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Understanding women from ethnic minorities' perspectives about contraception in the UK: a qualitative study using a participatory action research approach with community research link workers

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ABSTRACT

Background Contraception has revolutionised women's health, enabling planned pregnancies and improved outcomes for mothers and babies. However, disparities exist in rates of unintended pregnancies and contraceptive uptake among ethnic groups. The reasons for this are poorly understood.

Objective To understand women from ethnic minorities' perspectives about contraception.

Methods Our qualitative study used a participatory action research approach, utilising community research link workers. Public engagement was embedded in the study's conception. We used focus groups and interviews to elicit perspectives, then analysed the data using thematic analysis. The study participants were women who self-identified as being from an ethnic minority group in Sheffield, UK.

Results Thirty-six women participated in four focus groups and five interviews. Thematic analysis revealed four themes: (1) The role of contraception in a woman's life, (2) External influencers, (3) Cultural and religious considerations and (4) Everyone is different (individuality). Contraceptive needs should be considered holistically, rather than with a siloed, targeted approach. 'External influencers', such as partners, family and communities, determine how contraception is accessed and experienced. 'Cultural considerations', such as personal, sociocultural and religious factors specific to women from ethnic minorities, influence contraceptive choice.

Conclusions This study provides a transcultural perspective of the issues at play when a woman from an ethnic minority makes a decision about contraception. Practitioners and health providers must be culturally competent and tailor consultations and services to the individual.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Rates of unintended pregnancies are higher among underserved communities. Differing use of, or access to, contraception may contribute to this, but research is lacking.

BACKGROUND

Contraception has revolutionised women's health, enabling women to control their fertility and has social, economic and health benefits. Planned pregnancies have lower rates of obstetric complications and improved outcomes for both mother and baby.[1] The United Nations enshrines contraceptive access as a human right that "should be available to all, not just the wealthy or otherwise privileged".[2] Despite this, rates of unintended pregnancy are higher among those from ethnic minorities, lower socioeconomic groups, and those with mental health conditions.[3 4]

Women from ethnic minorities in the UK who are sexually active report using contraception less than their White

WHAT THIS STUDY ADDS

⇒ This diverse qualitative study provides in-depth insights into the factors that affect women from ethnic minorities when they make choices about contraception. Women described multiple forms of inequality or disadvantage, which often compound each other. These obstacles may be overlooked in traditional research and policy planning.

HOW THIS MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ A holistic understanding of the needs of women from ethnic minorities will enable clinicians to practise in a culturally competent manner. Understanding some of the unique challenges that women can face will allow policymakers to provide a more equal contraceptive service. Interventions and policies must be designed with users at the heart. Research without co-design can perpetuate inequalities due to subconscious biases by academics and policymakers.

counterparts; they are also less likely to use hormonal or permanent forms of contraception and rely more on barrier methods such as condoms.[5] Racial inequality exists widely within sexual and reproductive health. In 2021, Black women had disproportionality higher rates of abortion.[6] Use of emergency contraception and rates of sexually transmitted infections are also higher among certain ethnic minority groups.[7]

Some 18% of the UK population identify as being from an ethnic minority and 15% of the UK population are born outside of the UK.[8] International migrants face unique challenges within healthcare. There is a lack of research exploring the opinions of women from ethnic minorities about contraception, reflecting a wider context of underrepresentation of minority groups in research. Wider societal and historical influences have degraded trust in academic and healthcare institutions, and this is especially clear in reproductive health research.[9]

To enable women from ethnic minorities to have equal reproductive autonomy we need to understand their wants and needs. In this qualitative study based in Sheffield (UK), we set out to understand the perceptions of women from ethnic minority groups towards all contraceptive options and the services that provide them. Using an adapted participation model, our project focused on power sharing and co-production in research.[10] Participatory action research is an approach that is ideal for exploring unequal or harmful systems, with relationships between communities and academics being key to social change.[11] By determining what support is needed to make informed contraceptive choices, we can, in the future, work with women to co-produce methods of equalising access.

METHODS

Public and patient involvement and engagement

Acknowledging the positionality of our research team, public and patient involvement and engagement (PPIE) was embedded throughout the study. From conception, we sought the views of ethnic minority women. We scoped acceptability via an online survey distributed through social media links on Instagram. We held an in-person meeting with the research team and 20 women in local communities (eight Black African, five Black Caribbean, seven South Asian). The study's aims and methods were further developed and refined.[12]

Community research link workers

We recruited three female community research link workers (CRLWs) via local community networks within DeepEnd Research Alliance (DERA) in Sheffield. Each CRLW identified as being from a different ethnic group (South Asian, Black Africa, Black Caribbean). They underwent basic research skills training, which covered research ethics, focus group facilitation and analysis. CRLWs were paid for their time.

Participants

We used purposive sampling to recruit the participants.[13] The CRLWs approached community groups (including charitable organisations aiming to support ethnic minority groups, and English language classes). To reduce digital exclusion, the CRLWs used various methods to approach participants, including in-person, telephone calls, email and the instant messaging service WhatsApp . Women were eligible for inclusion if they were aged 16–55 years, currently resident in the UK, and self-identified as being from an ethnic minority (any ethnicity except White).

Data collection

Women were invited to participate in focus groups or individual semi-structured interviews. Focus groups enable the interchange of ideas whereas interviews allow personal perspectives.[14] We developed a topic guide using literature, online survey and PPIE. Focus groups were facilitated by the CRLWs, and a female research team member was present to offer logistical and technical support, taking contemporaneous field notes.

We took informed consent using participant information sheets and consent forms which were translated professionally. The four focus groups took place in community settings, each comprising 6–10 women, and lasted approximately 120 min. One focus group was conducted in English and Urdu, and the rest were conducted in English. Five interviews took place online on Google Meet, lasting around 30 min with a female White researcher (EL). All participants were reimbursed for their time with shopping vouchers.

Recordings were made on an encrypted device and transcribed professionally.

Analysis

Analysis followed the principles of reflexive thematic analysis.[15 16] This approach was chosen as it "emphasises the importance of the researcher's subjectivity as an analytic approach", thus acknowledging the crucial role of the CRLWs in the analysis.[16] This followed Braun and Clarke's six-step model, which follows a six-step process: familiarisation, coding, generating themes, reviewing themes, defining and naming themes, and writing up.[17]

The analysis team members, including CRLWs (EL, RLM, RM, KF, CAM, AA, SD, FNN), read transcripts individually to gain familiarity with the data. Open coding was used to ensure accessibility of the process. Some examples of codes include "culture", "religion" and "stereotypes". EL, RLM, KF, CAM, AA, SD and FNN then met to discuss codes, and used posters and coloured pens to create themes and discuss interpretation of themes and subthemes.

RESULTS

Demographics

A total of 36 women took part in four focus groups and five interviews. A majority self-identified as being Black, Black British, Caribbean or African (22/36), and 11 women identified as Asian or Asian British. A majority self-identified as members of a faith community. Age demographics were collected in categories with most participants being aged 35–44 years. Sixteen women (44%) were married. Full demographic information is presented in table 1. Among the 70% of women born outside the UK, we had representation

Table 1 Participant demographics

Demographic	Focus group participants n	Individual interviews n	Demographic	Focus group participants n	Individual interviews n
Total participants	31	5	Religion		
Age (years)			Buddhist	0	0
18–24	0	0	Christian	12	0
25–34	5	2	Hindu	0	0
35–44	18	2	Jewish	0	0
45–55	8	0	Muslim	16	5
Not recorded	0	1	Sikh	0	0
Marital status			Other	1	0
Single	9	0	None	1	0
Married	15	1	Not recorded	1	0
In a relationship	2	0	Employment		
Widowed	2	0	Yes	13	2
Divorced	2	3	No	17	2
Not recorded	1	1	Not recorded	1	1
Ethnicity			Sexual orientation		
Asian or Asian British	9	2	Straight	16	0
Black, Black British, Caribbean or African	21	1	Lesbian/gay	0	0
Mixed or multiple	0	0	Bisexual	0	0
Other	1	1	Other	0	0
Not recorded		1	Not recorded	15	5
Education			Experience of contraceptive services in UK		
No Formal	1	0	Yes	21	4
Primary school	5	0	No	9	0
High school	8	1	Not recorded	1	1
Degree	14	2	Born in UK		
Not recorded	3	2	Yes	6	2
			No	24	2
			Not recorded	1	1

from Botswana, Burundi, Congo, Iran, Kenya, Nigeria, Somalia, The Gambia and Zimbabwe.

Summary of themes

Thematic analysis generated four main themes which addressed the research question:

1. The role of contraception in a woman's life
2. External influencers
3. Cultural and religious considerations
4. Everyone is different (individuality).

The role of contraception in a woman's life

Pervading the data was discussion about the role that contraception plays in a woman's life. Conversations about whether and why participants might need contraception was inextricably linked to children. This was often connected to life and home circumstances, and participants discussed the effect that their background, ethnicity and culture had on this. Several women who were not born in the UK referenced how differences in way of life between the UK and their birth country influenced their lives, family size and requirement for contraception.

> *"If you go back to places in Pakistan or India or Bangladesh, it's very much the idea that a child is raised by a village, so in-laws, parents, aunts, uncles, they all come together to look after a child, so when you have a support network like that in place, why would you need contraception."* [South Asian participant]

Other participants spoke of the need to use contraception to improve their physical health or that of their offspring. Often this was by enabling spacing of children. A participant who spoke English as a second language stated:

> *"Not a baby gap in other baby, the little one baby then again, then again, so it's body wise. She can't take it".* [South Asian participant]

For many participants, the first time that contraception had played a role in their lives was when they encountered health professionals after the birth of their first child. Women discussed a lack of awareness about contraception prior to marriage or childbirth. They gave some examples about how the lack of knowledge might lead to potential consequences including unplanned pregnancy and abortion.

Abortion was not discussed in detail but was mentioned in relation to community stigma and taboo. One participant expressed fear of the impact of unwanted pregnancy. While this participant was South Asian, we understand that this is not unique to her community and is seen across all demographics within our society.

> *"I have experience of knowing an old neighbour… there was no kind of, like, information about contraception. And then she fell pregnant, and she went and had an abortion. And that then spelled the end of her marriage, and she was very much ostracised within the community."* [South Asian participant]

Other, less commonly cited reasons for using, or wanting information about contraception included it enabling women to achieve educationally or in a career. References to using contraception for protection against sexually transmitted infections were rare, and often accompanied by feelings of shame.

External influencers

Participants discussed external influences on women's choice and type of contraceptive to use. Several women discussed how the opinions of their extended family and their community culture affected their choices. Some highlighted mothers-in-law as having strong influence. One participant pointed out the dichotomy that can exist among certain cultures regarding attitudes to contraception.

> *"So there's that one side of like really treating it as… a taboo, but… in certain communities mothers-in-law and grandmas feel like they have the right to give an input into such a big decision."* [South Asian participant]

Much of the data contained references to men, often husbands, and women gave diverse opinions about their role in contraceptive choice. Some women felt that decisions about contraception should be joint between a man and a woman. More commonly expressed was the concept that men could have fixed ideals about number of children and thus the role, if any, of contraception.

> *"A lot of women have so many children, …, not because they want to,… but because the husband wants so many kids and he's not understanding why she can't continue having kids."* [Black African participant]

Sometimes, women discussed examples of reproductive coercion, whereby they did not have autonomy over their contraceptive choices. Some participants felt they had to keep their contraceptive choices "secret" from their husbands. Others shared examples of coercion by men around condom use.

> *"But some guys, I mean, I've heard stories of guys who put it on and then take it off in the middle, do you know what I mean, so yeah."* [African Caribbean participant]

One woman from Somalia discussed the impact of political policy for female genital mutilation (FGM) on her community. The repetitive inquisition by healthcare workers led to women disengaging, and in some cases delaying, essential care such as antenatal midwife booking.

> *"Every single appointment. Every single appointment. Even though it's in the notes, even though it's recorded I'm against it and everything,*

every time it's like 'by the way, you know FGM, blah blah blah', and after a while I got fed up of it, to me when I got home I was thinking like I wish they put all the effort on explaining contraception and all that time of wasting asking me about it and, like, I already told you, I don't want it, I'm not going to do it, all that stuff. So it's like, it's almost discouraging, I know ladies that avoid going to the midwife as long as possible because they're like they're going to only talk about this FGM, FGM, FGM." [Black African participant]

Safeguarding of girls and women is essential, protecting them from FGM being the highest priority, but this must be done in a way that promotes patient-centred care.

Cultural and religious considerations

The third theme relates to how a woman's culture and religion can affect her contraception decision-making. Some Muslim participants were uncertain if contraception was "haram" (forbidden by Islamic law) and thus whether they should use it at all. Others described how their religion affected their contraceptive choices. Sometimes this was due to a religious-specific context to certain side effects. Several Muslim participants said that they are not able to pray, fast, attend certain mosques or have "bedroom relationships with husbands" while they were bleeding and so contraceptive options with unpredictable bleeding patterns are less desirable. Religious considerations also governed contraceptive choice due to mechanism of action, with several women making a distinction between contraceptives which worked before and after fertilisation.

"Because tablet is definitely stop the pregnancy to be happened. The device, that it's installed somewhere, in the womb, that is not stopping the pregnancy." [East African participant]

Sometimes, this caused women to be suspicious of contraceptive devices.

"With everything, there's always there's myth that, like, the government or certain, like other ethnicities…manmade stuff – people trying to kill us off – things like that. So they don't want anything in their bodies." [African Caribbean participant]

Several participants expressed a preference for natural or herbal forms of contraception. Sometimes, this was tied to their cultural identity. Some Black African women discussed a preference for the "old fashioned African styles" of contraception and referenced the withdrawal method and "pouring lots of water" after sex.

Everyone is different (individuality)

The fourth theme reflects the heterogeneity of the groups. Often, participants would caveat a statement by saying that "everyone is different". One participant highlighted the challenges of making generalisations based on ethnicity during contraceptive consultations. Some participants felt that their ethnicity influenced the care they received during contraceptive consultations but expressed that it was difficult to quantify, and that stigmatisation could be "covert". Some felt their ethnicity had no impact. For others, however, the long shadow of reproductive coercion and impact of colonisation of contraception was evident.

Women discussed how often they felt judged or stereotyped because of their ethnicity.

"I feel like women, black women, I don't know, we're seen as more sexualised… That all we, like black females do is like twerk and dance." [Black Caribbean participant]

While some participants highlighted that they found generalisations based on their ethnicity challenging, others felt that their ethnicity should be better accounted for within contraceptive research and consultations. Several participants expressed a belief that their ethnicity affects how contraception is tolerated. Women felt that they had different biology, that their bodies were "built differently", which led to differing effects of contraception and medication.

DISCUSSION

This qualitative study was conducted with a diverse range of women and provides a transcultural overview of the issues at play when women from ethnic minorities make decisions about contraception. Our study showed many similarities regarding perceptions about contraception among these women in Sheffield. This review highlights the need for clinicians to be cognisant of culturally specific considerations, but this must not be at the expense of acknowledging the individual. Our findings concur with a recent global systematic review about what influences contraception access.[18] The review emphasises the role of a woman's knowledge and beliefs in contraceptive decision-making. This study goes further: providing granularity and showing the varied experiences of diverse communities while accepting that this diverse group of women's experiences may not be transferable to all women across the UK.

Participants highlighted a lack of awareness about contraception prior to adulthood or marriage. This finding likely reflects the high proportion of international migrants among our sample: contraception is taught in schools as part of the UK curriculum, but this is not the case worldwide.[19] The lack of awareness of the non-contraceptive benefits among women in our study was evident. Similar findings have been reported in studies from Lebanon and Singapore.[20 21]

It is well established that a woman's partner and community influence her choice of contraception, and our study supports this.[18] Reproductive coercion, whereby a woman loses the ability to make autonomous decisions related to her reproductive health, has

been linked to other forms of partner abuse.[22 23] There is some suggestion that women from ethnic minority groups might be more vulnerable to reproductive coercion.[24 25] Our study has given examples of this occurring, and contraceptive providers must be mindful of this fact.

The colonisation of contraception is well documented with several examples of historical abuses towards minority ethnic groups.[26 27] This study suggests that the shadow of this affects women's decision-making to this day. Participants voiced negative experiences of feeling stereotyped by safeguarding efforts, including discussions regarding FGM. This screening is doubtless necessary, but clinicians must move away from industrialised 'conveyor belt' care to ensure women feel more than a statistic.

Differences in opinions regarding contraception existed both within ethnic groups and between them. This highlights that although ethnicity plays a role in women's decision-making, all aspects of a woman's identity contribute to her choices. Personal characteristics such as race, class and ethnicity are uniquely combined to alter experiences and lead to discrimination or privilege. Inequalities are influenced by intersectional systems of society, which cause some to have more significant barriers to contraception care than others.[28]

This insight from this study will enable practitioners and health providers to be more culturally competent and better tailor consultations and services to the individual. A general practice survey in England found that patients from ethnic minorities report lower patient satisfaction compared with their White counterparts.[29] Several of the proposed reasons for this in previous literature (including a distrust of the medical system and negative stereotypes affecting the doctor–patient relationship) have been supported by our study.[29 30] Having an improved understanding of these barriers will better allow them to be overcome.

This study provided rich data outside the scope of the research. Several women listed side effects they had experienced from different contraceptives and suggested that these might be experienced differently due to their ethnicity. There is a lack of research into this topic and future work should evaluate side-effect profiles according to ethnicity.

Strengths and limitations

Community engagement was critical to this project and allowed us to define a research question and methodology appropriate for the topic. Our methodology was inclusive, giving participants a choice of method of participation and language. The CRLW-facilitated focus groups generated rich conversations, supporting the participation of women from a diverse range of backgrounds, including those who were not proficient in English and those born outside of the UK. Working with CRLWs at every stage, including analysis, allowed in-depth transcultural understandings and challenged the positionality of university researchers. This research was limited to participants in Sheffield, and although we had a diverse group, not all ethnicities could be represented. Three of the four focus groups were conducted in English, and translators were offered at all stages so this reflects participant preference, but future work should purposively sample women who do not speak English. The women in our study were predominantly from faith communities, either Muslim or Christian. We suggest caution when extrapolating these results to non-religious minoritised groups.

Our research team was diverse, but this is less so among other academic institutions locally and nationally where there is poor diverse representation among senior academics.[31] As researchers, we have explored complex and challenging subjects and gained so much from working with the CLRWs. Team members from White backgrounds have been on a journey to understanding intersectionality and racism. We hope this learning continues and that we can act as allies for those who suffer discrimination, especially within the reproductive health sphere. The positionality of 'power' is key when designing studies in reproductive health. We aim to move away from tokenistic input from underserved communities towards citizen power through stakeholder involvement and co-design.[10]

CONCLUSIONS

This study helps clinicians better meet the contraceptive needs of ethnic minority women in the UK. Understanding the barriers faced by women will enable practitioners to become more culturally competent, leading to improved outcomes and greater patient satisfaction. The co-production has formed enduring relationships: these will continue to flourish with ongoing and planned related research. This study has therefore had a dual effect: correcting the lack of evidence about contraception and ethnic minority women, while contributing to a growing momentum of reversing the underrepresentation of ethnic minority people in research.

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Author Note Regarding terminology and language, throughout this article the authors have tried to use words and phrases which closely match those used by participants, acknowledging that when used in other contexts, the terminologies can have altered connotations.

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