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Influences on ethnic minority women's experiences and access to contraception in the UK: a systematic qualitative evidence synthesis

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ABSTRACT

Background Accessible contraception is critical for promoting the health and well-being of women and their families. In the UK, contraception is free at the point of access, but only 55% of pregnancies are planned, with negative implications for maternal and infant outcomes. In general, women from ethnic minorities use contraceptives less than white women. Barriers to the uptake of contraceptives have been identified, including perceived poor information from healthcare professionals and concerns about side effects. However, most studies do not include representative proportions of women from ethnic minorities. Evidence suggests that ethnic minority (EM) women feel targeted and coerced by healthcare professionals regarding contraception.

Methods A systematic search of Medline, Embase, and PsycINFO via Ovid, CINAHL, and Web of Science was conducted to identify primary qualitative and mixed-methods studies exploring ethnic minority women's experience of contraception in the UK. The data were charted using thematic analysis, using both summary and synthesis.

Results and conclusions 16 studies met the inclusion criteria, including the perspectives of 717 participants from an ethnic minority. Four overarching themes were developed: contraceptive knowledge, beliefs, family, and services. Similar to women in general, ethnic minority women have concerns about side effects, especially infertility, value the perspectives of their peers and male partners, and express a preference for female healthcare professionals. Novel perspectives included conflicting ideas about the influence of religion and stereotyping of ethnic minority women. Culturally competent consultations and a better understanding of hormonal hesitancy are essential.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Accessible contraception is critical for promoting the health, educational, financial, and social well-being of women and their families.
⇒ Contraception is used less frequently by ethnic minority women, who also face a disproportionate burden of unintended pregnancy.
⇒ Ethnic minority groups are underrepresented in research, but the sparse evidence that exists suggests women can feel targeted and coerced when accessing contraception.

INTRODUCTION

Background

Accessible contraception is critical for promoting the health, educational, financial, and social well-being of women and their families, and has been identified as a UN Sustainable Development Goal.[1] In the UK, contraception is free at the point of access through the NHS. Despite this, only 55% of pregnancies in the UK are planned.[2] Unintended pregnancy, in general, is associated with adverse parental and infant outcomes including maternal morbidity, low birth weight and poor infant nutritional

WHAT THIS STUDY ADDS

⇒ Similar to the existing evidence, essential considerations for ethnic minority women are a perception of excessive side effects, particularly concerns about persistent infertility, as well as the influential role of their peers and partners.
⇒ For Asian Muslim women, there were conflicting ideas about the influence of religion and society on contraceptive decision making.
⇒ There are, however, additional barriers, including stereotyping, racism and cultural and language barriers.

HOW THIS STUDY MIGHT AFFECT RESEARCH PRACTICE OR POLICY

⇒ This qualitative review highlights the importance of cultural competence while being mindful not to stereotype heterogeneous communities.
⇒ However, a concern is that thematic analysis of pooled qualitative data from multiple publication sources might stereotype heterogeneous communities within broad ethnic categories.
⇒ Further research, utilising purposive sampling of underrepresented communities, is needed to provide equitable healthcare.

status.[3] Furthermore, evidence suggests that women from ethnic minority groups are less likely to use all forms of contraception than white women.[4] They are less likely to use hormonal contraceptives and more likely to use less effective barrier methods, a statistic which has persisted for decades.[5] The burden of unintended pregnancy also falls disproportionately on ethnic minority women. While representing 4% of the population,[6] 7% of abortions in England and Wales occur in black women.[7] Additionally, black women are four times more likely to die in childbirth than white women.[8]

Barriers to utilising contraception have been identified. This includes the impact of other's experiences of contraception, perceived poor information from healthcare professionals, and concerns about side effects and mechanisms of action.[9] However, most studies do not include a representative proportion of ethnic minorities or those from a lower socioeconomic status.[10] Consequently, there is a lack of research exploring the perspectives of ethnic minority women regarding contraceptive use and reproductive decision-making, and little evidence to support healthcare professionals when providing contraceptives. What little research does exist suggests that women from ethnic minorities can feel coerced and targeted by healthcare professionals to use long-acting reversible contraceptives.[11] This is a concerning finding considering the historical use of contraceptives to control women from ethnic minority and socioeconomically deprived populations, including through targeted public health campaigns,[11] which have been criticised for reducing women's reproductive autonomy.[12]

The goal of this qualitative evidence synthesis was to summarise the existing evidence regarding ethnic minority women's experiences of contraceptives and accessing these in the UK.

METHODS

A systematic review of qualitative and mixed methods primary research was selected to investigate the perspectives of ethnic minority groups on contraception and reproductive decision-making. Cochrane guidance was followed for quality evidence synthesis including the Preferred Reporting Items for Systematic Reviews and Metanalyses (PRISMA) checklist (see PRISMA checklist in online supplemental file 1).[13] The study protocol was registered on PROSPERO (402334).

Search strategy and selection process

The following databases were searched: Medline, Embase and PsycINFO via Ovid, CINAHL and Web of Science including articles published until May 2024. Additional searching (snowballing) was performed from seven identified articles via PubMed Similar Articles and Web of Science Reference Lists and Cited References (see Search strategy in online supplemental file 2). The search included MeSH terms associated with 'contraception' and 'minority groups'. Results were compiled using the reference manager Mendeley, and imported into the systematic review management software Covidence.[14] Titles and abstracts were independently screened by RC and one of RLM or EL, with discrepancies resolved through discussion (RC, RLM, EL). Full texts were screened independently by RC and EL according to the inclusion and exclusion criteria, with discrepancies resolved by discussion (RC, RLM, EL).

Selection criteria

Only studies conducted in the UK were included. Accepted methodologies included qualitative and mixed methods primary research examining the perspectives of ethnic minorities on contraception and wider reproductive decision making. For a study to be included a majority of its participants had to be from an ethnic minority. Studies examining the perspectives of healthcare professionals were not included. Case reports and conference abstracts were excluded. Review articles were excluded.

Quality summary

Quality assessment of 16 full text papers was done using the Critical Appraisal Skills Programme (CASP) tool for qualitative studies[15] by RC. As per Cochrane guidance, qualitative studies were not assigned an overall quality score or excluded based on their quality. In particular, there were areas of concern in several studies relating

to the 'relationship between researchers and participants' and 'consideration of ethics' sections. However, it was decided that these studies should be included in the synthesis, due to the rich data contained within.

Charting the data: summary and synthesis

The data were charted utilising both summary and synthesis. First, the data were extracted from the full-text articles using Nvivo14, a qualitative analysis software, including relevant background and methodological information. RC independently extracted representative sections of text and all verbatim quotes for line-by-line coding. Each verbatim quote and representative section of text was assigned a descriptive code using inductive coding, rather than applying an existing framework. All codes were then reviewed a second time to minimise overlap and repetition. Descriptive themes alongside representative verbatim quotes were then discussed for differences, similarities and hierarchy (RC, RLM, DA, CM) and organised into emergent concepts relating to the research question.

RESULTS

The database search elicited 3259 results, of which 1060 were duplicates, leaving 2199 for screening. Following independent review of titles and abstracts, 62 studies were included for full-text review. From those, 16 were suitable for inclusion in the qualitative synthesis (see PRISMA diagram online supplemental file 3).

Description of studies

Seven hundred and seventeen participants from an ethnic minority background are represented in the data. The largest groups were Bangladeshi (n=152), Pakistani (n=127), Black Caribbean (n=98) and Black African (n=84) (table 1); 392 participated in interviews, with 325 participating in 61 focus groups. Studies took place in London[5 16–21] (n=7), the Southwest[22 23] (n=2), the North[24 25] (n=2), Scotland[26 27] (n=2) and the West Midlands[28] (n=1), with two studies taking place across England.[29 30] Two of the studies[22 23] appear to involve the same methodology and participants, with similar but distinct results. Both studies were, therefore, included in the synthesis, but data were not duplicated in the demographic information shown in table 1. The study characteristics are summarised in table 2.

Table 1 Ethnicity of participants included in this synthesis

High level ethnic group	Ethnic group	Number of participants (%)
Asian (n=474)	Bangladeshi	152 (21.2)
	Chinese	10 (1.4)
	Indian	12 (1.7)
	Pakistani	127 (17.7)
	Asian other	5 (0.7)
	Asian not specified	168 (23.4)
Black (n=212)	Black African	84 (11.7)
	Black Caribbean	98 (13.7)
	Black other	12 (1.7)
	Black not specified	18 (2.5)
Mixed (n=12)	White and Black Caribbean	2 (0.3)
	Mixed not specified	10 (1.4)
Other (n=19)	Arab	14 (1.9)
	Latin	4 (0.6)
	Other not specified	1 (0.1)

Main themes

A visual summary of the themes is shown in figure 1.

Contraception knowledge

Forms of contraception

Condoms were seen as easy to access, conceal[22] and stop using without visiting a healthcare professional (HCP).[28] However, people acknowledged the high failure rates,[17 21 28] and worried that others may perceive them as promiscuous for using or carrying condoms.[21] The pill was seen as effective and convenient[23] but unnatural,[28] while the intrauterine device (IUD) was reserved for married women who had completed their families.[22 28] Women reported using different contraceptives at different points of their lives, with no contraceptives used, or only condoms before first birth, and the pill after.[22]

Negative effects of contraceptives

Women were particularly concerned about weight gain,[21] skin issues[21] and fatigue.[28] There were also concerns that contraceptives were generally ineffective,[21] might affect fertility[26] and could cause cancer.[23] Muslim women also expressed concern over altered bleeding, as this could affect how they worship[26] as in Islam women should not pray during menstruation. Changes in contraceptive method were often initiated by experiences of side effects or failure[21] and the next method chosen was often based on recollections of experiences by their friends.

> I think it's a lot to do with the misinformation out there. People hear about some experiences other women have about hormones or how it makes it difficult for women to get pregnant again. (Pakistani woman)[26]

Acquisition of knowledge

Acquisition of knowledge about contraception varied in both time and sources. Those born in the UK typically learnt about contraception and sexual health at school.[19 22] Asian women born outside the UK discussed learning about contraception from their husbands after marriage[16 22 23] and from midwives after the birth of their first child.[22 23 28] Friends' experiences

Table 2 Characteristics of included studies

Author, year	Recruitment	Location	Aims	Data collection	Participants	Analysis
Griffiths *et al*, 2008[19]	Community youth groups, schools	London	Establish the sexual health perspectives of young Bangladeshis and Bangladeshi parents/carers on the needs of their teenagers and the acceptability of sexual health interventions	Focus groups (7) single sex, similar ages	61 Bangladeshi: 36 young people and 25 mothers	Thematic analysis
Hennink *et al*, 1998[22]	Community groups, university	Southwest	Provide information on the use of family planning services by women from Indian, Pakistani and Bangladeshi backgrounds	1–1 interviews (39)	39 Asian women	Thematic analysis
Wayal *et al*, 2020[30]	Sexual health clinics, community settings	London and West Midlands	To explore attitudes towards and factors influencing concurrency among people of Black Caribbean ethnicity and implications for sexual health choices and STI risk	Focus groups (4), mixed sex, similar ages. 1–1 interviews (31)	59 Black Caribbean men and women	Thematic analysis
Hennick *et al*, 1999[23]	Community groups	Southwest	To provide information on the contraceptive use of Asian women; to identify the context in which contraceptive decisions are made and highlight sources of knowledge, the timing of first method use and the influences on contraceptive use and decision making	1–1 interviews (29)	29 Asian women	Thematic analysis
Gallimore *et al*, 2020[26]	Community groups, hospitals	Scotland	Sought to determine the views and experiences of both Pakistani women and maternity staff around post-natal contraception	Focus groups (3) and 1:1 semi-structured interviews (9) in Urdu, English or both	23 Pakistani women	Thematic analysis
Connell *et al*, 2004[18]	Youth centres	London	To compare normative beliefs about sexual health in young men and women from Black Caribbean, Black African, and white ethnic groups	Focus groups (6)	Black Caribbean (17) and Black African (15), (white participants (10) not included in synthesis)	Grounded theory analysis
Hampshire *et al*, 2012[24]	Community centres and classes	North (Teeside)	Understanding Pakistanis' feelings, beliefs, desires and motivations around marital and reproductive practices	1–1 interviews (91) in English	26 Pakistani men and 65 women	Grounded theory analysis
Griffiths *et al*, 2008[29]	Youth centres, community groups	England	To assess acceptability of different one-stop shop models of sexual health provision among different community groups	Focus groups (1) and semi- structured interviews (19)	14 Black African, 14 South Asian men and women (participants whose ethnicity was not accurately recorded not included (n=94))	Framework analysis
Sinha *et al*, 2007[21]	Community and youth centres	London	Explore sexual behaviour and relationships among Black and minority ethnic (BME) teenagers in East London. To examine how these relationships are shaped by culture, gender, peer norms and religion. To describe the implications for sexual health policy and practice in urban, multicultural area	Focus groups (30) and 1–1 interviews (3)	126 15- to 18-year-old south Asian (49), Black (55), mixed (2) (participants of white ethnicity not included (n=21))	Framework analysis
Woollett *et al*,1991[5]	Hospital	London	To explore reproductive decision making, the influence of religion, length of stay and identification with Asian culture on family planning and to explore ideas about family size and gender of children	100 1–1 interviews	100 Asian women (participants whose ethnicity was not accurately recorded not included (n=46))	Thematic analysis
Coleman and Testa, 2008[17]	Sexual health clinics, community settings	London	Exploring the sexual health attitudes of BME youth	1–1 interviews (50)	50 BME Black (n=18), Asian (n=14), mixed background (n=10), Latin American (n=4), Middle Eastern (n=3) and other background (n=1)	Thematic analysis

Continued

Table 2 Continued

Author, year	Recruitment	Location	Aims	Data collection	Participants	Analysis
Ochieng and Meetoo, 2017[25]	Community based organisations	North	To explore beliefs and attitudes regarding sexual health among minority ethnic families	Focus groups (4)	32 Black African adults	Inductive and descriptive analysis
Kaneoka and Spence, 2020[27]	Charities	Scotland	To explore SRHL related views and experiences of adult asylum seekers and refugee women living in Glasgow and their views on assistance required to improve their SRHL	1–1 interviews in English (14)	14 asylum seekers and refugee women from Middle East (11), SE Asian (1) and South Africa (2)	Interpretative phenomenological analysis
Verran *et al*, 2015[28]	Family planning clinic	West Midlands	Examine how female Chinese asylum seekers experiences and decisions about family planning in the UK are shaped by their cultural background	1–1 semi- structured interviews (10)	10 female Chinese asylum seekers	Thematic analysis
Kiridaran *et al* 2022[20]	Online, social media	London	To explore the views, attitudes, and experiences of South Asian women in the UK regarding sexual health services	1–1 semi- structured interviews (14)	14 South Asian women	Thematic analysis
Beck *et al*, 2005[16]	Sexual health services, community groups	London	To identify barriers to accessing sexual healthcare among the Bangladeshi community and to develop a model of community participation in service development	Focus groups (6) and 1–1 semi- structured interviews (12)	58 Bangladeshis	Interpretative phenomenological analysis

SRHL, sexual and reproductive health literacy; STI, sexually transmitted infections.

were a significant source of information about contraception and were trusted to a greater degree than HCPs.[28] In particular, negative experiences of side effects or contraceptive failure influenced decisions about whether to use a particular method of contraception. Friends' opinions were particularly valued due to poor explanations of contraception by HCPs.[28] General practitioners (GPs) were also a valued source of information.[16 23]

> The doctor explains to us about issues with contraception failing and we don't entirely understand so it makes us worry … I still would rather trust my friends' advice on the best method of contraception. (Chinese woman)[28]
> With regards to the coil, because everyone uses it and says that it is very tolerable, so I have also used it. (Chinese woman)[28]

Beliefs

Personal, religious and community belief systems influenced reproductive decision making and contraception use, to varying degrees. Contraception was generally more accepted in Asian Hindu and Sikh communities compared with Asian Muslim communities.[5 23] Nevertheless, women made decisions about reproduction and contraception based on personal, emotional and financial factors, alongside religious beliefs.[23]

> I'm a Muslim, and contraception isn't really encouraged, reproduction's encouraged more, but I'm strongly against that and I would use it. (Asian woman)[22]
> Religion plays a big role in whether I have sex or not in a relationship. I feel that when you are having sex, both of you are giving yourselves to each other in the whole bible, Christian thing. (Black African woman)[21]

Attitudes towards sex are also influential, with some communities forbidding premarital sex,[16 17 25] leading to beliefs that premarital sex did not occur in their community, and that sexual health services were therefore not needed. Consequently, anyone engaging in premarital relationships generally concealed this,[20] to avoid bringing shame to themselves and their families.[19] Furthermore, the topic of sexual and reproductive health was reported as inappropriate, in schools,[16] and the household[19 25] and participants reported feeling shame when consulting an HCP.[27]

> I think when you look at things like sexual advice and all that, people tend to feel that it's like bringing shame to yourself. (Bangladeshi woman)[16]

Family

Members of the family and ideals about family composition play an important role in decision making around contraception and reproduction. The following results all relate to South Asian Families.

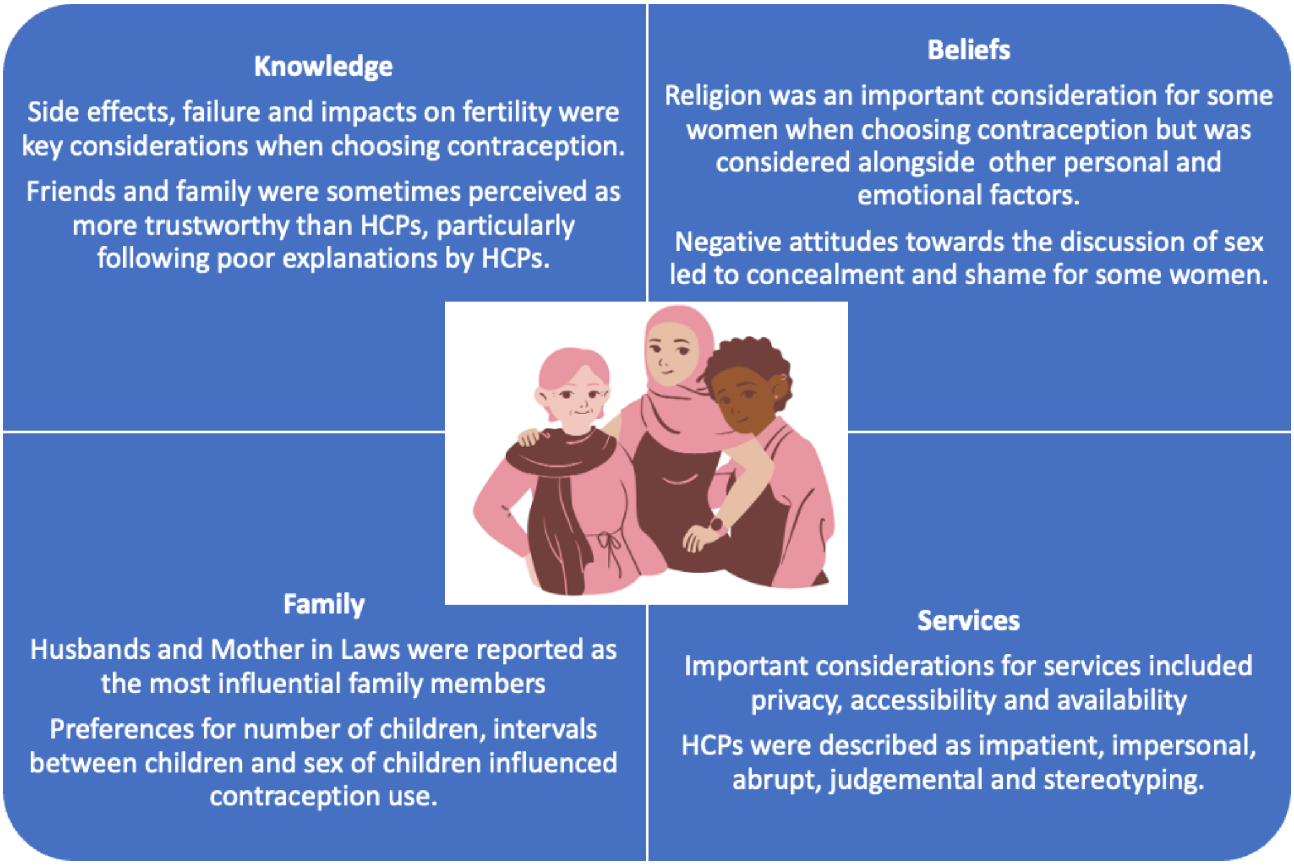

Figure 1 A summary of key themes. HCPs, healthcare professionals.

Role of the family

Husbands and mothers in laws (MILs) were the most important family members influencing reproductive decision-making, varying from no influence at all[24 26] to pronounced.[5 22 24] Decisions included time between marriage and children,[23] number of children,[5] time interval between children and preference for sons and daughters.[22] Sometimes, influence was perceived as being negative, such as feeling pressured to have more children,[22] which occasionally led to concealment of contraceptive use, especially when the individual's reproductive intentions did not align with their husband or MIL.[24] The extended family, rather than parents, had the critical role of imparting sexual information,[16 19] and were also sometimes considered when deciding if to have further children, depending on the presence and number of cousins.[24] Husbands also played practical roles, including translation[26] of verbal and written information and transportation[23] to appointments.

> My husband actually he wanted one more son and I keep saying No, No … He says two sons would be nice. (Asian woman)[23]

Family composition

Becoming pregnant soon after marriage was expected of Asian couples.[26] This was seen as beneficial for the woman, facilitating early access to the valued role of mother[5 24] and establishing her position in the family.[5] On the other hand, waiting for children meant more time together as a couple.[5 24] Some women reported regret about having children too soon, noting a general lack of awareness of contraception.[5 22]

> I … fell pregnant quickly after the wedding because we weren't using anything. Sometimes when I look back I think why did I not research more. (Pakistani woman)[26]

The women associated having fewer children with better quality parenting, fewer family arguments, less negative effect on employment and lower costs of living.[5] However, having more children was sometimes seen as a necessity to achieve their desired family composition, often at least one son and one daughter, as this was seen as socially beneficial for the children.[24]

Short intervals between pregnancy meant fewer years of parenting,[5] closer sibling bonds[24] and easier parenting, as children of similar ages are perceived to have similar parenting needs.[5] Large intervals meant greater enjoyment and perceived higher quality parenting, leading to perceived superior developmental outcomes.[24]

> Three years seemed right because then you can give them the attention. Also when he's three he'll leave his bottle and won't need nappy changing so it's

> easier. Also then the older child can give you a hand with the little one. (Muslim woman)[5]

Contraception was therefore used to avoid further pregnancies when the desired number and sex of children was achieved, or to space pregnancies, generally to facilitate perceived better parenting.

Services

Service preferences

Studies reported preferences for services centred around accessibility, including availability of appointments, accessible opening times, and local services.[20] Privacy was valued and facilitated by minimal time in the waiting room, to prevent patients being seen by members of their community, which could affect their social standing.[16] Confidentiality framed perceptions of specific services; some preferred GPs, as the purpose of the visit could be concealed from those in the waiting room, while others avoided them where HCPs treated or were known to their family.[29]

> I wouldn't have gone to my GP because my GP knows my family and I think that is a big barrier. And this GP has actually broke confidentiality before. (South Asian Woman)[20]

Many service preferences centred around the HCPs working within a service. Asian women preferred HCPs of the same sex for consultations about contraception,[22] sexual health,[16] and reproduction,[27] as seeing a male HCP was perceived as culturally[16] and religiously inappropriate.[29] Additionally male HCPs were perceived to have poor knowledge of women's health issues.[20] There were conflicting ideas about the ideal ethnicity of an HCP, with some reporting a preference for a different ethnicity, due to concerns about confidentiality when the HCP was from the same community.[22] However, this often was not possible due to language barriers, leaving women no choice but to consult an HCP from their community.[22] Some studies reported that an HCP of the same ethnicity would increase comfort and facilitate open discussions.[20]

> I didn't want to see the male doctor, I avoided going until I could get an appointment with the female… personal problems like that then I would prefer the female doctor…(Asian woman)[22]

Experiences of HCPs

Experiences with HCPs were generally characterised as negative. HCPs were described by participants as impatient,[18] impersonal, abrupt, and judgemental.[20] Asian women felt stereotyped because of their ethnicity; treated as unable to use contraception reliably, or as promiscuous for accessing contraception.[22] Asian women also reported experiences of HCPs breaking confidentiality.[22] The information provided by HCPs was also criticised, with participants reporting pressure to use hormonal contraception, with minimal information offered about alternate methods of contraception.[20] Language presented an issue, particularly where HCPs did not understand colloquial terms for contraception.[22] Overall partnership, confidentiality, and time to consider information were the most valued components.

> …at the time I felt like it was because I was Asian and they thought she's going to be unreliable with any other method of contraception. (Asian Woman)[22]

DISCUSSION

Summary

This systematic review is the first to synthesise the perspectives of ethnic minority women in the UK around the topic of contraception and reproductive decision-making. Women noted that perspectives of contraception were influenced by their family, friends, and peers, more so than HCPs. Excessive side effects, including a negative effect on fertility, were a particular concern for women. Husbands and in-laws were especially influential for some women. Generally, women expressed a preference to consult a female HCP and there were varying perspectives on the preferred ethnicity of an HCP. Concerningly, HCPs were described as judgemental and impatient. Multiple negative experiences were reported, including stereotyping and concerns about confidentiality.

Strengths and limitations

The studies included in this review involve the perspectives of over 700 participants from ethnic minority groups, particularly South Asian, Black African, and Black Caribbean communities. Considering that ethnic minority groups are typically not well represented in research,[10] this review and evidence synthesis represents a substantial sample size. Other important ethnic minority groups are less well represented in the review, including Chinese, Arab, Roma and Gypsy/Traveller communities.

Interestingly the majority of studies involving the Asian community focused on reproductive decision making and the family, while the studies involving the Black African and Black Caribbean community focused more so on sexual health. These differing research priorities appear to adhere to concerning stereotypes about these communities, particularly sexual stereotypes regarding black women. Some of the included studies are over 20 years old,[5 22 23] so it is critical to consider how the views expressed by participants in the 1990s may not be representative of current perspectives, considering changing demographics and availability of contraceptives. There is a concern that thematic analysis of pooled qualitative data from multiple publication sources might stereotype heterogenous communities within broad ethnic categories.

Comparison with existing literature

Many of the findings of this review reaffirm international research on women's perspectives on contraception across high, middle and low income countries. In particular, concerns about contraceptives causing excessive side effects, particularly decreasing fertility, are widespread across the world.[31 32] Previous research also supports the finding that friends and communities play an important role in informing women's perspectives of contraception.[33] This review found that peer's experiences of contraceptives were valued and trusted, sometimes more so than advice from HCPs. Similar to previous work, this review also noted the role of partners in choosing whether to use contraception. Evidence suggests that when male partners are involved in decision making, this is associated with lower discontinuation rates and more consistent use of contraception by women.[34] While it is undoubtedly important for women to involve their partners and peers in decisions about contraceptive use, it is essential that women are able to make autonomous and informed contraceptive decisions. For some ethnic minority communities, particularly those that are isolated, or where language barriers are present, reliance on others could leave women vulnerable to misinformation.

Little evidence exists regarding ethnic minority women's preferences for HCPs. It appears that, similar to the general population,[35] ethnic minority women prefer to access contraception from a female HCP, due to concerns that consulting a male would be culturally inappropriate and could cause shame for the woman. There were conflicting opinions about whether an HCP should be from the same ethnicity as the patient; perceived positives were more open dialogue and comfort, but women noted that there would be greater concerns about confidentiality. Religion was also identified by this review as an important consideration for ethnic minority women, particularly Asian Muslim women; however, there was not a consensus regarding whether use of contraception was encouraged or permitted in Islam. This most likely reflects differing interpretations within Islam, with some scholars concluding that contraception prevents the objective of procreation in marriage,[36] while others conclude that contraception is critical to maintain tranquillity and optimise the health and finances of the family;[37] however, it is also critical to note that some beliefs more accurately reflect cultural rather than religious perspectives. These conflicting interpretations are also not unique to Islam and are present in Christianity and Judaism.

Some research suggests that women experience significant sexism and misogyny when accessing contraception, particularly with regard to patient autonomy and respect.[38] Alongside misogyny, ethnic minority women have to navigate racism. In this review, black women reported experiencing sexual stereotypes when accessing contraception, which centred on ideas of promiscuity. Qualitative evidence suggests that such stereotypes disempower black women in reproductive decision-making and cause resistance to new information.[39] As a consequence, ethnic minority women face additional barriers to accessing services, including racism, religious prejudice, and cultural and language barriers, which are not experienced by white women in the UK.[40] These experiences of stereotyping may also partially explain why some women expressed a preference for female GPs of the same ethnicity. Furthermore, this review demonstrates how HCPs may be biased in their provision of information, favouring hormonal contraceptives. When HCPs provide biased information, they restrict women's reproductive autonomy. Recent evidence suggests as many as 43.8% of women feel pressured to use long-acting reversible contraceptives, particularly those from ethnic minorities, younger women and those with health issues.[11 40] If we design healthcare services based on non-representative research and with biased perceptions of communities, we risk worsening inequalities in access.

Implications for research and or practice

Identifying the perspectives and priorities of underserved populations is critical to providing equitable access to contraception. Ethnic minority groups have typically been underrepresented in research[10] and this review represents the first to chart the perspectives of ethnic minority women in the UK on this topic. A core component of providing equitable care is cultural competence, and it is important that HCPs have an awareness of how culture may shape someone's attitude towards contraception without stereotyping based on religion or race. For example, while an HCP should be aware of differing perspectives in Islam regarding the acceptability of contraception, there should also be an understanding that, typically, women consider many different factors alongside religion when making decisions about contraception. This review demonstrates that there is significant heterogeneity across ethnic minority communities. However, as previously discussed, many of the original research papers were over 20 years old and therefore some of the findings may not be as relevant to ethnic minority communities at this time. As such, further research is needed in this area to bring fresh novel insights with purposive sampling of underrepresented communities.

CONCLUSION

This systematic review is the first to synthesise the perspectives of ethnic minority women in the UK around the topic of contraception. There were unsurprisingly many similarities with how women in general form opinions and make decisions about contraception, with some notable differences, particularly experiences of stereotyping, and other harmful behaviours from HCPs, including breaking confidentiality.

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Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this study.

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