.* (GP4, female, Qld)

Language incongruence between patient and doctor impedes effective communication

Due to verbal communication challenges, most GPs found patient education on the EMA process to be more difficult with women who speak languages other than English compared with English-speaking patients. Adequate patient understanding is a prerequisite for women to provide informed consent, and communication challenges may contribute to misunderstandings of instructions regarding medication access and use and follow-up:

> *… if there is that language barrier, I always wonder a little whether they're fully consenting …* (and) *understanding the whole process properly.* (GP5, female, Qld)

GPs felt that written patient information could overcome some of the challenges in communication. However, most GPs found it difficult to find written information in the patient's first language for patients with poor English literacy. Consequently, GPs

highlighted the need for more multilingual EMA patient education resources to be available, so GPs were confident that women who speak languages other than English had an adequate understanding of the procedure they were consenting to.

Using an interpreter service was a common strategy for GPs to overcome the communication barrier. GPs emphasised the importance of interpreter services in supporting higher-quality EMA services. However, GPs also identified some issues with the use of these services that can be frustrating, including longer consultation times, inaccurate or biased translation with a third party present, confidentiality concerns (especially in smaller migrant communities) and logistical problems with interpreter availability (Table 2).

Sociocultural influences

Culturally prescribed gender roles increase GPs' concerns for reproductive coercion

Many GPs reported concerns about reproductive coercion when delivering EMA to women from CALD backgrounds. These concerns were accentuated when women attended appointments with partners who would 'keep talking over (them)' (GP4, female, Qld) or be 'answer(ing) on the woman's behalf' (GP6, male, Vic). The patriarchal gender roles and power dynamics within some CALD communities made it challenging for GPs to determine the woman's true needs and whether the male partner had an undue influence on the conversation:

> *I found that tricky that often it was the husband coming in leading the discussion … being more involved … it felt like there was less autonomy from the females and less of their concerns or feelings coming to the front.* (GP1, female, Vic)

GPs also found that detecting and assessing for reproductive coercion in women from CALD backgrounds was more difficult than with Australian-born women due to the language barrier and a reliance on using a male partner as a woman's interpreter, which could further facilitate reproductive coercion if the male partner was untruthful with the interpretation process:

> *Sometimes you wouldn't have an interpreter ready and so then you're reliant on their partner* (to interpret) *… which is not ideal if you're worried about coercion … because you don't know what they are saying.* (GP7, female, Vic)

GPs stressed the need for private appointments without the partner in the room so that they could assess for reproductive coercion and ensure that the woman was in control of her reproductive choices:

> *If I get that gut sensation that I'm not getting the full story … or the male is more dominant … then I want to get her alone so I can make sure she's making the right decision.* (GP4, female, Qld)

However, some GPs also acknowledged that male partners were an excellent source of support for women by assisting them in understanding the procedure and providing emotional comfort.

Stigmatisation of premarital sex and abortion

Many GPs noted that it is difficult for women from CALD backgrounds to access EMA services because of the cultural and/or religious stigma surrounding abortion and the conflict between making a choice that is best for them or one that meets their cultural and/or religious community's expectations and values. Cultural and/or religious norms that GPs found contributed to abortion being viewed as a taboo subject included the unacceptability of premarital sex, the belief that abortion is morally wrong and the idea that motherhood is central to the construction of a married woman's identity. These values resulted in some women believing that 'they will be punished by their God' (GP8, female, Vic) or that they are a 'bad woman because they are doing an abortion' (GP9, female, Vic), which could negatively affect emotional wellbeing. Given the fear of social or family exclusion, judgement and shame associated with having an abortion in some cultural and/or religious groups, GPs found it particularly important to provide extra support and reassurance regarding the maintenance of confidentiality.

Many GPs discussed that taking the time during consultations to acknowledge the woman's cultural and/or religious values and views on unintended pregnancy and abortion was necessary to build rapport, inspire trust and provide optimal care:

> *It makes things a lot more acceptable for them if they know that you respect or know where they're coming from with their background needs.* (GP10, female, Qld)

However, practical considerations around lack of time and insufficient Medicare rebates for EMA consultations make it difficult for GPs to incorporate cultural understanding in practice. GPs felt EMA consultations were already complex and detailed, and therefore reported having to prioritise clinical aspects of care.

Other strategies GPs wanted to incorporate into their practice to create a culturally welcoming environment included employing multicultural staff and using images and posters in multiple languages that reflect the diversity of their patient population.

Patient–provider gender and cultural background concordance can improve the clinical relationship

Most GPs noted that in some cultures, especially those in which significance is placed on female modesty, discussing SRH issues with male healthcare professionals is embarrassing and uncomfortable for women. Accordingly, female GPs noted that it may be 'easier and more culturally acceptable' (GP3, female, Vic) for them to deliver EMA services to women from CALD backgrounds rather than their male colleagues. Some GPs also discussed how sharing a cultural and/or religious background with the woman generated trust and rapport through greater sensitivity to community needs, cultural beliefs and language nuances:

> *… being CALD myself is something that makes me feel super comfortable … I'm already coming from a different perspective to your cisgender, middle class, White person … in a lot of ways it's already*

> *implied that there's some understanding there.* (GP11, female, Vic)

GP's important role in the community

A regular GP creates an environment of comfort and trust

GPs' pre-existing relationships with women from CALD backgrounds positioned them well to deliver EMA services because they have already built rapport and trust, which makes the service more accessible. In addition, as a woman's regular GP, they are more likely to understand her circumstances, language ability and any cultural and/or religious factors that may be essential to consider during service delivery, allowing them to provide personalised care that is catered to an individual woman's needs:

> *... particularly if English isn't your first language ... it would be nice if your own GP who understands your situation better and is more familiar with your circumstances provides the care.* (GP1, female, Vic)

Discussion

Our findings suggest that GPs may experience challenges in communication and cultural capability arising from insufficient cultural competency training, limited availability of multilingual EMA resources and difficulties in accessing interpreters. GPs also noted that abortion stigma and the need to prioritise clinical care over cultural aspects because of insufficient remuneration often made it difficult to provide EMA to women from CALD backgrounds. In addition, the patriarchal gender roles that are perpetuated by some CALD communities increased GPs' concerns for reproductive coercion. Despite these challenges, GPs believed they are well placed to deliver EMA services to women from CALD backgrounds because they may feel more comfortable accessing the service through a known provider.

Our findings highlighted that communication difficulties arising from language incongruence between patient and doctor are a significant challenge when providing EMA. This finding is not unique to EMA consultations and is consistent with the literature on both SRH-specific and general primary care consultations with CALD populations.[9,10,22] Language barriers result in substandard patient–provider communication and consequently lower satisfaction with care, lower adherence to treatments and reduce willingness to return for follow-up.[23,24] In addition, given that EMA is a time-critical service, delays due to communication difficulties could result in illegibility for the procedure. Although the importance of professional interpreters in bridging this communication gap has been consistently highlighted in the literature,[8,23] our findings demonstrate that some GPs report difficulties in using interpreters, most often related to the logistical issues of interpreter availability. For GPs to effectively use professional interpreters, they need support to integrate interpreters into the workflow of the consultation. This could perhaps be achieved by using practice administrative staff before the patient enters the consulting room; for example, screening whether an interpreter is required when patients first call and recording relevant patient information (eg languages spoken, literacy levels in their first language and in English, need for interpreter, preference of GP/interpreter gender and cultural background). This information may help staff to prearrange interpreters specific to gender or ethno-culture and allocate extended consultation times.[25] Furthermore, as highlighted by the GPs in this study, there appears to be a lack of up-to-date translated EMA patient education resources in the Australian healthcare system, with currently available resources only providing translations in a limited number of languages.[26] To address communication and patient education challenges when delivering care to women from CALD backgrounds, further advocacy and consultation with multicultural organisations is required to create translated EMA resources in various languages that are easily accessible for GPs.

Cultural capability refers to the 'skills, knowledge, behaviours, and systems that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner'.[27] Previous literature has revealed that training in cultural capability for GPs was generally lacking, but desired and

Table 2. Issues general practitioners have encountered when using interpreters during consultations for early medical abortion with women from culturally and linguistically diverse backgrounds, with examples of participant quotations

Issue with interpreter use	Quotation
Longer consultation time	*... us*(ing) *an interpreter ... makes everything extra slow and tricky ... instead of needing a 20-minute appointment ... it becomes a 40-minute appointment when the interpreter is being used.* (GP12, female, Vic)
Inaccurate/biased translation	*I had one that had her own opinion on* (abortion) *... and I could tell because the mood changed, and the woman just starts not wanting to talk about it anymore ... that's really inappropriate to put your opinions into a consult that's not yours.* (GP13, female, WA)
Confidentiality concerns	*They don't want anyone else to be in the conversation ... because for them it's like someone else is part of their conversation. And they think it's someone that they know from the community...* (GP13, female, WA)
Interpreter availability	*It's hard if we haven't pre-empted needing an interpreter because then we have to ring up and hope somebody is available ... it can take 10–15 minutes to get somebody back on the phone, or sometimes we just have to rearrange it for a whole different time.* (GP4, female, Qld)

GP, general practitioner.

deemed important.[28] Similarly, the GPs in the present study reported insufficient training in providing culturally safe and responsive EMA care to women from CALD backgrounds, with skills and knowledge formed through experience. Many studies have demonstrated that healthcare professionals engaged in cultural capability training and workshops have increased confidence, knowledge and positive attitudes towards delivering services to women from CALD backgrounds.[29,30] Consequently, we suggest that MS-2 Step (mifepristone and misoprostol) training include a cultural component that educates providers on issues specific to delivering EMA services to women from CALD backgrounds. This may include teaching on sociocultural and structural barriers that can affect how women from CALD backgrounds access healthcare services. Training may be particularly useful for GPs who have recently started delivering the service to avoid them feeling unprepared, and instead equip them with the knowledge and skills on how best to support women from CALD backgrounds. Given previous research has revealed that some Australian GPs view the current EMA training as unnecessary and time consuming,[31] we must consider whether additional training in cultural capability may disincentivise GPs from becoming EMA providers. Further research is warranted on exploring how cultural capability training can be effectively incorporated within GP medical abortion training. Beyond individual health practitioner development, organisational changes, such as policies to employ staff from locally representative ethnic backgrounds and the use of visual pictures and posters in multiple languages that reflect the diverse patient population, may help create a culturally safe and welcoming environment for women from CALD backgrounds.[25] In addition, systems for feedback from women from CALD backgrounds about their experiences with EMA services and participant-led action research can help understand and close gaps in service provision and access from the lens of care seeking.

One aspect of culturally safe care is being aware that discussing SRH issues with men in some cultures is considered shameful and embarrassing, especially in those cultures where significance is placed on female modesty; therefore, women from these cultures may prefer to receive care from female providers.[9,11,22] This preference for female GPs is reflective in our sample, where the majority of GPs were female, which is an overrepresentation considering that women make up less than half of the Australian general practice workforce.[32] This may indicate that females are more likely to provide EMA services to women from CALD backgrounds given their ability to create a culturally acceptable environment. Similarly, GPs from CALD backgrounds were overrepresented in our sample compared with the national general practice workforce,[33] which may be representative of GPs who feel comfortable and confident in providing EMA services to women from CALD backgrounds.

The influence of culturally prescribed gender roles whereby male partners exert undue influence on reproductive decision making is consistent with previous literature and has several implications for GPs providing EMA care.[22,34] Data from Children by Choice suggest that up to one in five women from CALD backgrounds reports reproductive coercion.[35] Accordingly, the GPs in our study were aware of the challenges in trying to understand women's true needs and preferences when partners were involved in consultations, especially when they served as interpreters. Similar to our findings, previous literature reports that GPs lack adequate training and support regarding appropriate screening for reproductive coercion in general practice settings,[36] especially among women from CALD backgrounds.[25] Further research and education could help GPs understand how to sensitively detect and respond to reproductive coercion in general practice settings when delivering EMA services to women from CALD backgrounds who may present with different risk factors and needs to Australian-born women.

One limitation of the present study was the targeted recruitment of GPs who provided EMA to women from CALD backgrounds, because they may have built skills and confidence in providing this service through experience, which could bias responses in favour of positive views. Future research should include the recruitment of GPs who do not provide EMA to women from CALD backgrounds to investigate barriers that may prevent GPs from initiating service delivery. In addition, purposive and snowballing recruitment methods may have resulted in the recruited GPs sharing similar characteristics or experiences, which may have caused data saturation to be reached prematurely. Another limitation of the study is that there was an overrepresentation of GPs from Victoria and metropolitan areas, so our results may not be transferable across all Australian states and territories or rural/regional settings. It is particularly important to explore the experiences of rural/regional GPs with EMA provision because there are an increasing number of individuals from CALD backgrounds settling in rural/regional areas because of Australia's immigration policy.[37] Finally, women categorised as 'CALD' come from various backgrounds and experiences, and we could not reflect on this diversity and variability in patient needs between and within cultures in our study.

Conclusion

As Australia grows increasingly diverse and welcomes young and working-age immigrant populations, understanding how to improve the quality of EMA care for women from CALD backgrounds is critical. We suggest four strategies to improve EMA delivery to women from CALD backgrounds:

- upskilling GPs in cultural capability and cross-cultural communication
- the development of multilingual EMA patient education resources in various languages that are easily accessible for GPs
- the development of efficient systems for interpreter use
- further research into the detection and management of reproductive coercion in women from migrant and refugee backgrounds in general practice settings.

In addition to a national SRH policy that explicitly recognises the unique reproductive health needs of women from CALD backgrounds, these four strategies may promote better quality EMA care to women from CALD backgrounds, in accordance with the goals delineated by the *National women's health strategy 2020–2030*.[14]

Key points

- Cultural capability training can be integrated within MS-2 Step training as one strategy to improve GPs' ability to meet the needs of their patients from CALD backgrounds.
- Additional training may be helpful for GPs on effectively organising and using interpreters during consultations, as well as sensitively detecting and responding to indications of reproductive coercion. GP resources include the RACGP-endorsed *Guide for clinicians working with interpreters in healthcare settings*[38] and *The White Book: Abuse and violence – working with patients in general practice* (see p. 283–303 for recommendations specific to migrant and refugee communities).[39]
- Developing EMA patient education resources in various languages may improve GP–patient communication. The Victorian Government's Health Translations website provides healthcare providers with fact sheets on medical abortion in some languages (www.healthtranslations.vic.gov.au/advanced-search?q=termination).
- GP–patient gender concordance is highly effective in facilitating the delivery of EMA services to women from CALD backgrounds.
- GP practices can consider incorporating organisational changes, such as employing staff from diverse backgrounds reflective of the patient population; creating policies and procedures on how to access interpreters and culturally appropriate support services; and using multilingual posters, brochures and visual images in waiting rooms.

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