

**All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health:
Inquiry on access to contraception in England**

**Written evidence submission from University of Sussex academics:
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EXECUTIVE SUMMARY

- We thank the All-Party Parliamentary Group on Sexual and Reproductive Health for this opportunity to submit our qualitative research findings on reproductive decision-making among women of Bangladeshi, Indian and Pakistani origin in the UK, which has a bearing on their access to contraception.
- The qualitative research findings presented in this submission are part of a broader interdisciplinary study focusing on prenatal sex-selection in the UK, which is funded by the Economic and Social Research Council (Principal Investigator: Dr Sylvie Dubuc, University of Reading; Co-Investigator: Professor Maya Unnithan, University of Sussex). Further information about our research project can be found at: www.sussex.ac.uk/anthropology/research/uksonpref
- Sexual and reproductive health services are increasingly expected to meet the needs of diverse populations and this evidence submission addresses the issue of inequalities in access to contraception amongst ethnic minority and migrant women. Our research shows that women of Bangladeshi, Indian and Pakistani origin have diverse contraceptive care needs, which differ according to place of birth, migration, education, employment and family pressures and that they face existing barriers to contraceptive care. Examples of these different barriers to access are detailed below.
- Our research has been conducted at a time when concerns have been raised by sexual and reproductive healthcare providers about cuts to funding and fragmented services, and the impact on women's access to contraceptive care across the country.¹ Our concern is how these structural changes to the delivery of services will compound the existing barriers to contraceptive care that women of Bangladeshi, Indian and Pakistani origin experience.
- Understanding the contraceptive care needs of women is important to inform the design of quality and inclusive sexual and reproductive health services, and it is equally important for services to be responsive, flexible and adaptable to help meet women's needs. While ethnic minority groups are diverse and heterogeneous, it is hoped the research findings and recommendations outlined in this evidence submission, which relate to women of Bangladeshi, Indian and Pakistani origin, will assist the APPG in considering more broadly the issues faced by black and ethnic minority women in accessing contraception.
- Our qualitative research findings have informed the following recommendations to ensure contraceptive services can be responsive to the diverse needs of women of Bangladeshi, Indian and Pakistani origin;

- Women of Bangladeshi, Indian and Pakistani origin require multiple referral pathways to contraceptive and abortion care due to perceived stigma in their communities and from their local GPs.
- Cultural-awareness training around perceptions of contraceptive use may help providers of sexual and reproductive health services to sensitively and accurately address the needs of Bangladeshi, Indian and Pakistani women.
- Enhancing the quality of contraceptive information and counselling available could support the increasing preference for smaller family sizes amongst UK-born Bangladeshi, Indian and Pakistani couples.
- There is an urgent need to ensure access to accurate sexual and reproductive health information and to address poor knowledge about contraceptive and abortion care that constrains reproductive decision-making.
- Quality and inclusivity of Relationships and Sex Education (RSE) in schools is regarded as necessary to support parents with the life decisions that young people might make.
- There is a need for providers of sexual and reproductive health services to engage with qualitative research evidence, as part of ongoing assessments of service provision and to ensure services meet women's needs.

1. OVERVIEW OF RESEARCH

- 1.1 How women perceive optimal reproductive health and what influences and constrains their decision-making is an emerging public health concern in the UK.² Understanding the cultural context of contraceptive use is important to support women from minority backgrounds with reproductive decision-making, particularly if decisions tend to be negotiated with husbands, kin or religious authorities.
- 1.2 Contraceptive care is most effective when services are responsive to the needs of women of Bangladeshi, Indian and Pakistani origin.³ Flexible services can address the challenge of equitable access to contraception in this diverse minority group.
- 1.3 In this submission of evidence we outline the particular sensitivities and opportunities around contraceptive counselling in abortion provision for women of Bangladeshi, Indian and Pakistani origin as highlighted by our research findings. Although public records indicate that Asian/Asian British women in England and Wales have higher abortion rates relative to population size,^{4,5} a focus on quantitative measures alone obscures the inequities in access to sexual and reproductive health services.

- 1.4 Contraceptive counselling in abortion care can raise conflicting priorities for women and providers when attempting to support decision-making (including the choice to decline contraception).⁶
- 1.5 The qualitative research draws on an analysis of over 90 interviews conducted amongst families of Bangladeshi, Indian and Pakistani origin living in Manchester, Greater London, Peterborough and Sussex between January 2018 and January 2019. This included UK-born and foreign-born participants who are of Muslim, Hindu and Sikh religious backgrounds, as well as intermarried families. Participants ranged from 18 to 84 years of age. We conducted a further 16 interviews with sexual and reproductive healthcare providers to investigate issues around contraception in abortion care provision, for women and men of Bangladeshi, Indian and Pakistani origin.

2. EVIDENCE FROM OUR RESEARCH STUDY REGARDING ACCESS TO CONTRACEPTION AMONGST WOMEN OF BANGLADESHI, INDIAN AND PAKISTANI ORIGIN LIVING IN ENGLAND

Patient-provider dynamics

- 2.1 NHS sexual and reproductive health providers widely reported that Bangladeshi, Indian and Pakistani women would withhold information from them if they shared a similar ethnic and religious background, fearing judgement or issues around confidentiality. This was particularly the case for women in pre-marital or extra-marital relationships. Having a diverse staff team was therefore viewed as a valuable aspect of healthcare delivery strategies, which could support women to disclose sensitive information at various stages of their care. Providers also reported that women would often access sexual and reproductive health care outside their home towns, to avoid being seen by family and friends from their ethnic or religious communities.
- 2.2 **Contraceptive counselling in abortion care provision**
Abortion care providers in our study perceived men of Bangladeshi, Indian and Pakistani origin as more likely to hold responsibility for contraceptive-use, compared to consultations with women and men from the general population. Married women, particularly foreign-born women, were described as deferring decisions or 'relying' on their husbands during contraceptive counselling. Reliance on male condoms, and non-use of contraception, was deemed a major reason why women would present for abortion care. Providers tended to view this as a 'cultural' issue, which was challenging for providers to grasp as it conflicted with their own values around women's autonomy in reproductive decision-making. Reliance on condoms indicated for the providers a lack of reproductive autonomy, with male partners exerting control over reproductive decision-making (especially in situations of domestic abuse).
- 2.3 Married women mainly used contraception (including reliance on male condoms) for birth spacing to delay initial childbearing within marriage, rather than to prevent conceptions altogether. Married women of Bangladeshi, Indian and Pakistani origin reported that forms of female contraception enabled them to maintain a degree of control over continuous childbearing.

- 2.4 Bangladeshi, Indian and Pakistani women in our study often relied on less effective methods of contraception (male condom; lactational amenorrhoea) due to fear of contraceptive side-effects and misinformation around side-effects. When childbearing is regarded as the primary purpose of marriage and a woman's social status, long-term contraceptive-use can present negative social implications for Bangladeshi, Indian and Pakistani women — such as rumours that women are unable to conceive. Long-acting reversible contraception (LARCs) can be problematic for observant Muslim women intending to go on *Haj* (pilgrimage), as the body should be in a 'natural' state (i.e. non-intervened).

Discreet access to contraception

- 2.5 Some women of Bangladeshi, Indian and Pakistani origin disclosed how they would take contraception without their husband's knowledge, particularly in abuse situations, indicating how women have varying levels of agency in contraceptive decision-making. Abortion care providers should have confidential consultations with the woman concerned to identify the grounds for abortion (or an opportunity where a partner or relative is not invited to join the consultation). This would also identify whether women prefer to discuss contraception alone or with a partner present.

Pre-marital relationships

- 2.6 Younger Bangladeshi, Indian and Pakistani women in pre-marital relations often make contraceptive decisions within the context of familial constraints. Parents were apprehensive about daughters taking contraception in case it encouraged pre-marital sex, which they were strongly opposed to. Pre-marital relationships can be risky for women due to notions of family shame, and in more extreme situations, crimes of control (so-called 'honour crimes').
- 2.7 Forms of contraception can cause infrequent periods, presenting implications for contraceptive counselling and decision-making. Parents are more able to identify irregular menstruation arising from contraceptive use in highly socioeconomically deprived areas, with issues of overcrowding and lack of privacy.

Relationships and sex education (RSE)

- 2.8 Inaccurate knowledge around contraception and abortion was widespread among adolescents and their parents. Analysis of online media targeting youths of South Asian origin also contained inaccurate information around sexual health and portrayed premarital sex as well as abortion negatively (framed in terms of 'promiscuity'). Sexually active youths practiced unprotected sex and relied on ineffective contraceptive methods, such as withdrawal or non-use of contraception, followed by emergency contraception (the morning after pill).
- 2.9 RSE is not considered appropriate to discuss in homes or community settings. Parents as well as religious and community leaders avoid these topics, and expect young people to know how to access sex and relationships information. Whilst parents claimed there was no issue of lack of knowledge pertaining to RSE due to school-based education curriculums, they were unable to confirm the extent or the quality of knowledge their children had.
- 2.10 Study participants described a need for universal and high-quality RSE education, with tailored programmes for students of a Bangladeshi, Indian and Pakistani origin to prepare them on how to respond to marital and

childbearing pressures. They also requested that RSE programmes support parents with the life decisions that young people might make in order to offer continuity between home and school.

3. KEY FINDINGS AND RELATED RECOMMENDATIONS

- 3.1 **Provider-patient relations:** Sexual and reproductive health is a unique area of medicine where women of a Bangladeshi, Indian and Pakistani origin may value the choice to seek this care from providers who do not share their ethnic or religious background, and require multiple referral pathways to contraceptive and abortion care due to perceived stigma in their communities and from their local GPs.
- 3.2 **Contraceptive counselling in abortion provision:** Contraceptive decision-making differs according to whether women of Bangladeshi, Indian or Pakistani origin are UK-born or foreign-born. Having services that are responsive and flexible can support healthcare professionals to understand and work within the cultural context of contraceptive use. Cultural-awareness training around perceptions of side-effects for shorter and longer-term contraceptive use may help providers to sensitively and accurately address the needs of Bangladeshi, Indian and Pakistani women.
- 3.3 **Supporting desires for smaller-family sizes:** UK-born Bangladeshi, Indian and Pakistani couples increasingly have a preference for smaller family sizes. Enhancing the quality of information and counselling will support younger women and men's aspiration in this regard.
- 3.4 **Sexual and reproductive protection:** There is an urgent need to ensure access to accurate sexual and reproductive health information and to address the chronic issue of poor knowledge pertaining to contraceptive and abortion care that constrains reproductive decision-making.
- 3.5 **Relationships and sex education:** Bangladeshi, Indian and Pakistani women in our study regarded schools as the most appropriate place to promote sexual and reproductive protection. Quality and inclusive relationships and sex education (RSE) was regarded as necessary to support parents with the life decisions that young people might make, offering continuity between home and school.
- 3.6 **Investing in qualitative research evidence:** Qualitative research methods are able to discern the complex and nuanced barriers to care through an analysis of the cultural context of contraceptive use among Black, Asian and other non-white minority ethnic (BAME) groups. Thus, there is a need for providers and statutory services to engage with qualitative research evidence as part of continual assessments of service provision.

4. FURTHER INFORMATION AND RESOURCES

Contacts

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Further information about our research project can be found at:
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Supporting references

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