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,

Women of

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.

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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 2 0 Td [(()-6 51 EMC /P av1

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. C(ont)4.3 (r)-6 (a)-2 (e.)-6.002 Tc 0.002

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Further information about our research project can be found at:
http://www.sussex.ac.uk/anthropology/research/uksonpref

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Supporting references

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