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Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: a qualitative study

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ABSTRACT

Objective: To explore the views, attitudes, and experiences of South Asian women in the UK regarding sexual health services.

Methods: We performed virtual semi-structured interviews with South Asian women 18 and over living in the UK. We explored participants' experiences of accessing sexual health services, including contraception, smear tests and sexually transmitted infection (STI) tests. We coded interview transcripts and analysed them thematically.

Results: From February to April 2021, we conducted 14 interviews with South Asian women between the ages of 18 and 40 living in England and Wales, from February to April 2021. We identified four overarching themes: Access to sexual health services, entry to sexual health services, quality of sexual health services and stigma associated with sexual health services. Important barriers to sexual health services include limited knowledge of local provision, stigma and shame, and concerns about confidentiality. Participants found it difficult to discuss their sexual health (with anyone) and were often being met with judgement and a lack of partnership from clinicians.

Conclusion: Our results suggest that South Asian women are uncomfortable accessing sexual health services and communicating their sexual health concerns with health care professionals. Service providers should collaborate with community-based organisations to ensure that services are discrete, confidential, and culturally appropriate.

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Introduction

Evidence suggests that sexual and reproductive health (SRH) services nationwide often fail to reach marginalised populations, such as ethnic minorities [1,2]. The English National Strategy for Sexual Health and HIV (2001) stated a need for health care professionals (HCPs) to engage with marginalised populations to address their SRH needs [3]. Despite this, the State of the Nation report 2020 confirms that England has some of the most unsatisfactory SRH outcomes in Europe, with unsuccessfully engaged populations continuing to be disproportionately impacted by higher rates of sexually transmitted infections (STIs) [4].

The general population face a variety of barriers to accessing SRH services including: service access (i.e., location, hours, confidentiality), service entry (i.e., waiting time, fear of being seen), quality of services (i.e., interactions with health care practitioners) and personal factors (e.g., stress associated with seeking sexual health services) [5].

South Asian women face particular barriers to accessing SRH services. Cultural and religious issues profoundly impact SRH knowledge, needs, and access to services [6,7]. In South Asian cultures, it is generally believed that unmarried women do not need to be educated about their SRH.

This assumption derives, in part, from the high social value on the preservation of a woman's virginity before marriage and the belief that discussions regarding SRH could encourage premarital sexual relations [8]. Being seen accessing SRH services could jeopardise one's standing in the community [6,7]. Amongst South Asian communities, individual and collective honour (or *izzat*) and shame are fundamental concepts that serve as a basis for social control, promoting public conformity and fostering the masking of shameful behaviour. Modesty and shyness are also significant barriers to accessing SRH services. South Asian women may feel uncomfortable with physical examinations by a male practitioner, which acts as a deterrent. People for whom English is not their first language face many barriers to services, resulting in a lack of confidence and difficulties communicating [8]. These factors mean that many South Asians feel unable to access SRH services and receive the support they require [7].

There is a paucity of research on the SRH of South Asians in the UK, despite being the largest ethnic minority group in the UK [9,10]. To explore the barriers and facilitators to accessing SRH services, we interviewed South Asian women regarding their attitudes towards and experiences with SRH services in the UK.

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Methods

This study used qualitative methods to explore the views and experiences of South Asian women with SRH services in the UK.

Sampling strategy

From February 2021 to April 2021, we used a purposive sampling strategy to recruit South Asian women aged 18 and over, living in the UK and able to speak English. We aimed to recruit participants from a variety of South Asian ethnicities and diversity in age. The term ‘South Asian’ included those belonging to ethnic groups from the Indian subcontinent, including Indians, Pakistanis, Bangladeshis and Sri Lankans and individuals from Bhutan, Nepal, and the Maldives [11].

Participants were recruited online by circulating a recruitment advert on Twitter, Instagram and in Facebook groups. We also emailed the advert to national and regional organisations that work with the South Asian community. VK’s email was provided on the recruitment advert, inviting participants to contact her if they were interested in taking part. Snowball sampling was also utilised.

Data collection

One investigator (VK) conducted the one-to-one semi-structured interviews between February and April of 2021. VK is a young female South Asian woman. A semi-structured topic guide was used as prompts to explore participants’ SRH knowledge, thoughts, feelings, experiences, and views of SRH services. This included discussions about SRH clinics, general practice, and pharmacies, accessing contraception, STI tests and cervical smear tests. For participants who had not used SRH services, reasons for non-attendance were explored.

The duration of interviews ranged from 45 minutes to 1 hour. A pilot interview was performed to ensure the topic guide was appropriate. We emailed an information sheet and consent form to participants before their interview. Written consent was obtained through signing the consent form electronically before the interview.

Data analysis

The video recordings were transcribed verbatim and thematic analysis was carried out using Atlas.ti for coding and analytic notes. VK read the transcripts several times to ensure familiarity with the data. The codes were grouped into conceptual groups and summarised in themes [12]. The barriers to SRH services outlined by Bender et al. were used as a theoretical framework to categorise overarching themes under service access, service entry, quality of services and personal factors [5]. The coding framework and emergent themes were discussed within the research team to ensure that themes were coherent and represented the data accurately.

Ethical approval was granted by the UCL Research Ethics Committee (Reference no. 19257/001).

Results

We interviewed 14 women. The participants were of South Asian ethnicity, above the age of 18 and living in England

Table 1. Characteristics of South Asian participants of semi-structured interviews on experience with SRH services.

Demographic characteristics	Number of Participants (N = 14)
Age	
20–24	7
25–30	2
30–40	5
Ethnicity	
Bangladeshi	3
Indian	3
Pakistani	4
Sri Lankan	4
Religion	
Christian	1
Hindu	3
Muslim	6
No religion	4
Employment	
Employed	8
Unemployed	0
Student	6
Region	
East Midlands	1
London	7
South West England	1
Wales	1
West Midlands	4
Marital Status	
Married	3
Divorced	1
Unmarried	10

and Wales (see Table 1). 11 participants had used SRH services and spoke about their experiences and 3 participants discussed perceived barriers to a service they had never used.

Four overarching themes were identified: Access to SRH services, Entry to SRH services, Quality of SRH services and Stigma associated with SRH services.

Access to sexual health services

Promotional and educational materials

Many participants were unaware of the SRH services offered and where to access them and felt that more needs to be done by service providers to raise awareness of the services available, perhaps via social media. Many would have liked more informative posters and handouts in waiting rooms.

Those leaflets are okay, but there’s nowhere to go next if you want more info or want to really research something more. It’s given you something basic. (P13-35y)

Availability of sexual health services

The opening times of sexual health clinics and the availability of appointments were a common barrier to access. Participants said that while some clinics had flexible opening times, clinics were not always close by, and some faced a long journey which could interfere with other commitments.

And then that’s when I went to like some community health service clinic and I was sat there waiting and then they said ‘Oh, we do’t have any diaphragms, you have to go somewhere else’ and so that was like an hour away. (P13-35).

Concealing sexual activity and clinic visits from family

Many young and unmarried participants conceal their sexual activity and hide their use of SRH services from their

family. For participants living with their family, clinic visits were more difficult to conceal.

I only got the confidence to do it when I was like 18 but people younger than that are having sex and should be getting tested. [...] people who are still living at home with their parents. (P3-21y)

Entry to sexual health services

Waiting times

Some participants experienced long waiting times at walk-in clinics which created a sense of panic for those who already felt anxious about using SRH services.

I went to like a drop-in, and then I literally had to wait like two to three hours just in the waiting room and I think that just built up in my head like crazy and like it was really late on a school night and my mom was like calling me asking me where I was and stuff like that definitely doesn't help. (P1-21y)

Being seen by members of the community

Younger, unmarried participants felt worried about being seen by members of the South Asian community, with concerns that gossip would circulate. Participants described that clinics located in busy and open areas carried more risk of being seen by other members of the South Asian community.

The actual place where the clinic is, there's quite a lot of South Asian shops so there'll be a lot of elders around that area. (P2-21y)

Some participants were also worried that they would be seen by a member of their community in the waiting room or be overheard by others.

If you go to the GP or the receptionist, if there's a relative or another aunty from the community in the waiting room, gossip or whatever could come about. (P4-21y)

Fear of health care professionals breaking confidentiality

Many participants were worried about discussing their SRH with their GP if the doctor also knows and/or treats their family. SRH clinics were felt to be a safer and more confidential option.

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. (P8-40y)

Quality of sexual health services

Attitudes of health care professionals

Many participants said that their appointments with doctors felt rushed and impersonal. They felt that they were not listened to, with queries not addressed adequately, and this was not conducive to them opening up about their SRH.

Just abrupt and very much in outs, kind of assembly line, rather than, stop and listen. [...] I feel it was very much a case of this isn't a priority and we've got other priorities. (P12-38y)

Building a partnership with HCPs sometimes helped to facilitate difficult SRH discussions.

That first appointment was quite productive and felt more balanced. It felt more like a partnership. We'd obviously started to build up a relationship which I think is super important. (Participant 13, aged 35)

However, some participants said there was often a lack of partnership with HCPs. Participants reported feeling pressured by doctors to use hormonal contraception despite repeatedly expressing that they were uncomfortable using such methods, suggesting that HCPs often took a paternalistic approach.

I always express my views on [hormonal contraception], but they always kind of pushed back on it. [...] They don't really take into account my opinion about it. I think at one point you need to kind of respect, you know, my decision. (P5-26y)

Many participants said that a reassuring and non-judgmental approach from HCPs was crucial to enable open discussions. Some participants experienced judgement from HCPs, which was especially concerning as many participants said that they were unable to discuss their SRH with their family due to faith and cultural taboos, and often rely on HCPs for support.

When going in to ask about the pill I just felt like it was very awkward, very uncomfortable. I felt the woman was being very judgmental, but maybe that was just because I was younger. (P11-21y)

Characteristics of health care professionals

Participants generally preferred female HCPs due to the awkwardness of discussing their SRH with a male clinician. Some participants feared that male HCPs would not understand sensitive SRH issues and the female reproductive system.

There was like a male pharmacist and it is a little bit awkward talking to the guy about it and as soon as you mentioned [emergency contraception], it was like muffled voices and felt very like judgmental in a way. (P5-26y)

Some participants said that they would like more ethnic diversity among HCP. Some participants suggested that having a HCP from a similar background may make them feel more comfortable and help facilitate more open discussions about their SRH. This was particularly mentioned by participants living outside London, where they felt healthcare services were less ethnically diverse.

I don't really think there's a lot of like Asian women within these services. I always found that I've just always been encountered with white women, and [...] sometimes I do feel like it would make me more comfortable. (P3-21y)

Explanations from health care professionals

Participants said that doctors frequently gave a strong recommendation for the combined contraceptive pill, without sufficient information on other contraceptive options, consequently reducing informed choice. Most participants felt that HCPs assumed their knowledge and did not explain information thoroughly.

I think they could have probably just talked through the different options. [...] It might be better to just map out every single option, like the pros and cons of them. (P11-21y)

Some participants also felt that there should be leaflets in different languages in order to cater to those whose first

language is not English, and a need to raise awareness of where to find resources.

I remember those Bengali leaflets I got from the internet were produced by a hospital up north. And I thought, wow, what we need is these resources to be centrally available. (P12-38y)

Stigma associated with sexual health services

Participants seldom discussed their SRH with their family because of faith and cultural values forbidding premarital sex. Participants described a sense of shame and nervousness accessing SRH services and found it difficult to discuss their SRH with strangers.

With strangers I'm totally awkward. I just don't want to talk about or listen to stuff like that. And I think that is because culturally it is taboo. (P2-20y)

When you're trying to tell the receptionist like what you're here for like I just feel like I have to keep my voice down, I feel that sense of shame. (P1-21y)

For this reason, several participants felt that telephone or video consultations with sexual health clinicians encouraged greater access (beyond the context of the Covid-19 pandemic).

I think definitely using like technology to break that barrier, because a lot of people won't want to come in face-to-face and talk to a nurse or doctor about these things. [...] I think making it more accessible is just the first step until we can have these conversations within our community. (P9-25y)

Discussion

There are many barriers to SRH services for South Asian women in the UK. Important barriers to accessing SRH services include limited knowledge of local SRH services, stigma and shame and confidentiality concerns. Participants faced difficulties in discussing their SRH with HCPs, often being met with judgement or a lack of partnership from clinicians.

Information provision

South Asian women face several barriers to SRH knowledge. We found that a lack of awareness of the local SRH services (both specialist and primary care services), inadequate promotion of SRH services and limited information on leaflets and posters regarding SRH issues can be a barrier to access, echoing previous research [13,14]. More information is needed, particularly within the community setting, on *how* to access contraceptive information [13]. Studies also suggest that social media may be a powerful tool to improve engagement with SRH services, particularly for young South Asian women [15,16]. Social media interventions can be successful in populations at risk of disadvantage (i.e., the young, older adults, low socioeconomic status, rural), suggesting that these interventions promote health equity [15].

Confidentiality and privacy concerns

Younger, unmarried participants were concerned about service confidentiality and of personal information being

inappropriately shared, particularly in the primary care setting and if a GP knows their family. Patients may be concerned that GPs of the same ethnicity are disclosing information to family members [16,17]. Young people tend to be unaware of the duty of doctor-patient confidentiality until it is clarified by the service provider [18].

A fear of being seen accessing SRH services is a barrier to access for South Asian women [6,19]. Cultural and religious beliefs forbid premarital sex for many communities, and dialogues around SRH may be seen as unnecessary or shameful which may amplify fears of being seen accessing services [6,20]. Behaviours which deviate from cultural, or faith norms are often concealed, and this may mean that individuals in need of SRH care may face extra difficulties in accessing appropriate services [7].

Experiences with health care professionals

Inadequate provision of information on contraception from HCPs coupled with rushed and impersonal consultations may reduce informed choice [21]. A strong recommendation from HCPs for the combined contraceptive pill and paternalistic approaches deterred participants from asking about alternative methods and did not foster an environment in which participants could openly discuss their SRH concerns. British Pakistani women faced similar issues related to medical paternalism, often finding it difficult to ask questions about contraception and finding that HCPs often made decisions for them [13]. White British women may face similar issues related to medical paternalism, but a greater sense of empowerment (particularly if they are middle class) can allow them to overcome this (e.g., by switching to an alternative provider) [22].

Most participants preferred to seek advice from a female practitioner. Many women, regardless of culture or religion find it inappropriate and difficult to voice their concerns to male HCPs and be examined by them [3,6,17]. As family honour and shame can impact on most areas of South Asian women's lives, this is likely to have made it more difficult for them when encountering male HCPs [22,23]. Being unaware that they can request a female HCP is a deterrent to accessing services [17].

Cultural awareness

Cultural values and social expectations about sex and sexuality have a huge influence on knowledge, beliefs, attitudes, and sexual behaviours, and this affects access to, and experiences within sexual health services [6,7,13,24]. For South Asian communities, this means recognising the pervasive issues of stigma and shame associated with transgressing societal norms and the importance of protecting the public honour ('izzat') of one's family and community [7]. Cultural and faith values and attitudes make discussions around SRH difficult and may prevent women from accessing SRH services. Training in cultural competence for health care staff, in collaboration with members of the South Asian community and religious leaders, may facilitate a greater understanding of pertinent cultural issues [25,26]. There is ample evidence highlighting the value of co-designing education interventions with

community-based organisations to address sensitive and complex health issues in marginalised communities [25,26].

Strengths and limitations of the study

Despite the small sample size, our findings bring to light some important and transferrable themes. The Covid-19 pandemic coupled with the sensitivity of SRH as a topic in relation to the South Asian community made recruitment difficult. The interviews were conducted online due to the Covid-19 pandemic, which meant that establishing a rapport was sometimes challenging [27]. However, online interviews allowed participants to turn their camera off and remain anonymous if they wished.

It was particularly challenging to recruit women over the age of 40 – older women may hold more traditional views regarding SRH issues and feel uncomfortable discussing it [8]. As such, some organisations felt uncomfortable sharing the study with their members. There were privacy concerns around online interviews (such as being overheard by family members), which were particularly relevant for women living with others during Covid-19 related lockdowns. We also decided not to recruit participants under the age of 18 because they are more likely to be living with family. Due to the lack of a translator, we could not recruit women who do not speak English. However, the impact of language barriers to accessing SRH services has been explored in previous studies [8,26]. We were only able to recruit one member of the LGBTQIA + community, and further research exploring the experiences of the British South Asian LGBTQIA + community is needed.

Conclusion

This research highlights the factors that underpin engagement with SRH services. The limited knowledge and dialogue around SRH within the South Asian community highlights the need for HCPs to explore and address patients' concerns in an informative and non-judgmental manner. It is important for HCPs to acknowledge that South Asian women may need more time, regardless of language barriers, to express their sexual health needs and understand tests, diagnoses, treatment, and choices. Additionally, there is a need to raise awareness of local services, emphasise their confidentiality, and develop more informative materials to educate South Asian women on their SRH. Collaboration with community-based organisations is a promising strategy to develop culturally appropriate initiatives to facilitate equality of access.

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No potential conflict of interest was reported by the author(s).

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