

Contraception Counselling for Women from Ethnic Minority Groups

SUPPORTING CLINICIANS IN HAVING CULTURALLY SENSITIVE
CONVERSATIONS ABOUT CONTRACEPTION

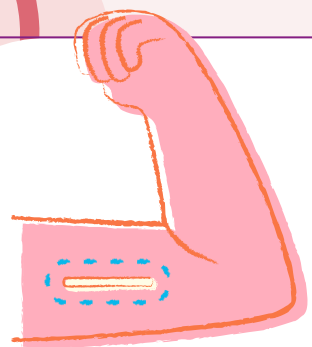


Background

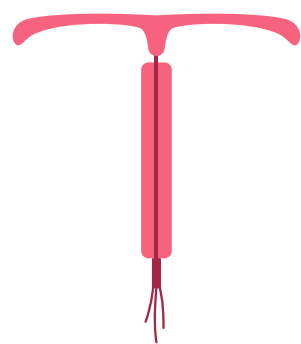
Unintended pregnancy is associated with **adverse parental and infant outcomes** and is a key priority in the Swindon Sexual Health Strategy.

Ethnic minority women in the UK use contraception **less frequently** than White women, including long-acting reversible contraceptives (LARC), the most effective type.

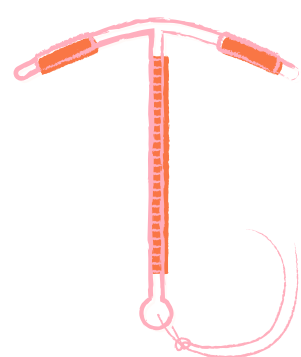
Also, higher rates of **unplanned pregnancies, unsafe abortions and STIs** among certain ethnic groups.



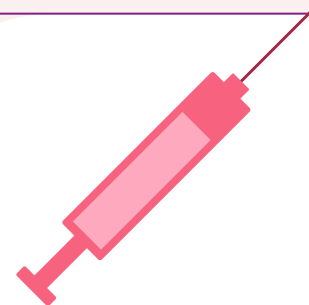
The
implant



Mirena coil



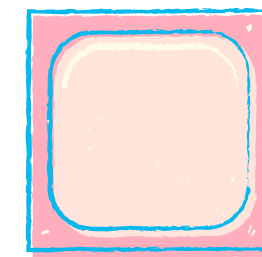
Copper coil



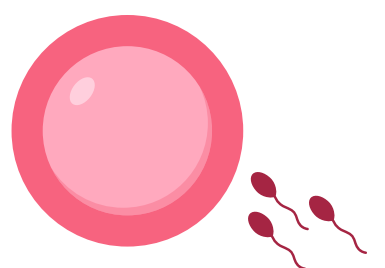
Depot
injection



Pill



Patch



Condom

Historical Context

Historically, contraception was used as a tool of **reproductive control** for Black and minority ethnic women.

due to **racialised and socio-economic assumptions**,

LARC methods disproportionately promoted, often with **limited autonomy or informed consent**

Contributed to ongoing **mistrust** of contraception and healthcare systems

Forced implant insertions as requirement of reduced judicial sentencing in 1990s of African and Latino Americans

Depo-Provera was disproportionately prescribed to **Black** and **working-class** women, sometimes outside guidelines in 70-80s

Colonial governments often promoted birth control to **reduce population growth**, rather than to improve women's health or autonomy

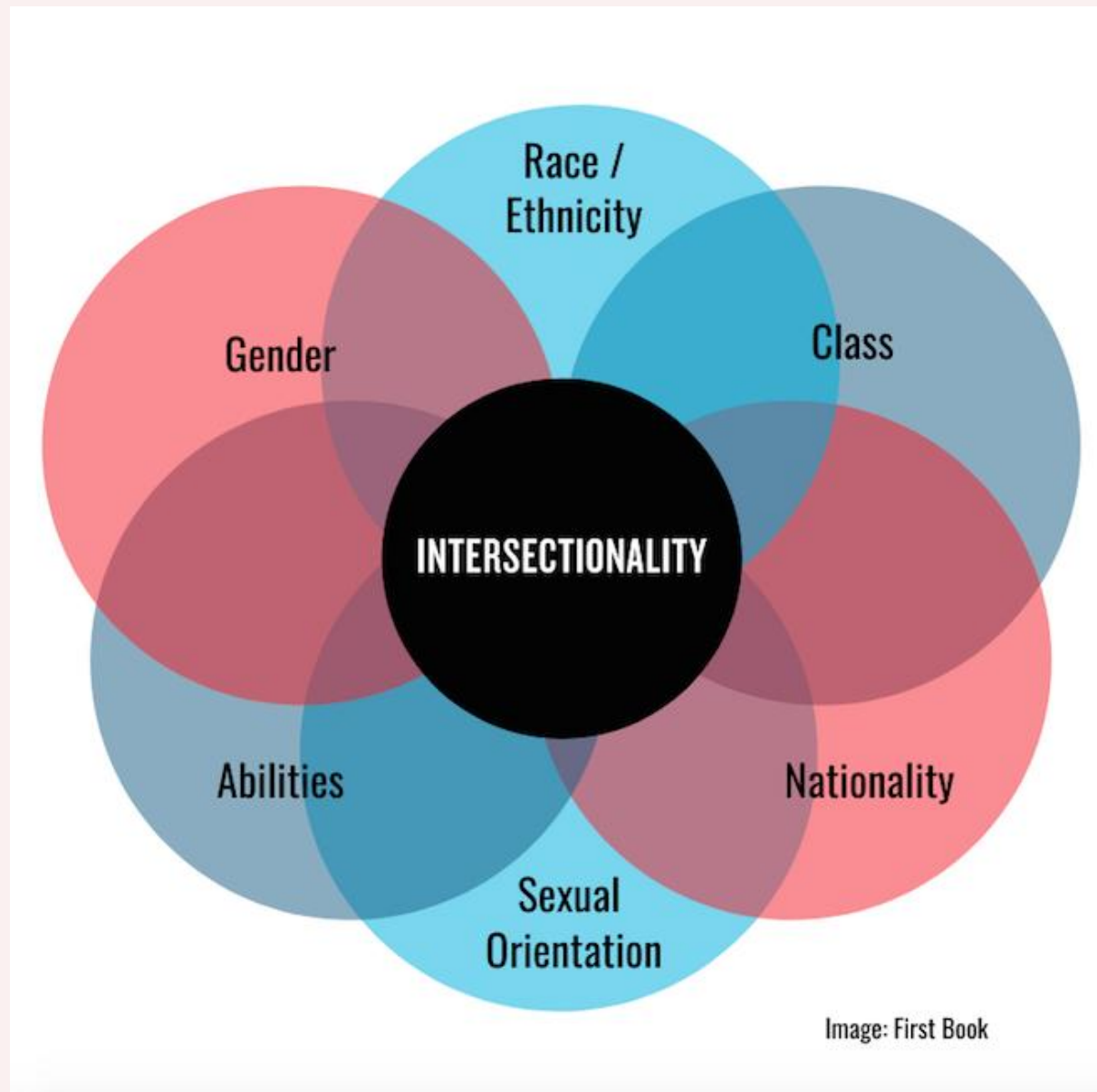
Women reporting racial discrimination more likely to use **less effective** contraceptive methods ie pill and condoms

Research indicates some ethnic minority women feel **targeted or coerced** by healthcare professionals toward contraceptives

Decisions were often justified using racialised **stereotypes**, such as women being labelled **“irresponsible”** or **“unfit”** mothers

INTERSECTIONALITY

Ethnicity intersects with other factors that shape access, safety, and autonomy



<https://www.inclusify.dk/en/hvad-er-intersektionalitet/>

Exploring access and safety

“Are there any practical or personal things that might make it harder for you to come to appointments or use certain methods?”

Domestic abuse

- Reproductive choices may be influenced or monitored
- Attendance, consent, or method choice may not be fully voluntary

Immigration status

- Fear of authorities or data-sharing
- Uncertainty about entitlement to free NHS care
- Previous experiences of restricted or unsafe healthcare

Neurodiversity

- Sensory sensitivity, processing time, or communication differences
- Need for clear structure, predictability, and explicit choice

Disability or chronic illness

- May be wrongly assumed to be asexual
- Less likely to be offered contraception proactively
- More likely to experience loss of autonomy or paternalism

Case

A 35-year-old woman (G5P5) is seen at her GP surgery for her 6 week postnatal check following an emergency LSCS. She is breastfeeding and recovering well. You wish to discuss contraception with her

How would you start this consultation and explore the patients priorities?



Starting the conversation



"We offer advice about contraception and the different methods, is that something you would like to explore today?"



The consultation should be pressure-free → declining contraception is a valid choice

A successful consultation is one where the patient feels heard and empowered, regardless of the method chosen!

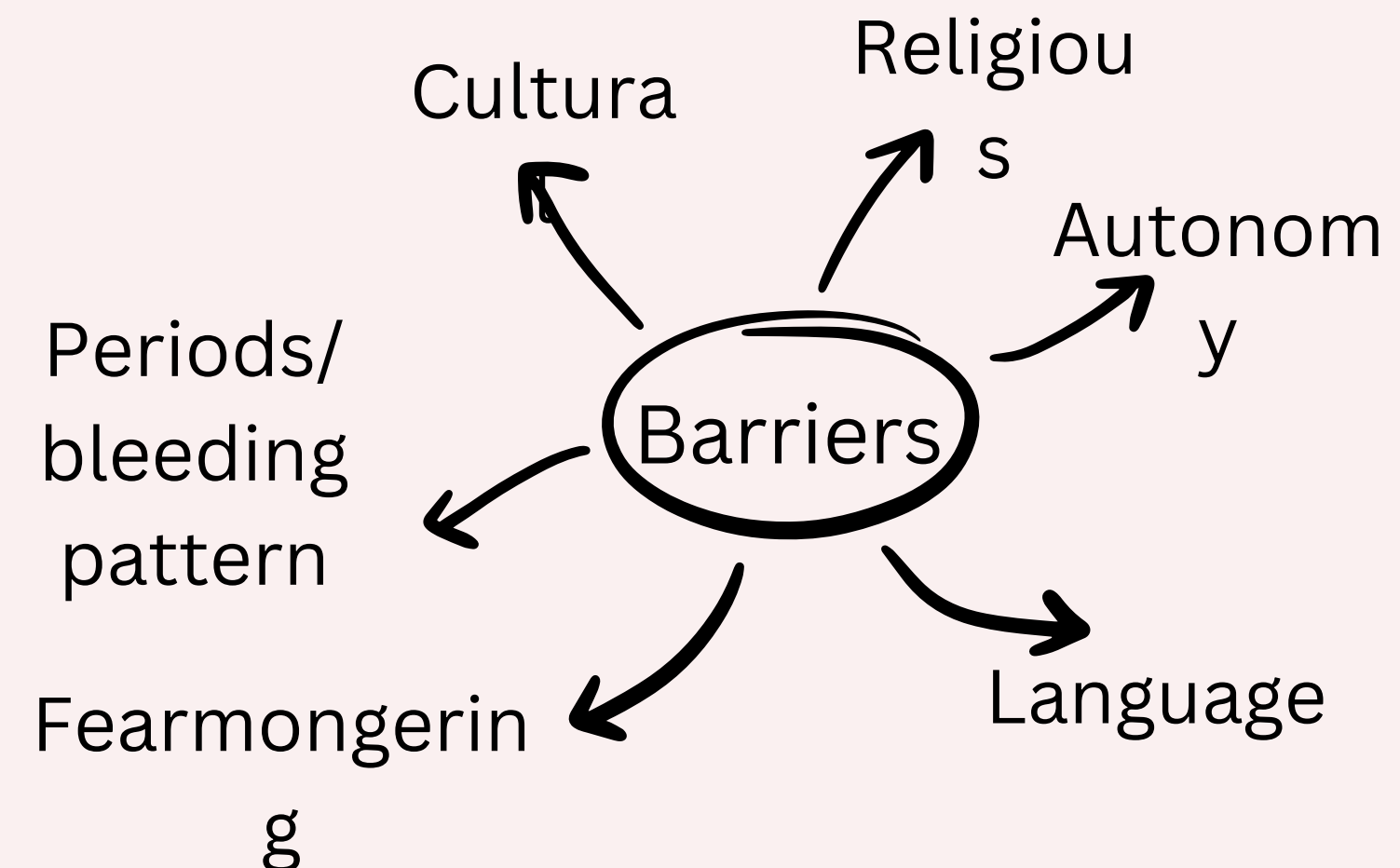


Exploring patient priorities

Ask open questions:

- *"What matters most to you when thinking about contraception?"*
- *"Do you have any worries about these options?"*

Avoid making assumptions and ask before giving advice!



Case continued...

She appears to understand simple points (e.g. “coil lasts 5 years”) but struggles with risks, alternatives, and follow-up, suggesting a language barrier.

This limits informed consent and genuine choice. Reliance on partners or community members as informal interpreters may distort sensitive discussions and widen postnatal and SRH inequalities



Action: Use a **professional interpreter**, and allow **extra time**. Re-do counselling using **teach-back** (“*Can you tell me in your own words what this method does and the main side effects?*”) and clearly **document** language needs, mode of interpretation and confirmed understanding





Case continued...



After providing a language line, you find out that the patient is reluctant to discuss her options without her husband present and waits for him to join to continue the consultation.

Why could the patient be hesitant to discuss contraception without her husband present?

The patient discusses her options with her husband, but he seems reluctant her to start contraception...





Cultural considerations



Top tips

Gender and family dynamics

Patriarchal and/or family centred norms may expect to involve partners or extended family members (e.g mother-in-law) in reproductive decisions.

Reluctance to discuss contraception may reflect fear of **partner disapproval** in not being involved in the decision making rather than lack of interest.

Involve partners if important to the patient. However, try to create opportunities to ensure the patient is **not being coerced**.

Be mindful women may prefer **female clinicians** for SRH discussions



Cultural considerations



Top tips

Gender and family dynamics	Patriarchal and/or family centred norms may expect to involve partners or extended family members (e.g mother-in-law) in reproductive decisions. Reluctance to discuss contraception may reflect fear of partner disapproval in not being involved in the decision making rather than lack of interest.	Involve partners if important to the patient. However, try to create opportunities to ensure the patient is not being coerced. Be mindful women may prefer female clinicians for SRH discussions
Taboo	Sex and contraception can be taboo topics, with significant shame and fear of judgment limiting open discussion. At the same time, childbearing often highly valued as central to a woman's role and status, which can make any decision to limit or delay pregnancy particularly sensitive.	Emphasise contraception as a choice that can be used to plan timing of pregnancies and explicitly separate it from ideas of "promiscuity" and "good/bad" or any myths (such as contraception causes infertility)
Autonomy	Whilst partner involvement can be supportive, this can also create opportunity for coercion. Concerns about LARC removal are common and may relate to prior experiences or mistrust	Establish autonomy by checking woman is comfortable/not under pressure and offer private discussion sensitively <i>"Would some time alone be helpful for you?"</i> Emphasise patient-led decision: LARC is fully reversible, removable at any time, and to present early if side effects

Case continued....

After discussing options with the woman and her husband, she is clear she does not want another pregnancy but is worried about side effects, especially any changes to her bleeding pattern.

Why may this be a concern and how can the clinician explore this and support a decision that respects her wishes?

Religious considerations

The woman is a **practising Hindu** and does not go to the **Mandir (temple)** when she is on her period. **Irregular bleeding** would prevent her from worshipping at the temple. Daily prayer and religious observance are central to her identity and wellbeing, which would make this particularly distressing.



Islam:

Generally permitted within marriage but irregular bleeding can stop prayer, fasting, and mosque attendance



Christianity:

Some groups (Catholic and Orthodox Church) generally oppose artificial contraception;
Church of England approves of artificial methods



Judaism:

Permitted in many circumstances but views vary by denomination;
Orthodox practice of *niddah*: during menstrual period spouses may not touch, sleep in the same bed, or have intercourse



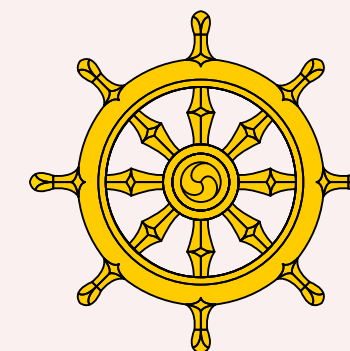
Hinduism:

Contraception widely accepted, but menstruating women may refrain from prayer or rituals



Sikhism:

Contraception generally permitted



Buddhism:

Contraception generally permitted

Safety netting advice

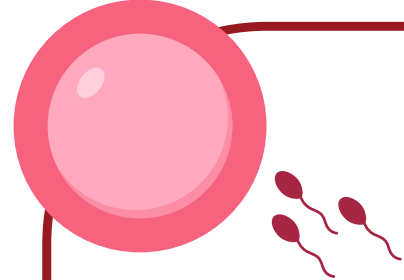


Red flag symptoms

Explain clearly when to seek help:

- Sever abdominal pain
- Chest pain/ Shortness of breath
- Heavy bleeding
- Fever

Also where they can access immediate help.



Ongoing protection

It is important to explain that no method is 100% effective and the use of condoms should be encouraged for the protection against STI's.



What to do if contraception fails.

For example:

- Missed pills.
- Late injections
- Vomiting or diarrhoea

Explain where they can get emergency contraception from and what to do after.



Follow up and culturally sensitive communication

- Encourage return if they experience side affects or have any concerns
- Inform them that methods can be changed
- Offer translated information
- Acknowledge cultural/religious concerns
- Check understanding.



Don't forget!

Tips for communicating with awareness, respect and cultural understanding



Offer interpreters and translated materials where needed



MOST IMPORTANTLY: A successful consultation is pressure-free and never pushes contraception- it is about CHOICE!



Provide follow up appointments for easier access to services



Ask, don't assume!
Avoid assumptions about cultural or religious beliefs.
When in doubt, ask!



Provide space for questions without rushing and validate concerns



Provide leaflets, weblinks and written information



Use simple, non medical language



Use models of contraception when explaining



contraception website in different languages

TEACHING FEEDBACK FORM

