Exploring the attitudes and behaviours of Bangladeshi, Indian and Jamaican young people in relation to reproductive and sexual health

A report for the Teenage Pregnancy Unit

November 2005

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Research Briefing

Key research question

What are the attitudes and behaviours of young people from specific BME groups in relation to reproductive and sexual health, with specific reference to teenage pregnancy, and what factors influence them?

Key Findings

- There are marked variations in relation to reproductive and sexual health attitudes and outcomes among Bangladeshi, Indian and Jamaican young people in Britain today.

- Cultural factors, such as the amount of socialising, the role of religion, parental attitudes and beliefs, and peer-group adhesion and norms, are strong influences on young people within each of these ethnic groups. These factors impact on how teenage pregnancy is viewed.

- Gender differences in attitudes and behaviour are strong, with very distinct and often conflicting messages being given to young men and women.

- Factors unique to living in Britain, such as receiving sex and relationships education in school, living in a multi-ethnic society, and more relaxed social attitudes towards sexual relationships, are contributing to a gradual harmonisation of attitudes towards sexual and reproductive health. This was observed to a varying degree within the three ethnic groups and was moderated by adherence to cultural norms and religious beliefs.

- Parents from these communities are very aware of the changing context and sometimes feel powerless to fight against these trends. Many parents felt that they did not have adequate skills to engage with young adults on sexual and reproductive health. Maintaining strong religious beliefs, focusing on education and social advancement were strategies they employed to meet these challenges.

- Current knowledge and use of existing sexual and reproductive health services varied substantially across ethnic groups. There was some disagreement regarding the need for culturally specific services. Many felt that well-staffed, culturally competent services with appropriate access times were more important than there being ethnically matched staff. Nevertheless, the role of ethnicity specific role models and culturally identified resources were identified as being very important to young people.

Background

People from some Black and Minority Ethnic (BME) groups are at higher risk of teenage pregnancy and sexually transmitted infections (STIs) than the general population. Clear differences in sexual attitudes and behaviour between different BME groups have been
shown by national survey data, but the explanations for this have not been well researched. Previous studies have tended to suffer from selection bias by recruiting those already accessing services. The aim of this project was to explore, amongst a community based sample, attitudes and behaviours relating to reproductive and sexual health of three groups of young people, namely Bangladeshis, Indians and Jamaicans. These target groups were selected so that a comparison could be made with previous research with adults from these ethnic groups (see below). Teenage conception rates have been found to be higher amongst young Bangladeshi and Jamaican young women than the general population and lower amongst Indian young women. Anecdotal evidence suggested that the attitudes and behaviours with regards teenage pregnancy were likely to be very different between these three groups.

About the study

The research took place from June 2002 to December 2003 in London, Manchester and Birmingham. 75 in-depth interviews with Bangladeshis, Indians and Jamaicans aged 13-21 years were carried out. The themes explored in the interviews were informed by secondary analysis of two previous studies: the second National Survey of Sexual Attitudes and Lifestyles (Natsal 2000) and Exploring Ethnicity and Sexual Health (ExES), the latter study being a qualitative piece of work with Bangladeshis, Indians and Jamaicans adults. 12 focus groups with young people, parents of teenagers, health care workers and representatives of community organisations were then used to consider the implications of what emerged from the in-depth interviews for provision of sexual health services.

Recruitment to the project was facilitated by community organisations but still proved challenging, for example many potential Bangladeshi participants felt that sexual health was not an appropriate topic for discussion. Interviews and focus groups were taped and transcribed verbatim, and analysed using a thematic approach.

Findings

Knowledge and attitudes

There was agreement across all groups that insufficient emphasis was placed on sex and relationships education (SRE) in schools. In particular, young people and their parents felt that SRE programmes rarely take account of cultural and religious influences on sexual attitudes and behaviour. In relative terms, Jamaican mothers were the most confident about speaking to their children about sexual matters. However, difficulties in discussing sexual matters between parents and their children were expressed by the great majority of participants and parents often felt ill equipped to do this. Young men, in particular, were felt to have little access to SRE outside school. The Internet was described as a useful

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source for gaining more information about sex, especially for those who felt unable to talk to friends and family or had difficulty accessing health services. The majority of Bangladeshi participants frowned upon sex outside marriage for religious reasons. There was more diversity amongst Indian participants in their views. The Jamaican participants had the most liberal attitudes to sex outside marriage, but there were concerns raised that the lack of male role models negatively affected men’s attitudes to sex and relationships.

**Sexual experience**

There was ample evidence that attitudes and behaviours are changing fast, particularly among Indian young people. Young Bangladeshi and Indian people were more likely than their parents to report sex before marriage, but there was still pressure to keep such relationships secret. It was felt that sexually transmitted infections (STIs) remained untreated because there was often denial that sex was taking place. The consequences of having pre-marital sex were far greater for young women than men. For some, particularly Bangladeshi women, it was anticipated their first sexual experience would occur once married. Jamaican respondents tended to be sexually active at a younger age, which is in line with Natsal 2000 data.

**Teenage pregnancy and parenthood**

Although sex before marriage is increasing amongst Indian and Bangladeshi young people, negative attitudes to unmarried parenthood and especially abortion, remain firm. However, for these women, the fear of being rejected by family and community meant they would most likely seek an abortion if they became pregnant, despite strong opposition for religious reasons. If parents became aware of the pregnancy, young people may be forced to marry. Unmarried teenage parenthood was more acceptable and common amongst Jamaicans. However, it was felt young single Jamaican mothers living in the UK had less support available to them, particularly from an extended family, in comparison to young single mothers in Jamaica. Young mothers were often isolated and fathers were not directly involved in parenting. This sometimes meant children lacked positive male role models.

**Sexual and reproductive health services**

Many participants, particularly Bangladeshi women, described the difficulty or impossibility of accessing sexual health services locally. Lack of representation of BME groups amongst staff was likely to increase reluctance to access services or discomfort in doing so. However, the gender of the member of staff was generally seen as more important than ethnicity. Young people, in particular Indian young people, were concerned that breaches of confidentiality could occur, particularly by general practitioners who might know their parents. Responses to questions about an ideal sexual health service were similar to those expressed by other groups of young people and are reflected in guidance for services from the Teenage Pregnancy Unit (TPU). All groups agreed that there is a need for variety and creative thinking in terms of service delivery. However, concerns were raised in each of the professional and community representative groups that much of the work with BME young people is done in isolation at a local level, is poorly funded, short-term and is not widely disseminated.

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Conclusions and policy implications

This study illustrates the multiple influences on Bangladeshi, Jamaican and Indian young people’s attitudes and behaviours with regards to sexual health and teenage pregnancy. Although many of the issues raised were relevant to all young people, there were often specific elements of culture and religion that shaped the views and behaviours of young people within these communities.

A consistent theme was that, whatever their ethnic background, young people who were confident and had high educational and career aspirations were keen to delay pregnancy until they were independent, older and financially secure. Some BME communities have higher levels of unemployment and are at a disproportionate risk of living in poverty. It is therefore not just a case of focusing on health services when trying to improve the sexual health of BME groups. Inequalities elsewhere need to be addressed, such as improving education and employment opportunities.

There is still evidence that some young BME people have poor knowledge regarding sexual health, find it difficult to access the appropriate services and are putting themselves at risk of unplanned pregnancies and STIs. There would be significant value in setting up a national database of projects, so that professionals can seek advice and support from others about how to further develop this work. Setting up sustainable, acceptable and effective programmes with BME young people takes time. Therefore, adequate time and resources are needed to allow quality programmes to develop and to undertake meaningful evaluation.

About the programme

The TPU, in partnership with the Research and Development Division, Department of Health has commissioned a major research programme under a number of themes in order to inform implementation, and development of, the Government’s Teenage Pregnancy Strategy. Five themes were identified through consultation with the TPU’s policy team, other government departments, the research community and practitioners:

■ The impact of growing up in rural and seaside resorts on the sexual behaviour and life-chances of young people.

■ Attitudes and behaviour of black and minority ethnic young people, relating to sexual activity, contraceptive use and teenage pregnancy.

■ Black and minority ethnic young people’s experience of teenage parenthood.

■ Educational experiences of pregnant young women and young mothers of school age.

■ Long term consequences of teenage births for mothers, fathers and their children.

Reports and research briefings from the nine projects commissioned under these themes will be published throughout 2005. See www.teenagepregnancyunit.gov.uk for more details.
Acknowledgements

We would like to acknowledge the Exploring Ethnicity and Sexual Health study team and the 2nd National Survey of Sexual Attitudes and Lifestyles who allowed their data to be used in this report.

ExES team: Kevin Fenton, James Nazroo, Anne Johnson, Jane Ritchie and Gillian Elam.


We would like to thank the following for their help organising focus groups: Dorrett Graham, Simone Sharpe, Tony Hall, Al-Haj Nazir Uddin Ahmed, Ali Khan, and Mary Rogers.

We would like to thank all of the young people, parents, professionals and community group representatives for their contribution to this work.

The research was supported by a grant from the Teenage Pregnancy Unit, Department of Health (now Department for Education and Skills). The views expressed in this report are those of the authors and not necessarily those of the Department of Health or Department for Education and Skills.
### Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<tr>
<td>BMRB</td>
<td>British Market Research Bureau</td>
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<td>CI</td>
<td>Confidence interval</td>
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<tr>
<td>DfES</td>
<td>Department for Education and Skills</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>ExES</td>
<td>Exploring Ethnicity and Sexual Health Study</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<td>GUM</td>
<td>Genitourinary medicine</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>PSHE</td>
<td>Personal social and health education</td>
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<td>SRE</td>
<td>Sex and relationships education</td>
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<td>STIs</td>
<td>Sexually transmitted infections</td>
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<td>TPU</td>
<td>Teenage Pregnancy Unit</td>
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<td>UCL</td>
<td>University College London</td>
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1. Introduction

Ethnicity is often used to define group identity based on a shared set of biological, cultural and socio-political characteristics (Fenton, 1997). An ethnic group is a segment of a larger society whose members are thought, by themselves or others, to have a common origin, share important segments of a common culture and in addition, participate in shared activities in which the common origin and culture are significant ingredients. The value of ethnicity varies with context. It may be a resource, liability or without any alliance of any kind, depending upon the environment, and other things happening within it. Factors such as immigration history and social status also need to be acknowledged (Zenilman et al, 2001). Thus, being an ethnically mixed population is not necessarily predictive of whether or how ethnicity is defined on a day to day basis.

In the UK, black and minority ethnic (BME) groups represent 7.9% of the general population of the UK population (4.6 million) and 9% of the general population in England (Census 2001). BME groups have a younger age structure in comparison to the White population, due to immigration and fertility patterns (ONS, 2002). The Bangladeshi population has the youngest age structure, with 38% of the Bangladeshi community being aged under 16 years.

Data from the 2001 Census show that there are variations between ethnic groups in terms of family and household structures (ONS, 2002). Asian households tend to be larger, sometimes because three generations are living in one household. The average number of people living in Bangladeshi households is 4.7, 3.3 in Indian households, and 2.3 in both Black Caribbean and White households. More than half (54%) of families headed by someone of Black-Caribbean origin were lone parent families. Lone parent families were most common amongst people of mixed origin (61%) and least common amongst people of Indian origin (9%).

Indian pupils are most likely to achieve their expected educational level, with 60% of Indian pupils achieving five or more GCSE grades A-C. Lower achievements are seen amongst Bangladeshi and Black pupils, with 36% and 41% achieving five or more GCSEs, respectively (Department for Education and Skills, 2002). Some research which looked into factors that influenced educational attainment amongst BME groups found that 50% of Bangladeshi pupils were eligible for free school meals and Black-Caribbean pupils were three times more likely to be excluded from school (Bhattacharyya, 2003). Bangladeshi pupils are the most likely ethnic group to leave school without any qualifications (44%).

Bangladeshi people are much more likely than people from other ethnic groups to be living on low incomes (ONS, 2002). Bangladeshi women have the lowest rate of economic activity, with only 22% either working or looking for a job. Over 40% of Bangladeshi men aged under 25 are unemployed. High rates of unemployment are also seen amongst young Black-Caribbean men.

The first large-scale immigration from the Caribbean was after the Second World War and during the 1950s. The Indian community largely migrated to the UK during the 1960s, while the Bangladeshi community migrated to the UK more recently, mainly in the 1980s. The majority of people who define their ethnicity as Black-Caribbean and Indian are UK born (94% and 79%, respectively), compared with 25% of Bangladeshi people (ONS, 2002). Some of the UK’s Indian population have migrated from countries
other than India. For example, a large number of Indians from East Africa migrated to the UK due to political, economic and social circumstances (Prasad, 1994).

With regards to religious affiliation, Census data show that the vast majority of Bangladeshi people are Muslim (92%). Over two-thirds of Black-Caribbean people describe their religion as Christian. Much more diversity is seen in the Indian community, with 45% saying they are Hindu, 29% Sikh and 13% Muslim. Bangladeshi people, are less likely to report not having a religion (ONS, 2002).

People from BME groups are at a disproportionate risk of social exclusion (Social Exclusion Unit, 2000). They are more likely to live in deprived areas, to be poorer, and to be unemployed compared to White people with similar qualifications. These factors all lead to greater inequalities in health. The reproductive and sexual health of young people from BME groups has been identified as a priority area, particularly in relation to the fact that young people from some BME communities have a higher than average risk of teenage parenthood (Social Exclusion Unit, 1999). Data on ethnicity of parents is not collected at the registration of a birth or at abortion. Therefore it is survey rather than routine data which suggests that young people from some BME communities, such as Black-Caribbean and Bangladeshi, are more likely to have teenage pregnancies in comparison to the general population (Teenage Pregnancy Unit, 2000).

The reasons behind these variations in attitudes, behaviours and health outcomes are multifaceted and have been explained by factors such as poorer access to health services, preference for non-barrier methods of contraception amongst some ethnic groups, and cultural norms regarding sex and relationships education (Fenton and Wellings, 2000). However, with regards cultural norms, young people may be more likely to share the group norms of the majority ethnic community rather than sharing the beliefs of their parents, who may adhere to more traditional norms. For example, exposure to sex and relationships education (SRE) in schools and the media have led to more openness amongst the second generation of BME young people, but this also could have negative consequences caused by discordance between behaviour and cultural norms.

In response to concerns about the poorer reproductive and sexual health outcomes amongst some BME communities and in order to improve access to sexual health services, the Teenage Pregnancy Unit (TPU), formerly at the Department of Health (DH) and now based at the Department for Education and Skills (DfES), documents for professionals working with BME young people. These include Diverse Communities: Identity and Teenage Pregnancy (Department of Health, 2002) and Guidance for Developing Contraception and Sexual Health Advice Services to Reach Black and Minority Ethnic (BME) Young People (Teenage Pregnancy Unit, 2000).

This research study is part of a larger programme of work on teenage pregnancy that has been jointly funded by the TPU and the Policy Research Programme, DH. The overarching aim of this study was to explore the attitudes and behaviour of Bangladeshi, Indian and Jamaican young people in relation to sexual and reproductive health. More specifically the study investigated sexual behaviour, contraceptive use, pregnancy and views on young parenthood.

The primary target groups were Bangladeshi, Indian and Jamaican young people aged 13-21 years. In addition, parents of teenagers from these groups, and service providers (including teenage pregnancy co-ordinators, youth workers and health care workers) and
representatives from relevant community-based organisations had an input to the research (see Chapter 2).

Indians represent the largest BME group in the UK (Census, 2001), 1.8% of the general population and 22.7% of the BME population. Bangladeshi people make up 0.5% of the general population and 6.1% of the BME population, and Black-Caribbean people make up 1% of the general population and 12.2% of the BME population. The reasons Bangladeshi, Indian and Jamaican communities were chosen as the target groups in this study were as follows:

1. This research focused on individual ethnic or cultural identity and its effect on sexual health beliefs and behaviours rather than focusing on racial identity (e.g. White, Black, Asian).

2. These groups corresponded to the BME communities included in the Exploring Ethnicity and Sexual Health (ExES) study. The qualitative interviews conducted as part of ExES provided useful data for the development of research tools in the first stages of this study. Black-Africans were also included in ExES, but it was decided not to include Black-African young people in this study because they account for a relatively small proportion of BME communities in Britain. In addition, ‘Black-African’ would obviously account for people from all African countries and would not be representative of a single ‘cultural group’.

3. Anecdotal evidence suggested that the attitudes and behaviours with regards teenage pregnancy were likely to be very different between these three groups.

In this study, we elected not to include a White group for comparative analysis for a number of reasons. Methodologically, researchers in ethnicity and health have criticised the validity of comparing defined ethnic groups with broad ‘racial’ comparators (Bhopal, 1997; McKenzie, 1996). White racial groups in Britain are likely to include many ‘ethnicities’ or cultural subgroups, therefore finding the appropriate comparison ethnic group may be difficult. Comparing with ‘White’ racial groups has also been criticised for perpetuating a racialist research paradigm in which ethnic groups are not studied in their own right, but need the validation of a White comparator as a ‘baseline’. Good research practice suggests that the best comparator (if they must be used) should be the ethnically diverse ‘general population’. Such a strategy has been used for analysing ethnicity data in the Health Survey for England and is currently being employed on analyses for the second National Survey of Sexual Attitudes and Lifestyles (Natsal 2000).
2.1. Aims and objectives

The aim of this study was to use qualitative research methods to provide a better understanding of the attitudes and behaviour of Bangladeshi, Indian and Jamaican young people (aged 13-21 years) relating to sexual behaviour, contraceptive use, pregnancy and young parenthood.

Qualitative methods aim to define and describe the range of emergent issues, rather than measure the extent and produce statistics - seeking to understand ‘why’ and ‘how’, rather than ‘how often’ and ‘how many’.

There were three broad components to the research; 1) Establishing priorities and themes, 2) Exploration: in-depth interviews with young people, and 3) Discussion and debate: focus groups with young people, parents, and professionals and community representatives. The methods used in each of these components are described below.

The objectives were as follows:

♦ To determine what factors directly and indirectly influence the young people’s beliefs and behaviours with regards to their reproductive and sexual health.

♦ To examine the differences between the targeted minority ethnic communities as well as those within the targeted minority communities, including differences in gender, religion, culture, and educational and employment aspirations, which may affect attitudes and behaviours.

♦ To examine attitudinal differences between young people, parents of young people, service providers and community based organisations.

♦ To investigate the extent to which minority ethnic young people’s needs are being met through the Teenage Pregnancy Strategy and relevant Guidance documents [e.g. Guidance for developing contraceptive and advice services to reach Black and Minority Ethnic (BME) Young People].

♦ To use participatory methods in order to ensure that Bangladeshi, Indian and Jamaican communities, especially the young people within these groups, are actively involved in making recommendations for future policy, service development and provision, and research.

2.2. Setting

The research took part in three cities: Birmingham, London and Manchester. These settings were chosen as relatively large proportions of people from BME communities in England are resident in these areas and members of the team already had some links with community-based organisations in these cities. People from BME groups tend to be concentrated in cities. Nearly half (45%) of England’s BME community lives in London,
where they make up 29% of the total population. Nearly two-thirds of all Black-Caribbeans (61%) and 54% of Bangladeshis live in London. Other BMEs groups are more dispersed across the country (Census, 2001). In Manchester, the proportion of residents who are Indian is 1.5%, Black-Caribbean is 2.3% and Bangladesh is 0.9%. In Birmingham these proportions are 5.7%, 4.9% and 2.1%, respectively.

2.3. Study design

Establishing priorities and themes

The first phase of this work was informed by secondary analyses of existing data sources relevant to the topic under discussion, the Natsal 2000 (Ethnic minority boost) and the qualitative study ExES. Both studies have been landmarks in UK based research in ethnicity and sexual health. The researchers were able to utilise these data sets to develop research tools (i.e. topic guides) and to inform the thematic frameworks for analysis.

A brief summary of the methods used in these two studies are provided below.

ExES Study

The ExES study used in-depth interviews to investigate sexual attitudes and behaviours among Jamaican, Black African (Nigerian and Ugandan) and South Asian (Indian and Bangladeshi) people aged 16-44 years living in London (Elam et al., 1999). ExES was the first community-based socio-anthropological study of sexual attitudes and lifestyles of BME communities in the UK. One of the great strengths of this study was that it was able to cross different generations and therefore examine acculturation amongst second and third generations. Information related to fertility and pregnancy was collected, but was not analysed in the original study. Data that were available include: start of sexual activity, early reproductive experience, and attitudes to child-bearing and child-rearing. The archived ExES data from Bangladeshi (n=10), Jamaican (n=19) and Indian people (n=11) were reanalysed to investigate issues related to reproductive and sexual health that are identified as being relevant to young people. In this report we have focused on data related to contraception and pregnancy, as a comprehensive report already describes the sexual lifestyles and attitudes (Elam et al., 1999).

Natsal 2000

In 1998, the Natsal 2000 was funded by the Medical Research Council. Data were collected from a probability sample of around 12,000 16 – 44 year old men and women in Great Britain. As well as providing data on sexual behaviour and lifestyles, this survey has also collected data on reproductive histories, such as pregnancy, abortion, contraceptive use, and use of contraceptive and sexual health services. Unlike the first survey, the Natsal 2000 had an “ethnic boost” to increase the numbers of BME participants, in recognition that existing data from these communities are inadequate. Four minority ethnic communities were sampled: 1) Black-Africans, 2) Black Caribbeans, 3) Indians, and 4) Pakistanis. Computer-assisted person interviews (CAPI) and
computer-assisted self-interviews (CASI) were used to collect data. Wherever possible, we used quantitative data related to sexual behaviours and attitudes of young people in the overall British population in Natsal 2000 to provide the context for comparing and interpreting qualitative data from young people from the target BME communities in our study. Unfortunately there were insufficient numbers of Bangladeshi respondents in Natsal-2000 to provide any meaningful data. Further details of the survey methodology for the ethnic boost and the sample characteristics have been published elsewhere (Fenton et al., 2005).

**Exploration: In-depth interviews with young people**

**Recruitment**

The recruitment was organised by BMRB’s internal team of field managers, who coordinated a network of recruiters in the three areas visited in this study – Birmingham, London and Manchester. The field managers were fully briefed on the project by the lead researchers at BMRB and they were provided with detailed recruitment instructions and screening documents, which they passed onto their network of recruiters. It was up to the young people to define their ethnicity through completion of a Recruitment Questionnaire (see Appendix 1), and then the recruiter could ascertain whether or not they were eligible to take part.

Respondents for the in-depth interview stage of the project were recruited by the BMRB field team using a combination of **free find techniques**, **snowballing methods** and also via **community groups**. In total, 51 respondents were recruited using free find/snowballing techniques and 24 were recruited via community groups or community group contacts.

The free find technique is a commonly used method for recruiting in qualitative research. It involves recruiters randomly approaching people, who they believe may be eligible for the project, and asking them a series of recruitment screening questions in order to ascertain their eligibility and willingness to take part in the research.

In some instances, respondents were recruited by snowballing from those young people who had been found using free find methods. For example, the recruiter may ask the young person if they had any friends or family who would fit the criteria and would be willing to be interviewed. These potential respondents would then be asked the same recruitment screening questions and then if they matched the criteria exactly and were willing to take part, they would also be recruited. It must be noted, that for this study it was decided that no more than one person should be snowballed from any one respondent, in order to prevent the sample comprising people from the same family or friendship group, as it was felt this may impact on the research findings.

It was also decided at the outset that some respondents should be recruited from community groups, as it would be an additional way to access young people and may result in the recruitment of a wider range of young people. However, although BMRB had a list of possible community groups supplied by UCL, accessing young people in this way proved to be very difficult and particularly time consuming (See chapter 8).
Primary selection criteria (age category, ethnic group and gender) and secondary selection criteria (residence, religion and sexual experience) were used by the recruiters to ensure there was diversity in the interviewee sample.

Written parental or guardian consent was required for young people under the age of 16 years.

At recruitment stage, young people were asked if they had any preference in terms of the interviewer’s ethnicity or gender. Preference was matched where possible.

A number of young people failed to keep their interview appointment. The field team felt in retrospect that it was impossible to provide exact figures on this, but felt it had ranged from no drop outs to two out of three on any given fieldwork day.

Interviews

Data were gathered using in-depth, face-to-face interviews, as this approach enabled the researcher to explore the respondents’ views and experiences in depth, and was also deemed to be the most appropriate method for discussing sensitive issues and taboo issues. All the interviews were conducted in a private and informal setting (chosen by the respondent), which enabled the respondents to talk openly and comfortably about their knowledge, experiences, views and attitudes regarding sexual and reproductive health.

The interviews were carried out between February and April 2003. Each interview lasted approximately one and a quarter hours. All the interviews were undertaken by experienced qualitative researchers, using the technique of non-directive interviewing. Interviews were guided by a topic guide or aide memoir, which was developed by UCL and BMRB (see Appendix 2). The topic guide was informed by the Natsal 2000 and ExES studies.

Body maps were used during the qualitative depth interviews as a visual and practical tool to enable the young people to express their views regarding their ideal partner. Respondents were given a piece of paper with a picture of a stick person drawn on it and were asked either draw or write down characteristics or qualities they would like their ideal partner to have, including physical traits such as hair and eye colour, as well as what ethnicity or religion they would prefer their ideal partner to be.

Body maps were thought to have been a good way of enabling the young person to express their views without being asked direct questions about issues that may have been deemed sensitive. Also it meant that the respondent was able to express their opinions without being led in anyway by the researcher. Moreover, by introducing a different medium, this type of exercise was also thought to have broken-up the verbal discussion. Examples of some of the body maps are shown in the Appendix (see Appendix 3).

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1 To calculate this we would have needed to have asked the recruiters to do this from the outset, as this was not identified as being a potential issue at this point (as consequence of being a relatively exploratory area of research), this was not done. It is felt that in any other project of this nature, this type of calculation would be advisable, especially considering the impact on cost.
Life matrices were also used throughout the interview as a tool to help explore what and how the young person learnt or knew about sexual and reproductive health issues, as well as to look at the sexual history and experiences of respondents (see Appendix 4). The matrices were used for the in-depth interview stage of the project as they were felt to aid the research by helping to focus the discussion; assist with recall; and also help to reduce the pressure of discussing sensitive issues.

The sample

Seventy-five in-depth interviews with young people who defined their ethnicity as either Bangladeshi, Indian or Jamaican were conducted. Table 1 provides a breakdown of the sample profile by ethnicity, age group, gender and city of interview.

Analysis

All the interviews were recorded and transcribed verbatim. The verbatim transcripts were then analysed using a thematic approach, based on the general principles of ‘framework’ analysis (Ritchie and Spencer, 2002). The data were summarised and synthesised using a range of techniques, such as cognitive mapping and data matrices. The themes derived from the data were discussed amongst the members of the research team. A thematic matrix was created in Word. The subject headings included in the charts used on this project were as follows:

1. Personal circumstances, attitudes and views
2. Knowledge and learning about sex
3. Sexual experience
4. Teenage pregnancy and parenthood
5. Contraception and contraceptive services
Table 1: Sample profile: in-depth interviews

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>13 – 15 years</th>
<th>16 –18 years</th>
<th>19 – 21 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BANGLADESHI</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>2</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>London</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>1</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Manchester</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

| INDIAN | 9 | 16 | 25 | |
|--------|---|---|---| |
| Birmingham | | | | |
| Male | 1 | 1 | | 8 |
| Female | 2 | 2 | 2 | 6 |
| Manchester | | | | |
| Male | 2 | 2 | | 8 |
| Female | 1 | 1 | 2 | 4 |
| London | | | | |
| Male | 2 | 2 | | 9 |
| Female | 2 | 2 | 1 | 5 |
| Total | 9 | 16 | 25 | |

| JAMAICAN | 9 | 16 | 25 | |
|----------|---|---|---| |
| Birmingham | | | | |
| Male | 2 | 2 | | 10 |
| Female | 3 | 2 | 1 | 6 |
| Manchester | | | | |
| Male | 1 | 1 | | 8 |
| Female | 2 | 2 | 2 | 6 |
| London | | | | |
| Male | 2 | 2 | | 8 |
| Female | 3 | 2 | 1 | 6 |

**Focus Groups**

Focus groups were used to explore results from the in-depth interviews and to investigate what implications these findings had for the provision and delivery of services. Separate groups were held for young people, parents, and service providers and representatives from community-based organisations for each ethnic group. The
involvement of parents, service providers and representatives from community-based organisations was felt to be crucial in helping to understand some of the issues that effect BME young people’s sexual attitudes and behaviours. Participatory research and interventions remain key strategies for improving the health of marginalised communities. Participatory research was initially developed to improve social and economic conditions of the people being studied, and to provide a framework for responding to health issues within a social and historical context. It is particularly relevant for improving the sexual health of BME communities, among whom fear of stigmatisation, and mistrust of research and researchers may be problematic. The benefits of community participation include self-empowerment, capacity development, improved social capital, and increased lay involvement.

Aims

- to explore results from the in-depth interviews with Bangladeshi, Indian and Jamaican young people (13-21 years).
- to investigate what implications the results have for the provision and delivery of services for each of the target groups.

Recruitment

For logistical reasons, and to help with an understanding of the context, it was planned that focus groups for each BME community would be held in a separate city: the Bangladeshi groups in Birmingham, the Indian groups in Manchester and the Jamaican groups in London. It was not the intention of the research team to compare findings between the different cities. The first point of contact in each of these cities was generally those working in or alongside statutory organisations (e.g. teenage pregnancy coordinators, contraceptive and GU nurses and doctors). These providers were then asked to provide contacts for voluntary organisations and community groups. The snowballing process continued to identify potential participants for each of the focus groups (i.e. teenagers, parents of teenagers, and service providers and representatives from community-based organisations). Other means, such as Internet searches, were used to identify any relevant groups.

Letters of invitation were sent out. The same consent procedure for the young people under 16 years participating in the in-depth interviews applied to those participating in the focus groups. All of the participants in the young people’s focus groups were aged 16 or above, with the exception of a group with Jamaican young people organised through Brook. In this case the member of staff who helped with recruitment knew the parents and parental consent for the under 16s was arranged through her.

The sample

Table 2 shows the number of participants recruited to each group, along with some characteristics of the sample. In the original proposal, the team had planned to run nine
focus groups, however on local advice many of the groups were organised to be gender-specific (See chapter 8). In the end, 13 groups were held.

### Table 2. Sample profile: focus groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of participants</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladeshi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional / community representatives</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Young people</td>
<td>10</td>
<td>Groups for males and females conducted separately. 6 females aged 17-21 and 4 males aged 17-18</td>
</tr>
<tr>
<td>Parents</td>
<td>0</td>
<td>1 father did attend (see chapter 8)</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional / community representatives</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Young people</td>
<td>5</td>
<td>Groups for males and females conducted separately. 3 males and 2 females.</td>
</tr>
<tr>
<td>Parents</td>
<td>5</td>
<td>Groups for males and females conducted separately. 3 fathers and 2 mothers</td>
</tr>
<tr>
<td>Jamaican</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional / community representatives</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Young people</td>
<td>8</td>
<td>5 females and 3 males aged 15-18</td>
</tr>
<tr>
<td>Parents</td>
<td>6</td>
<td>Groups for males and females conducted separately. 3 fathers and 3 mothers.</td>
</tr>
</tbody>
</table>

Managing the groups

Advice was taken on the most appropriate setting for the focus groups. For example, it was felt that it would have been inappropriate to run the Bangladeshi groups within a sexual health service.

The focus groups were structured in following way:

1. Presentation of focus group aims
2. Background to the research, e.g. rationale for the study
3. Ground rules, e.g. confidentiality, listen and acknowledge differences of opinion
4. Presentation of the findings from the in-depth interviews

5. Exercises and discussion of themes arising from the data (See Table 3.).

6. Summing up

How results were presented was dependent on the group and setting. The groups with professionals tended to be formal PowerPoint presentations followed by a discussion, while the groups with young people were less structured informal discussions.

**Table 3. Focus group exercises**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Questions</th>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting information about sex and relationships</td>
<td>How (e.g. from whom, what setting/media) and when should young people receive information about sex and relationships</td>
<td>Split into pairs to discuss and then report back to the group.</td>
</tr>
<tr>
<td>Partnerships</td>
<td>When is the right time for a person to have sex? Describe the ideal partner and the status of the partnership? Prompt: How might their views differ from the other groups (i.e. young people or parents)? What are the reasons for their beliefs and attitudes?</td>
<td>Brainstorming as a whole group. Right down suggestions, etc on flipchart paper</td>
</tr>
<tr>
<td>Consequences of teenage pregnancy</td>
<td>What are the likely consequences for a young Jamaican/Indian/Bangladeshi person if they become pregnant? What could be done in response to these consequences? Get group to think in context of the individual, family and wider community. Get group to think about factors that may influence their/others’ opinions – e.g. does marriage make a difference?</td>
<td>Brainstorming as a whole group. Right down suggestions, etc on flipchart paper</td>
</tr>
<tr>
<td>Communication in a health setting</td>
<td>What are some of the barriers and how can these be addressed? First from a professional perspective and then from a young person’s perspective.</td>
<td>Brainstorming as a whole group. Right down suggestions, etc on flipchart paper</td>
</tr>
<tr>
<td>Delivering sexual health services</td>
<td>How would they design services to ensure that they were more accessible to their target group?</td>
<td>Split into groups of around two-three. Using flipchart paper and coloured pens get participants to draw their ideal service for their target group (e.g. maps, labelling)</td>
</tr>
</tbody>
</table>
Analysis

The focus groups were taped, transcribed and analysed using a similar approach described for the analysis of the in-depth interviews. The team at UCL was responsible for the analysis of the focus groups. Themes arising from these data, in conjunction with data from the in-depth interviews, provided input for recommendations in the final report. The data were also used to explore any similarities and differences in views of the young people, the parents, and the service providers and community-based organisations.
3.1. Background

The aim of this chapter is to provide a context to the findings that are described in subsequent chapters. Composition of family and friends, religious affiliation and strength of beliefs, cultural heritage, and also education and aspirations of the young people participating in the research are discussed. Information collected from the focus groups was used to look at changes over time and to provide further historical context, for example what changes are notable between the different generations.

In ExES, two-thirds of Jamaicans were born in the UK. A smaller proportion of the Indian and Bangladeshi samples were UK born. However, ExES did show that the young Indian and Bangladeshi people who were born in the UK were becoming more acculturated compared to their parents generation.

.. youngsters now they get more Westernised.. they are going to do things before marriage, where our own minds are different.. we follow our parents' footsteps. So next generation are going to be worse they are going to follow the footsteps of English people.

(In Indian male, ExES)

Three-quarters of the Jamaican participants and around half of Indian participants had been educated in UK. Half of Bangladeshi women had received no secondary education.

The Jamaican participants were more likely to have parents that were no longer together. They were also more likely to have lived with other members of the family, such as ‘aunties’ or grandmothers.

3.2. Bangladeshi young people

Although most Bangladeshi young people lived with both parents, a number of the Bangladeshi respondents were living with immediate and extended family members, such as grandparents and in-laws.

The Bangladeshi respondents described a close affiliation with their cultural heritage. Some respondents were born in Bangladesh and had come to England at an early age, but on the whole, respondents in our sample had been born in England. Conversely, the young people’s parents had generally been born in Bangladesh and had come to England to live once they were married. There were no cases of mixed parentage Bangladeshi respondents in our sample and all these respondents were Muslim.

Bangladeshi young women were more likely to describe Bangladesh as ‘home’, even those who had never been there. The Bangladeshi young men nearly always referred to themselves as Asian rather than Bangladeshi.

Some young people had visited Bangladesh and felt it was important to do so in terms of preserving cultural identity and to keep in touch with family who lived there. Bengali was widely spoken, with a number of respondents saying that either one or both of their parents could not understand or speak English fluently. Respondents generally talked
about speaking English with their siblings and Bengali with their parents. However, one respondent said that although her parents could not speak English fluently, they were able to understand it, so she also spoke English at home.

There was consensus over the importance of religion and the strength of religious belief among Bangladeshi respondents. Respondents often described themselves as ‘quite religious’. The male respondents suggested they regularly visited the mosque, while religion was said to be a more private and home based activity for the female respondents. Even those who did not regard themselves as being religious said they did have a basic understanding of the Islamic faith from things they had been taught as children.

Female respondents conveyed the significance of wearing a headscarf as a sign of religious commitment - one respondent said she did not regard herself to be a ‘good Muslim’ because she did not wear one. When asked if they intended to wear a headscarf in the future, respondents generally suggested they would.

3.3. Indian young people

Most young Indian respondents lived with both parents. Some young people came from one-parent families, where they lived with either their mother or father. Other parents had remarried and so respondents were living with step-fathers and step-brothers or sisters. In some cases the young people suggested they no longer had a relationship with their father, as contact had not been maintained following their parents’ separation.

Cultural influences and religious practices among the Indian young people were more diverse than for the Bangladeshi group. Parents of respondents were mainly from India, although in some cases, respondents had one parent who had been born in England and the other in India. Some respondents were of mixed parentage but they generally expressed some affiliation with Indian culture.

Some of the parents who participated in the focus groups originally migrated from East Africa and still had family there. They felt very different from those who had migrated directly from India. This also explained some of the regional differences amongst the Indian UK population. East African Indians have tended to settle in the Midlands and in the South whereas those migrating directly from India have tended to settle in the North of England.

A range of languages were spoken by the Indian respondents, including Punjabi, Gujarati and Hindi. Respondents often spoke a mixture of English and their Indian language when they were at home with their parents. However, despite being able to understand the language spoken by their parents, some young people only spoke English and this had resulted in communication difficulties between some respondents and their parents. For instance, one respondent believed she had a closer relationship with her English-speaking father, because she could not speak Hindi and her mother did not speak English.

A number of different religions were practised by the Indian respondents. On the whole, respondents were Hindu, although there were also some Sikh and Muslim respondents. In addition, some young people suggested they were agnostic, but generally these were respondents from mixed parentage backgrounds. Religion did not seem to be a strong
determining factor in terms of attitude and behaviour, in the same way as it was for the Bangladeshi group, rather culture, parental and community views appeared to be more influential.

The Indian young women suggested that a big factor determining attitudes and behaviour in the UK was a change from the traditional ‘caste culture’ to British ‘class culture’ and that middle class Indians had very different attitudes to working class Indians.

The Indian parents described how there had been huge changes in India in recent years, with attitudes becoming much more liberal. Indian parents in the UK were far stricter because it was important for them to hold onto their cultural identity. Being second or third generation did not necessarily equate with a more ‘relaxed’ upbringing. This need to protect cultural identity was something also recognised by the participants in the professional and young people focus groups:

*Back home it is more modern than it is here because our parents still stuck to the views of thirty years ago when they first came over here. People from back home laugh. ‘Why haven’t you moved forward?’ ... It’s MTV culture over there.*

(Indian young man, London, Focus group)

The value of education was particularly emphasised by the Indian mothers who saw university education as a prerequisite to financial security.

### 3.4. Jamaican young people

There were some Jamaican respondents from one-parent families and these young people generally lived with their mother and in some cases with both their mother and their mother’s partner. Levels of contact with absent parents among these respondents varied between those who saw their absent parent regularly and those who had little or no contact, especially for those cases where the absent parent lived in Jamaica.

Where there were parents of different ethnic origin, this often meant young people did not receive any cultural input from their Jamaican fathers, unless the mothers were proactive in ensuring their children learnt about Jamaican culture. The Jamaican fathers agreed that some men do not provide emotional or financial support. As a consequence mothers were independent and did not rely on men. They felt that this type of matriarchal society was easier in the Caribbean where women would have more support from members of their extended family than in the UK. The fathers also described how men were often not encouraged to have contact with their children even if they wanted it.

The mothers disagreed with this statement and felt that many Jamaican fathers did not act responsibly and although they might complain about not seeing their children they did not do enough or were not consistent in their efforts to participate in their children’s lives. One Jamaican mother explained that the behaviour of her child’s father meant that their child treated them both very differently and gave her more respect.
The Jamaican group of young people appeared to have more tenuous links with their culture. The Jamaican respondents’ country of birth varied with some people having been born in Jamaica and others in England. Some respondents had been born and raised in Jamaica, and in one case, the respondent had lived in Jamaica until the age of 14. Conversely, others were second or third generation British. Furthermore, some young people had never been to Jamaica.

The young people generally described themselves as being ‘Christian’ in faith. However, religion was not widely practised and a number of people said they rarely or never attended church. The focus groups discussions around the role of the Church within the Jamaican community were not always consistent between the different groups. The young people, in agreement with the young people who participated in the in-depth interviews, felt that religion had little importance in their lives. Some of the professionals and parents felt that religion did have a strong influence, particularly on attitudes towards abortion. However, these tended to be participants who had been brought up in Jamaica rather than in the UK. The influence of religion was felt to be greater in Jamaica than in the UK:

...everywhere you go there is a church [in Jamaica]. Different kind of churches. So it is in your face. Everybody goes to Church on a Sunday.... The family tree has broken down as well. Over there you used to have your grandmother, your grandfather and whatever and everyone was like a big family tree. If grandma say she’s going to Church, everybody is going to Church. The attitude over here has changed.

(Jamaican father, London, Focus Group)

Although young people may not themselves be religious, the impact of their parents’, their extended families’ and the wider community’s beliefs, or in fact the beliefs of Jamaican professionals, may indirectly affect their values, behaviours and experiences.

The importance of migration history was also raised by the Jamaican fathers. They explained that the majority of immigrants who came to the UK in the 1950s and 1960s were working class people who came over with virtually nothing. They had to work extremely hard.

The Jamaican mothers drew the distinction early on in the focus group between what they referred to as ‘English-Jamaican’ and ‘Jamaican-Jamaican’. They felt huge differences existed between these two groups in terms of religious beliefs, educational aspirations and views about the family unit. The Jamaican fathers described different experiences in their upbringings. Two of the fathers had been brought up in Jamaica and continued to have strong links in Jamaica, while the third was born and brought up in England. If he visited Jamaica he was viewed as English, as a tourist. He described how his own children were even further removed from their Jamaican roots:

Their Jamaican culture is important to them by the fact that they are mixed. They have a background that is Jamaican and English. If they need to go to Jamaica or have to go, they have family there. Their beliefs are rooted here, not there.

Although the Jamaican fathers also acknowledged the value of education they were concerned that prospects for Jamaican young men were often poor.
3.5. Similarities and differences between the groups

Family

Young people generally lived at home with their parents and siblings, or with members of their extended family, such as grandparents. There was less evidence of one-parent families among the Bangladeshi respondents, compared to the other BME groups. Diversity in family composition was found among the Indian respondents, although this was less pronounced than the Jamaican group. Jamaican young people were more likely than Bangladeshi and Indian young people to report no or little contact with their father.

Many of the parents, irrespective of ethnic group, thought that there was less discipline in the home than previously. The Jamaican mothers and fathers described how their upbringings had been much stricter. However, one of the fathers felt that this was a reflection of general changes in British society, people used to be more polite. It was felt that this lack of discipline was the consequence of the breakdown in family structures through separations and divorces.

Friends

On the whole, respondents were friends with people from school, university and in some cases places of worship. This latter source of friends was particularly true of Bangladeshi and Indian respondents, a number of whom highlighted the social aspect of attending the mosque, gurdwara or temple.

Diversity in friendship groups in terms of ethnicity and religion seemed to partly depend on the level of contact respondents had with other groups of young people. For instance, some of the Bangladeshi and Indian young people felt their friendship groups were predominantly Asian as the area they lived in, and the school they attended, were populated mainly by Asian people. Consequently, some respondents said they had only begun to make friends outside the Asian community when they had left school and had gone on to university, or started working:

> When I was at college I met other races. I met White people, Pakistanis, and Africans and all sorts. So it was like I was learning the new path then.

(Bangladeshi young woman, Aged 19-21, Manchester, In-depth Interview)

In contrast, there were some respondents who had been educated with people from different cultures, or perhaps lived in more ethnically diverse areas, and this was said to be reflected in their friendship groups. However, one respondent suggested that although he had White friends at school, he would not socialise with them outside of it:

> Yeah, I don’t, I don’t hang around with the White people after school, I suppose … I don’t know, I just know them in school and that’s it.

(In Indian young man, Aged 13-15, Manchester, In-depth Interview)
The Jamaican respondents’ friendship groups were more mixed in terms of ethnicity and religion. This was attributed to living in ethnically mixed areas and also having a diverse ethnic mix of pupils at their school or college.

**Education**

For the most part, the young people were high educational achievers and were focused and ambitious in terms of their future career. Some respondents were attending college at the time of the research, and some of the younger respondents, who were attending school, expressed a keen interest in pursuing further and higher education. The exception was the focus group with Bangladeshi young men where all the participants had left full-time education.

Bangladeshi and Indian females, in particular, spoke about the importance of achieving a high level of education before getting married or having children. However, one young Indian woman respondent had dropped out of university because she missed her friends and living at home.

The educational attainment of the Jamaican young people was more mixed and they were engaged in a wider range of activities, including NVQ and B-TEC course. Some were unemployed.

All parents acknowledged the importance of education and career for their children. Although there was recognition amongst the Jamaican fathers that prospects and opportunities for Jamaican young men were sometimes poor.

**Religion, Culture and Community**

Religion played an important role in Bangladeshi young people’s values, such as sex before marriage was against Islamic teaching. In the Indian groups culture was generally observed to have more impact than religion. It was acknowledged that sometimes it could be very difficult to distinguish between the effects of religion and the effects of culture on behaviour, and often people misinterpreted the effects of culture for those of religion. However, the professionals and community representatives discussing the Indian young people’s interviews highlighted the need to acknowledge the diversity of religious beliefs amongst the Indian community. It was also important not to assume that just because people were of the same religion they would share the same values. For example, Indian Muslims will be very different to Bangladeshi Muslims.

Definitions of what constituted as culture and community were far more complex. An area that everyone agreed upon was the importance of not treating each of the BME groups as one homogeneous community. There were a variety of influences that impacted on cultural values that were discussed during the groups, including migration history, where you lived, class, caste and country of origin.

It was felt important to recognise that the cultural beliefs and values of BME communities in the UK were not necessarily the same as those held in the countries of origin. For example, the Bangladeshi participants explained how in Bangladesh you
would never see a woman walking around without a headscarf. However, some felt there were examples where attitudes were stricter in the UK than in Bangladesh.

The parents did feel that it was sometimes hard to accept social changes. The Indian fathers explained that they were ‘apprehensive and fearful’ of the effects of an alien culture. For example, it was a luxury to go to the cinema when they were young, while these days it was seen as the norm. However, some parents felt that these social changes were generational rather than specifically due to acculturation. There had been huge changes across British society in the last thirty years.

Cultural beliefs were not only being influenced by British White culture. There was mention of how Jamaican culture has had a huge influence on Indian young men. The Jamaican fathers and mothers mentioned the effect of American culture on young Jamaican people. This influence was viewed as something negative.

There was a fair amount of debate within the adult focus groups about definitions of ethnicity, culture and community. Generally, this was not an area that preoccupied the young people despite prompting. The adults felt that young people defined their ethnicity depending on their current environment. For example, they would be British at school, but something else at home. Although all the young people participating in this research defined their own ethnicity as either being Jamaican, Bangladeshi or Indian, few described any strong affiliation with their parents’ or grandparents’ country of origin – the exception being some Bangladeshi women. In the focus group with Jamaican young people, only one of the group had been born in Jamaica and less than half of the group had ever visited Jamaica. The adults explained that UK Jamaicans’ ideas of what being Jamaican involves is very different from those living in Jamaica:

Some of them (young people) go on culturally as if they are Jamaican. They have never been to Jamaica, but I suppose it is who they are hanging around with, who they go with.

(Professional and Community Representative Group: Jamaicans)

There was some discussion in the focus groups about the extent to which people feel part of a community, whether it is defined by ethnicity or some other shared interest. It was felt that many people who were born in the UK or who had lived here a long time would not necessarily see themselves as part of a community defined by ethnicity. Nor was it felt that even amongst those who did identify with a particular ethnic community it could be assumed there would be shared values. For example, Bangladeshi young people may disagree with the views of their elders, but it would be very difficult for them to talk about this openly. There were concerns voiced that some young BME people were very cynical and disengaged from any sense of community:

They feel the injustices that happen within society very passionately and take it very personally. If you feel that society doesn’t view you or judge you or value you on your terms you are not going to buy into their systems or their terms and their values .. Society is there. It’s a system. It’s an intangible thing. Something apart from them. They will never vote. They will never take part .. That trickles down to their values.

(Professional and Community Representatives Group: Jamaicans)
Key points

- Bangladeshi young people described a close affiliation with their cultural heritage. There was consensus over the importance of religion. All participants were Muslim.

- Family structure, cultural influences and religious beliefs were more diverse amongst Indian participants compared to Bangladeshi participants. The Indian young people described Indian parents as strict. It was felt this was because they were keen to hold on to their cultural identity. Great value was placed on education.

- The family structure of Jamaican participants was the most diverse. Some young people described little or no contact with their fathers. Most were second or third generation and some had a non-Jamaican parent, so links with Jamaican culture were often tenuous. Concerns were raised that the educational and employment prospects for young Jamaican men in particular were often poor.

- All participants felt it was important not to treat BME groups as one homogenous community. A variety of influences shaped cultural values, including migration history, where you lived, school, class, caste and country of origin.
4. Knowledge and Attitudes

4.1. Background

There is very little research that has looked at sex and relationship education (SRE) and ethnicity. Most guidance documents that have been produced for schools on the delivery of SRE to young people from BME communities have been based on anecdotal evidence. A criticism of SRE delivery is that religious and cultural backgrounds of pupils are ignored and teachers assume “mainstream youth culture identity is the most important factor for all young people” (DoH, 2002).

Young people from BME communities can be more reliant on schools for SRE than White pupils (Holland, 1993). Due to stigma, sex is not discussed within families, within community groups or by professionals (not wishing to offend). Also, parents can feel ill-equipped at discussing sex and relationships as they themselves received no formal education. Therefore, some BME young people are unable to make informed choices and may unknowingly be putting themselves at risk.

Overall, the majority of parents (94%) are supportive of SRE. However, this proportion is lower amongst parents from Muslim, Hindu and Sikh communities, 49%, 78% and 75%, respectively (Sex Education Forum, 1996). Although it is recognised that schools need to link up with parents, schools can be nervous about doing this. Language and cultural factors can also act as barriers to effective communication.

In ExES, the majority of Jamaican participants described receiving some form of SRE at school, but commented that it tended to be very biological. Sex was generally not discussed at home. The women described how if there were any discussions at home they tended to relate to periods and not getting pregnant. Jamaican men said they received even less information. The Indian and Bangladeshi participants received very little information in either home or school settings, although those educated in the UK were more likely to have had some form of SRE. Some of the Indian women described receiving indirect messages about the importance of maintaining their modesty. Bangladeshi respondents, particularly the women, described knowing very little about sex prior to getting married. Some described health services, in particular general practice, as the main source of information, but this was usually after the birth of their first child. Interestingly, many of the participants thought they would be much better at discussing sex and relationships with their children than their own parents had been with them.

Many of the Jamaicans who participated in ExES described how sex before marriage was a good thing. It was healthy and it ensured sexual compatibility with a partner prior to cohabitation or marriage. There were some more religious Jamaican participants who believed sex should not happen until after marriage. Some of the participants described how they were very cynical about marriage:

I don’t really see marriage as anything because all it’s doing is just putting a ring on your finger … the man or the woman is still going to do a dirty with you either way, so I don’t really see the point in it, it’s just a fashion basically, so I’m not getting married, no point, you just waste all that money.

(Jamaican male, ExES)
Sex outside marriage was seen as a sin amongst the older and some of the younger, but traditional, Indian and Bangladeshi interviewees. The younger and more acculturated, felt that it was possibly a good idea to have some sexual experience prior to marriage. However, even amongst this group the ultimate goal was a committed and faithful marriage.

Almost all of the married Indian and Bangladeshi people had had an arranged marriage. Arranged marriages were generally viewed as positive, but there was evidence that views were changing, particularly amongst those who had been brought up in the UK. It was felt that it was better to get to know the person before marriage, and the younger interviewees felt that their parents were supportive of this.

Some of the Indian men and women spoke about the importance of caste when choosing a partner, as parents were more likely to be supportive of the union. Some also felt that it was important to have the same ethnic origin as your partner as this would be easier for the children.

### 4.2. Bangladeshi young people

Some young people felt that they could not talk to either parent. There was overall consensus in the Bangladeshi focus groups that sex was not discussed at home with either young men or women. The Bangladeshi young women agreed that most of the messages they received from their mothers were indirect ones such as ‘Don’t go near boys’.

Those professionals and community leaders participating in the Bangladeshi focus group explained that if a meeting with Bangladeshi parents is set up to discuss sexual health issues, they will not turn up. The way around this was to first combine sexual health into meetings on general health in order to introduce the topic. It would be important to emphasise the seriousness of the meeting, and to ensure there were authoritative and respected speakers.

In general the young people thought that they would be different with their own children and ensure that there was better communication. The Bangladeshi young people explained that this was because their knowledge was much greater than that of their parents as they had gone to school in UK and most had received some form of SRE:

> I think it’s going to change because younger people are going to know about it as they lived in this country, and their parents didn’t tell them everything, so they’ll try and give all the information and support to their children.

(Bangladeshi young man, Birmingham, Focus group)

Interestingly, improved communication skills and awareness about sexual health would not necessarily lead to more liberal attitudes towards sex, as one Bangladeshi women pointed out:

> … when we have kids, I think we will feel more comfortable talking about all of this, and that should happen. Because most of our parents are from back home. They are uneducated, they have a language barrier, and we don’t feel that comfortable talking with them, because they are
from back home. I think when we have our kids in 10-15 years, I think we will talk to them, whether they are a son or daughter, we should talk to them and educate them and tell them these things are happening. You've got to be aware. . . . I definitely wouldn't want my kids to have sex before marriage, no way. I would say to them, no way. I would say, if you have such desires, you come to me and I'll get you married.

(Bangladeshi young woman, Birmingham, Focus group)

Finally, young people felt that their parents did not understand what it was like to be young these days. Some described being more ‘streetwise’ than their parents had been:

They (parents) should really understand about how life is evolving and how things change . . . they want to keep it in the traditional way, but they can’t do that.

(Bangladeshi young man, Birmingham, Focus group)

In contrast to the more liberal views espoused by the Jamaican respondents (see Section 4.4.), the Bangladeshi young people fervently opposed sex outside of marriage, so were against both pre marital and extra marital sex. Across this group there was a general consensus of views and attitudes between both genders and across age groups, even those individuals who were sexually active expressed these views when asked. Unlike both the other groups, the right time to have sex was not therefore determined by age or any other factors, rather it was decided by whether the person was married or not:

It’s forbidden to have sex before you’re married. My view is that I think you should wait until you get married . . . I would say wait ‘til you get married . . . it’s the best time like. I think it is one of the best feeling you have once you’re married.

(Bangladeshi young man, Birmingham, Aged 16-18, In-depth Interview)

In line with their general views regarding sex, Bangladeshi respondents did not agree with casual sex, except for some male respondents who were having casual sex themselves. Reasons for these views were directly related to views and attitudes about sex before and outside of marriage and were consequentially a reflection of both religious and cultural beliefs and values.

The Bangladeshi group were against co-habitation, not because they disagreed with people living together, but because it suggested that pre-marital sex was occurring and, as already discussed, this was against the religious and cultural beliefs of this group. Moreover, respondents disagreed with co-habitation as a consequence of the values and views held by their family and local community, who they believed would look unfavourably on co-habitation.

When asked about arranged marriage both Bangladeshi respondents highlighted the distinction between ‘forced’ arranged marriages and ‘introductions’ that may or may not result in marriage. This distinction was important for respondents. Although they disagreed with forced arranged marriages, introductions were viewed more positively, with some respondents suggesting they would be happy to find a husband in this way. Some of the Bangladeshi respondents likened these introductions to a dating agency that could be used if people were unable to find themselves a suitable partner. For instance, one respondent said they would ask their parents to introduce them to someone, if they had not found a partner by the age of 30.
Some of the Bangladeshi young people, were also against the idea of arranged marriage – particularly the male respondents, as they believed it was important to ‘get to know’ your partner before getting married and they had also experienced some arranged marriages that had failed. For instance, one Bangladeshi male explained how his sister’s marriage was failing as she had married a man who did not speak English and consequentially was unable to get work. Although it was felt that forced marriages were rare, some Bangladeshi females were concerned they would be taken to Bangladesh and married. One respondent said she heard of cases where people were drugged and married in Bangladesh.

The ‘right time to get married’ was thought to be related to when a person completed their education or established their career. Bangladeshi respondents, especially the females, believed they would not get married until after they had finished University. Consequentially the right age to get married was said to be anything between 23 to 25 years, although it was said that this could be younger for those who did not go on to University.

Bangladeshi respondents believed it was important for them to marry someone of the same ethnicity and religion as themselves, as not only would it be expected by the family and local community, but as they believed there would be greater understanding between partners as they would share common values. Although ethnicity was seen to be important, it was felt that having the same religion, that is, being a Muslim, was of even more significance:

>If they [partner] were something like Christian, you know, they’ll be doing their own religion thing and they kind of won’t understand mine, if you know what I mean. So I would like them to be the same as me so then they do kind of understand what my religion is about and stuff.

(Bangladeshi young woman, Aged 13-15, London, In-depth Interview)

There was a consensus amongst young people that their religion says that sex is for after marriage:

>It’s religious, Islamically it’s totally wrong before marriage….. Whether a man or woman, we know we have these desires and do not sin outside marriage.

(Bangladeshi young woman, Birmingham, Focus Group)

Even though many young people felt times were changing, it was felt that sex should first occur within marriage. In terms of the timing of sex, some young people felt the right time for sex in a ‘love’ marriage was immediately after marriage, while in an arranged marriage it might be best to wait a couple of months and get to know one another. They did feel that young people needed to be more prepared for sex within the marriage context. Some of the young women explained if they knew for sure that they were going to marry a certain man in the future they would probably have sex with them before the marriage.

The young men felt that 25 – 35 years was the right age to get married. They thought women should get married at a younger age than this and that there would be pressure from parents if their daughters showed no interest in getting married, ‘Get them married off in Bangladesh, take them to Bangladesh before they do something stupid here.’ The young women did feel that women were getting married at an older age, after they have finished their
education. Ten years ago this would have been at 16 years old once they had finished their GCSEs, now it was often after finishing college in your early twenties. In Bangladesh, women still tend to marry at a much younger age.

4.3. Indian young people

The parents felt the family did have an important role in delivering SRE. They also explained how sex should be discussed in context with other health and social issues, such as drugs and alcohol. The Indian mothers described how good communication and the need to build on trust was necessary with both young men and women. They used the analogy of food to describe the benefits of this – good ingredients and cooking ensure a healthy body. The Indian mothers went on to explain that they, and not the fathers, would be blamed if ‘anything went wrong’, such as a teenage pregnancy.

The Indian fathers thought that religion was used as a convenient barrier at times. One father explained that there was nothing in the Muslim faith that said parents should not provide SRE to their children, in fact he thought it was a parental duty. The Indian young men and women agreed that lack of communication was cultural rather than religious and used as a convenient excuse but attempting to change things would be very difficult.

Some of the young people said that they would not discuss sex with any members of the family as just asking questions would be viewed as an admission to guilt. One Indian young man explained that if he broached the subject of sex with his parents they would automatically assume that he had got someone pregnant.

Indian respondents expressed mixed views about sex before marriage. The young male respondents’ views about pre-marital sex varied, while some thought pre-marital sex was acceptable, others suggested they had chosen not to have sex before they were married. Unlike the Bangladeshi respondents, there was less emphasis on this decision being made as a consequence of pre-marital sex being wrong per se, rather they had made an individual choice not to. This decision not to have pre-marital sex was generally said to be the result of religious views, although the respondents pointed out that this decision was based on personal preference and interpretation of their religion, rather than their religion dictating this behaviour.

As with the male respondents, the Indian young women also expressed differing views about sex before marriage, with some suggesting they would engage in pre-marital sex; and others suggesting they would not have sex before marriage. However, the reasons given for these views differed. Those who were against sex before marriage were less likely to highlight religion as their reason, rather they were concerned about pregnancy and STIs, or were adhering to the views of their parents.

For those who did advocate pre-marital sex, the focus was generally on love and it was generally seen as acceptable as long as it occurred within a loving, long-term relationship:

*I think that as long as you have sex with someone that you’re in love with, then I think it’s all right. Some of my friends since they’ve been at uni as well, they’re having sex with different guys here, there and everywhere and I think that’s wrong.*
Some Indian young women thought it would be good to have sex before marriage, as it meant they would have sex with someone other than their husband. For the most part, those who advocated sex before marriage suggested the right time to have sex was when you were in love and felt you wanted to have sex with your partner. When probed on what age this should be, suggestions differed ranging from 16 years to late 20s.

Both Indian young men and women tended to disagree with casual sex, even by some of those who had engaged in casual sex themselves. For the most part, male respondents suggested they chose not to have casual sex as they deemed it to be disrespectful to women and felt they should treat women as they would wish their female family members to be treated. Conversely, some male respondents thought casual sex was acceptable.

The Indian young women offered multiple reasons as to why they disagreed with casual sex, including fear of catching STIs, loss of self respect, the view sex should occur within a loving and safe relationship; and also as they believed it would make them less eligible for marriage.

Although, the Indian young people were often less personally opposed to co-habitation, they generally suggested they would not live together outside of marriage, even if they wanted to, as a consequence of the negative views held by their parents, their wider family and local community. It was felt by some, that co-habiting with a partner would not only reflect badly on the individual but would also bring shame upon the family as a whole. Some female respondents also felt this may impinge of their chances of finding a suitable husband in the future as it could ruin their reputation.

Like the Bangladeshi young people, the Indian young people talked about the importance of distinguishing between ‘forced’ arranged marriages and introductions. Although some of the Indian respondents suggested they would expect and be happy to have an ‘introduced’ arranged marriage, a number of the Indian young people were against having this type of marriage for themselves and a range of reasons were given for this including:

- Concern over risk of physical abuse. It was felt by some that arranged marriages could become physically abusive. One respondent said she would be expected to marry a man from India, which concerned her as she had heard they could be ‘perverted’ and ‘abusive’;

- Wanting to get to know a person prior to marrying them; and

- Having experienced failed arranged marriages amongst family and friends. For some respondents the failure of other arranged marriages, particularly the marriage of their parents, gave them a negative view of arranged marriages.

The Indian young people suggested the ideal time to get married would be in their twenties, and suggestions ranged from early twenties up to mid thirties.

As with Bangladeshi respondents, Indian respondents felt their partner would ideally be of the same ethnicity and religion, although for some the emphasis was placed on being Indian rather than being of the same religion:
I wanted to do it [marry] with an Indian girl. I’m not that strict on my religion or anything or I don’t have to have an Indian relationship or anything, but I want to. It’s probably in my head or something. I’ve been brought up to think like that.

(Indian young man, Aged 19-21, Manchester, In-depth Interview)

Having said this, religion was seen as important for some who believed this would be completely unacceptable to their families. For example, one Indian female was dating a Muslim and they kept the relationships secret as a consequence of their partner’s religion. Reasons given for these preferences focused around people of the same ethnicity and religion having a greater understanding of one another and it was also thought to be easier when having children. Less importance was placed on either ethnicity or religion by some respondents who had parents of different ethnic origins.

Most Indian young people did think that marriage is important and is strongly influenced by community, culture and religion. There was general agreement that the right time for marriage for both men and women was on completion of education. The Indian young women suggested that some parents would not mind if a woman met her husband at college or university because the men there would be educated and more likely to be financially secure in the future. It was very rare to see women who had been brought up in the UK married before 18 years, but young women who are born and brought up in India are sometimes very young when marry. One professional group participant mentioned that he had heard young Indian men say that they would not want to marry an Indian woman born in the UK because she would be too Westernised. However, one of the Indian young women who wanted to remain a virgin until marriage stated that she wanted to marry an Indian man born in India because he would appreciate her traditional values more than an Indian man born in the UK.

Parents did talk with their children about marriage and it was felt that generally parents were happy for their children to chose their own partner. However the mothers did stress that it was important that partners were of the same religion and they thought that the same language was important. Although spouses in mixed marriages might visit each other’s place of worship, it was very rare for someone from another ethnic group to learn their partner’s language.

4.4. Jamaican young people

When parents were asked how young men learnt about sex it was felt, “We just learn as we go along. Experimentation.” (Jamaican father, London, Focus group).

Some young people explained that they did not want to talk to their parents about sex or at least, they wanted any discussions to be ‘kept to the basics’ and to remain unemotional:

I’ll talk to my mum, but I don’t wanna hear what she’s got to say or what she’s done. I’ll ask her questions about basic stuff, but I don’t want her to go into detail and tell me what she did with this person and that she likes that person.

(Jamaican young woman, London, Focus group)
Some parents acknowledged that at times they too needed to look at their attitudes and behaviour before ‘lecturing’ their children. Some of the Jamaican mothers explained that they were lectured by their parents and felt that it was important to have an open relationship with their children.

Some of the Jamaican young people described how they never really had a relationship with their fathers and it was too late to start once you were in your teens:

*It’s too late, when their children wanna start bonding with them, it’s too late. They need to start having that sort of relationship from the start and I never had that relationship with my dad. I still haven’t got it. I can’t talk with him about them things.*

(Jamaican young man, London, Focus Group)

The men in the Jamaican groups described how young men often received negative messages from parents. Mothers could sometimes portray the father as ‘the bad boy’ or ‘the sperm donor’ and this has a negative influence on the children, particularly the boys. It was felt that because fathers were not always around that many young men did not have a positive male role model. Some described how it was necessary to help young Black men with the rejection this caused. Jamaican mothers felt that a male role model was not always necessary if they were bringing up a boy without a father. They felt that it would be important for them to be strong, for them to surround themselves with positive role models, such as members of their family, and that they would teach their sons to be sensitive to women:

*because he has strong women around we would never stand for that…he would be compassionate…*

Another parent pointed out that it was not just a case of increasing parents’ knowledge about sex, “It’s not that parents don’t know what to say to their kids, it’s that they are too scared”. (Jamaican father, London, Focus Group.)

Jamaican young people exhibited less strong views about sex before marriage and were more likely to judge the ‘right time’ based on a person’s age and how ‘ready’ to have sex the individual felt:

*You know, you’ll just know when it’s right. Although I chose to wait with my boys, it was just a question of when I felt ready. I don’t think there is a time or anything like that.*

(Jamaican young woman, Aged 19-21, London, In-depth Interview)

In fact, some respondents actually advocated sex before marriage, as they felt it was prudent to have sex in order to either gain sexual experience or to ensure sexual compatibility with a partner. The only concern expressed regarding sex before marriage, according to the Jamaican young people, came from younger respondents who highlighted the risk of teenage pregnancy. According to this group, the ‘right time’ to have sex was between the ages of 15 to 18 years. Some male respondents advocated sex at the younger end of this scale.

Casual sex was met with mixed reactions by the Jamaican young people. On the whole the male respondents felt casual sex was acceptable, however the female respondents expressed more mixed views. While some were against casual sex, as a result of possible
risk of infection and finding themselves pregnant without the father’s support; others thought it was acceptable providing everyone was happy and safer sex was practised. According to one respondent, casual sex was even thought to be positive, as they believed it could boost confidence levels and be empowering.

No strong views were exhibited by the Jamaican respondents regarding co-habitation, although views varied between those who said they would co-habit and those who said they would not. Neither group expressed strong opinions either way. Views tended to be based on individuals’ views and were not thought to be directly related to religion or culture, for instance, one female respondent said she disagreed with co-habitation as she felt this would require her to carry out domestic chores for her partner.

The value of marriage per se was questioned by a number of Jamaican respondents who expressed some cynicism towards marriage. This was generally felt to have occurred as a result of negative experiences relating to their own parents’ marriages that had impacted on their own views. For others, the best time for marriage was thought to be between the ages of 25 to 35, or after they had established their career.

Views on what constituted an ideal partner were more varied for the Jamaican young people. They were more likely to see their ideal partner as being of mixed race and often said they had no preference regarding ethnicity or religion.

This range of views was thought to be a reflection of the exceptionally diverse nature of this group regarding their family and friendship background. As explained in chapter 3 (Context), individuals from this group were often from single parent or re-constituted families, where the Jamaican parent was absent. Consequently, these young people often had limited knowledge and exposure to Jamaican culture and had a greater affiliation with other cultures, such as White British culture. Also, some young people described how their Jamaican parents placed less emphasis on marrying someone from the same culture. In fact according to one respondent their mother had actively discouraged them from marrying a Black man, as they thought them to be ‘less reliable’.

Some of the parents felt that young people’s attitude to relationships reflected their upbringing. One woman explained that her views on the importance of marriage were based on her own upbringing and she would want her own children to have these same values. Others felt that the Jamaican young people’s cynicism towards marriage stemmed from the fact that many of them had experienced the marriage or relationship breakdown of their own parents. This also affected their attitudes to parenthood (see Chapter 6.). The fathers’ group felt that parents needed to look at their own behaviour, as it was important for children to have respect for their parents.

4.5. Similarities and differences between the groups

Knowledge

Overall, differences in awareness and knowledge within and between the three ethnic groups were minimal at this age, with the exception of some Bangladeshi young women who suggested they had absolutely no knowledge of sex when they were 11 years old. Awareness and knowledge regarding the physical act of sex increased aged 12, this was thought to be a consequence of beginning SRE classes and also mixing with a larger and
often older group of young people at secondary school. Differences in awareness and knowledge of the act of sex tended not to vary between the BME groups or between genders, except for some of the Bangladeshi young women, who continued to have a minimal awareness of the physical act of sex.

Information about the act of sex had been gathered from a range of sources including SRE classes, friends (particularly older or more experienced friends), media sources (such as the TV), magazines and pornography, family and also through personal sexual experience. Informal sources were used by all respondents regardless of gender or ethnicity. Respondents discussed the act of sex with friends, and Bangladeshi and Indian young men suggested they received information from a number of older, more sexually experienced friends at school and from community centres.

In addition to information gathered through discussions with friends, some respondents also discussed sex with their family. However, while the Jamaican young people discussed these issues with a wide range of family members, such as: parents (particularly their mother), aunts, siblings, and cousins; the Indian and Bangladeshi young people tended only to speak to their cousins and in some cases their siblings.

Aside from an increased awareness of oral and anal sex by some respondents, awareness and knowledge of the act of sex tended to be linked directly with personal experience from the age of 16 onwards. Consequently respondents who were sexually inactive tended not to increase their knowledge after this age. For some Bangladeshi girls this meant that it was only once they married that they gained detailed knowledge of the act of sex.

Jamaican young men knew less about contraception than either the Bangladeshi or Indian young men. There were also some misconceptions regarding contraception among the Jamaican group, for instance, one Jamaican respondent (aged 13-15), thought getting a man drunk would act as a form of contraception, as they would ‘fire blanks’.

Some advice had been given on types of contraceptive methods by Jamaican and Indian parents. The Jamaican parents tended to give their children advice at an earlier age in comparison to the Indian parents, who only offered advice once their children were older and often already sexually active – aged 18 plus. Generally, awareness of STIs occurred around age 12, although this was not universally true, as a number of male Jamaican respondents suggested they became aware of them under 11 years. In contrast, some Indian and Bangladeshi females did not become aware of them until much later, aged 16 and in some instances 18 years.

Many of the young people agreed with the finding from the in-depth interviews, that not enough time is given to SRE. The professionals raised concerns that the time devoted to SRE in schools is decreasing.

In terms of timing, there was general agreement amongst young people that the beginning of secondary school was the right time to start SRE. However, the Bangladeshi boys suggested that a refresher course when they were 18 would be a good idea as they would have more understanding at this age.

The group discussions on SRE focussed on two areas: the need to take account of 1) cultural influences and 2) gender issues when delivering SRE. Personal Social and Health Education (PSHE) teachers, and others who deliver SRE in school settings, need to be
aware that traditional beliefs can be strong. It may therefore be necessary to look at alternative methods in delivering SRE. For example, participants in the Indian Professionals Group explained how young Indian women will not necessarily speak out in a large ethnically mixed (and often predominantly White) group. Therefore smaller groups will be more effective. Both young people, and the professionals and community representatives from the Bangladeshi and Indian groups highlighted the importance of keeping genders separate, particularly when working with Muslim young people. It was felt that young men and women could always be brought back together for a discussion at the end.

The parents felt that SRE should take account of other factors that can affect young people’s sexual behaviour, for example, the influence of crack and cocaine.

There was general agreement that young people, especially young women, were more likely to speak to their mothers than their fathers about sex and relationships. Both mothers and fathers described SRE in the home as the role of the mother.

The parents explained that for the most part their own parents had not discussed sex. Therefore talking about sex in the home was not the norm. All groups agreed that it was important to raise awareness and skills amongst parents. However, it was also acknowledged that this is easier said than done.

The role of the extended family was viewed as an important source for information about sex by the young people. Some said they found easier to talk to aunts and uncles, or cousins. Women overall were also more likely to speak to other family members.

Peers were also mentioned as an information source. Some of the health and education professionals said that they had successfully used peer education as a means of reaching young people from BME communities. However, it was recognised that there are also problems with just relying on peer education. Most programmes with BME young people targeted sixth forms rather than schools. Parental consent could sometimes be a problem with the recruitment of peer educators. And there was no evidence base in how effective peer education was with young BME people in the UK.

The young people felt it was very difficult to remain completely ignorant about sex these days because of the influence of the media. Many young people felt the media should be used more in the provision of SRE, particularly for young people who could not talk to their parents or would find it difficult to access services. A couple of young people suggested an interactive internet service, which would be private and confidential, “Like a chat room, but it’s one to one, rather than being on the phone” (Bangladeshi young woman, Focus group). Access could be made available in settings such as youth clubs. Boys, in particular, mentioned the internet and magazines as an important information source. They also confirmed the finding from the in-depth interviews that pornography is used to learn more about sexual acts.

**Marriage and relationships**

The family was thought to be a centrally important source in providing information and shaping views about marriage and relationships, through both direct teaching and through example. The young people often formed their views of marriage based on their
parents’ relationships and this had led to both positive and negative perceptions of marriage.

There was a general feeling in the groups that fathers needed more education on how to talk about sex to their children. In particular there was a strong message from community representatives and the Bangladeshi young people interviews that the process of education should begin with Bangladeshi mothers because they carried the main responsibility for communicating about sexual health matters at home. As with views on sex, the young people’s views and attitudes towards marriage and relationships varied between and within the ethnic groups. Overall, there was more diversity in the views expressed by the Indian group.

Respondents generally believed they would be able to marry for love if they wanted to. Parents and people within the Indian and Bangladeshi communities were thought to be becoming more accepting of love marriages, providing they were deemed to be a suitable match – that is, of the right religion, race or culture.

**Attitudes and views on sex**

Views and attitudes towards sex differed between all groups of respondents. These views were often strongly influenced by a wider value and belief system, particularly religious and cultural values and beliefs held by the respondent or by the respondents’ family, friends and local community.

The views and attitudes of each group differed according to ethnicity, rather than by either the age or gender of the respondent, although there were differences in views noted between the male and female Indian respondents. A consensus of views was demonstrated by the Bangladeshi group and on the whole, the Jamaican young people also espoused similar views to one another. In contrast the Indian young people’s views and attitudes were more diverse.

It was felt that to some extent both the Bangladeshi and Indian young people’s views were influenced by either religion, culture or by both. This was especially true of the Bangladeshi respondents. They not only expressed strong religious views, but also exhibited close connections to their culture and in particular a close association with Bangladesh itself, either as a consequence of visiting the country, contact with family living in Bangladesh, and also through marriage.

In some ways, the Indian respondents demonstrated an equally close connection to their culture and community. However, this group often had less strong religious views and even where they did, these views tended to be less prescriptive on issues such as sex and relationships. How actions would be perceived by their parents, family and local community appeared to have greater significance.

In contrast, the Jamaican respondents’ affiliation to either their religion or to the Jamaican culture was less pronounced. Their views were more strongly influenced by their parent/s and friends, who were from a mix of ethnic backgrounds and religions. The most common thread running through the views and attitudes of this group, related to the view of some sexual activities as ‘dirty’, particularly oral and anal sex. This group
emphasised a greater concern about the relationship between sex and infections, although paradoxically, it was this group who were more likely to have unprotected sex.

The views and attitudes of Bangladeshi young people were thought to reflect the views of their parents and friends. However, some respondents suggested their friends at school had differing views and were thought in a number of cases to be sexually active. Also, it was noted that the behaviour of some of the male respondents did not necessarily align with either their own views or those of their culture and religion.

Similarly the views of parents, friends and the views of the local community were reflected in the views of a number of the Indian respondents. Nevertheless, it was often the case that these young people had also developed their own views and attitudes. In some cases, they suggested that they simply adhered to the views of their parents and community due to a sense of duty and respect for their family, rather than because they shared the same views.

In contrast, some Indian respondents suggested they had inverted the views and beliefs held by their family and community, particularly some of the traditional views said to be attributed to women.

As with the other groups the Jamaican young people felt their views were generally aligned with those of their family and friends, although the diverse background of this group meant there was less affiliation with a specific value or belief system.

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**Key points**

- **Bangladeshi young people** rarely discussed sex and relationships at home, so SRE classes at school are often their only source of information. Knowledge about sex was poorest amongst Bangladeshi young people. The majority frowned upon sex outside marriage as it is against Islam.

- **The Indian young people** felt that the lack of communication about sex and relationships at home was due to cultural rather than religious barriers. Parents did feel that the family had an important role in the delivery of SRE. Views on sex before marriage varied. Some young women felt sex outside marriage would bring shame on the family and could affect their eligibility for marriage. Even those who were not against sex before marriage thought it should happen in the context of a long-term loving relationship.

- **Jamaican young people** tended to discuss sex with a wide range of family members and their attitudes towards sex were more liberal than the other two groups. Concerns were raised with all the Jamaican participants that lack of male role models negatively affected young men's attitudes to sex and
Key points: contd.

relationships.

- There was general agreement from all participants on the need to take account of cultural influences and gender issues when delivering SRE in school settings. The role of the extended family was also viewed as an important information source.
5.1. Background

Analysis of data from Natsal 2000 shows that there are significant differences amongst ethnic groups in age at first sexual intercourse and whether or not contraception was used at first intercourse. Amongst the general population, 20.4% (95% confidence interval 19.3-21.5) of women and 27.4% (95% CI 26.0-28.9) of men report first heterosexual intercourse before 16 years of age (Wellings et al, 2001). Higher proportions of Black-Caribbean women and men report first heterosexual intercourse before 16 years in comparison to the general population, 22.3% (95% CI 16.3-29.7) and 56.3% (95% CI 47.3-64.8), respectively (unpublished Natsal 2000 data). Lower proportions are observed for Indian women and men, 1.0% (95% CI 0.4-2.7) and 10.3% (95% CI 6.1-17.0), respectively. The proportions of Black-Caribbean women and men who reported that neither partner used any contraception at first intercourse were 36.4% (95% CI 29.1-44.3) and 35.9% (95% CI 26.4-46.7), respectively. These were higher than those for the general population, with 21.9% (95% CI 20.8-23.0) of women and 23.0% (95% CI 21.6-24.4) of men reporting that contraception was not used at first intercourse. The proportions for Indian women and men were 27.7% (95% CI 20.7-36.0) and 28.1% (95% CI 19.2-39.0), respectively. With regards to condom use, 41.2% (95% CI 34.4-48.4) of Black-Caribbean women and 41.1% (95% CI 30.1-52.2) of Black-Caribbean men reported use at first intercourse. This compares to 52.7% (95% CI 42.8-62.3) of Indian women and 53.5% (95% CI 41.9-64.7) of Indian men, and 53.3% (95% CI 52.0-54.7) of the female general population and 48.2% (95% CI 46.6-49.9) of the male general population.

The later age of first sexual intercourse has been put forward as one of the reasons for explaining the lower rates of STIs amongst Asians (Bradby and Williams, 1999). The high STI rates amongst some BME groups has been explained by the fact that partnerships tend to be within the same ethnic group, i.e. within “core groups” (Ellen et al, 1998; Low et al, 2001). Black-Caribbean men are more likely than men from other BME groups to have concurrent partnerships (Low, 2001), which may in part explain the higher prevalence of STIs in this group. In Natsal 2000, the proportion of Black-Caribbean men and women who reported that they had been diagnosed with an STI was 19.7% (95% CI 13.6-27.9) and 22.7% (95% CI 17.3-29.3), respectively. Lower proportions were reported amongst Indian men (3.4%, 95% CI 1.0-11.9) and women (7.8%, 95% CI 3.8-15.1) (Fenton et al, 2005).

Variations in the types of contraceptive methods used by women from different BME groups have been reported. For example, one study found that injectable methods are more commonly used by Black-Caribbean women, and condoms were more popular with Indian women (Christopher 1999). Another study found that sexually active young Asian women, irrespective of marital status, were less likely to use the pill and Asian men were significantly less likely to use condoms in comparison to non-Asians. (Brady and Williams, 1999).

Overall contraceptive use amongst sexually active unmarried South Asian women has been found to be high (Saxena, 2002). A study conducted in Leicester in the late 1980s with Asian women found there were no significant difference between contraceptive usage amongst different religious groups, i.e. Hindu, Muslim and Sikh (McAvoy and Raza, 1988). However, both young Asian men and women are significantly more likely than non-Asians to report religious beliefs as the reason for their sexual abstinence.
Unmarried Asian men were more likely than unmarried Asian women to have had sexual intercourse.

ExES illustrated that gender and the degree of cultural and religious affiliation influenced the timing of first sexual experience for each of the ethnic groups participating in the study.

Nearly all of the Indian and Bangladeshi women described how their first sexual experiences were within marriage. This pattern was also reported by the Indian and Bangladeshi men, but to a lesser extent. Those who were not married at the time of interview explained that they wanted to abstain from any sexual contact until after marriage for religious and cultural reasons. This included participants who were brought up and educated in the UK. There were also practical factors, such as having limited contact with the opposite sex, which prohibited any sexual contact. However, there was some evidence from ExES that attitudes towards sex before marriage were changing.

Some of the Indian and Bangladeshi participants (more frequently women, but not exclusively) described how the first time they had had sexual intercourse (i.e. penetrative sex) on their wedding night or some time afterwards, had been a negative experience. Some of these described being frightened because they did not understand what was happening.

Gender differences were more apparent amongst the Jamaican interviewees. Both men and women described having a varied range of sexual experiences prior to first sexual intercourse. But Jamaican women tended to have their first sexual experience in a stable relationship. Jamaican men were more likely to say that the first time they had sexual intercourse was unplanned and within a more casual relationship. A few of the men described first sexual intercourse with an older, more experienced woman, such as the “baby sitter” or the “girl next door”.

For the most part, the participants understanding of safer sex was in relation to pregnancy prevention. Some of the women thought condoms were only for preventing pregnancy and did not realise they were also for STI prevention. The Jamaican women explained that they generally stopped using condoms when they were in a serious relationship.

Knowledge of contraception prior to sexual intercourse was very poor amongst Bangladeshi women. For many their first discussions about contraception were following the birth of their first child, either with a health professional or with sister-in-laws. Contraception was never discussed with husbands.

5.2. Bangladeshi young people

The sexual experiences of the young people involved in the research varied. Overall, Bangladeshi females were the least sexually active of all respondents and had engaged in very few sexual activities. Although some girls suggested they had kissed, hugged and held hands, these respondents said they had rarely engaged in sex (either vaginal, anal or oral):
We just exchanged numbers and used to chat on the phone and stuff and he was always asking me out and I never used to say anything but then my friends said “oh just say yes, just go out with him” and then we did and we went out for three months but that was it … I didn’t hug him, he did kiss me on my cheeks and stuff but that was it.

(Bangladeshi young woman, Aged 13-15, London, In-depth Interview)

Those Bangladeshi females who were sexually active were either married, or as in one isolated case, sexual activity was said to have been a result of sexual abuse.

In contrast, some of the Bangladeshi male respondents were sexually active, having experienced both vaginal and oral sex. For some of these respondents sexual activity began aged 13 and for others it occurred later:

I've had sex; I wouldn't say like a lot yeah … It was when I was 15 … I had it because like I just wanted to have sex.

(Bangladeshi young man, Aged 16-18, London, In-depth Interview)

However, not all Bangladeshi males were sexually active. Some suggested they had no sexual experiences and did not intend to engage in sexual practices until after they were married.

The sexual activities of this group occurred both casually and also within relationships that lasted between three and eight months. The number of sexual partners ranged from one to three.

Levels of sexual activity, particularly the low sexual activity of the female respondents, was thought to be a consequence of the Bangladeshi young people's views and attitudes towards sex and marriage, which were said to stem from both religious and cultural beliefs. Interestingly, it was noted that although the Bangladeshi males espoused the same views and beliefs as the female respondents, their behaviour did not always reflect this.

The Bangladeshi young women tended not to have boyfriends. Where they did, these were generally kept secret from their parents and from the local community as they felt they would disapprove and this would reflect badly on them, potentially damaging their ability to secure a marital partner.

For the most part, the sexually active Bangladeshi young men were using contraception. Condoms were the main method used, mainly as they were thought to be easily available and also an effective method of protection against pregnancy and STIs. However, it is worth noting that protection had not always been used, when this was questioned further respondents were generally unable to articulate why.

The Bangladeshi young people agreed that lack of knowledge could have a negative impact on people’s first experience of sex, although this was seen in the context of marriage. They did feel this was less likely to happen these days, because they had greater knowledge of than their parents. However they recognised that young women from Bangladesh who come to UK for marriage have very little knowledge.
5.3. Indian young people

The sexual histories of both the young male and female Indian interviewees varied. Some began to have sex between the ages of 16 to 18, while others were not sexually active and held strong views about not having sex before marriage. For the most part, sex tended to be vaginal and instances of oral or anal sex were low. Some respondents had engaged in ‘foreplay’ at a younger age, such as taking their top off and kissing.

The Indian young women in our sample seemed to be more sexually active than the Bangladeshi young women. However, the experiences of both Bangladeshi and Indian males were similar.

The Indian young women felt that the consequences of being open about sexual activity were too great. One young woman explained ‘every Indian boys loves a good girl – even the bad boys, so girls usually keep quiet about what they’re up to’. Although there was some evidence of casual short-term sexual relationships, sex tended to be placed within ‘trusting’ and ‘loving’ longer-term relationships and respondents reported having had just one or two sexual partners. Moreover, the decision to have sex was more likely to be discussed with their partner prior to the act taking place.

There was mixed behaviour regarding informing parents about relationships. While some young people said they told their parents, others had not as they believed their parents would disapprove, especially as some of the respondents were in relationships with young people from different ethnic backgrounds and religions. In some cases, the respondents said they had told their parents about their relationships but had been asked to be clandestine, as it would be looked upon disapprovingly by the local Indian community.

On the whole, this group used contraception when they had sex and both the condom and the pill were cited as methods that had been used. However, the emergency contraception had been taken the following day in instances where contraception had not been used. Overall, the condom was thought to be the safest method as it protected against pregnancy and STIs. Although the problems of condoms splitting was highlighted, they still believed condoms to be the most effective method, up to 99% effective according to one respondent.

The Indian fathers thought there was much more pressure on young women. The situation for young men was easier, ‘boys will be boys’, ‘it’s a sign of their manhood’, or ‘they’re just simply men’. The fathers went on to say how they were concerned about that the family ‘shame’ surrounding young women was portrayed in the media. They explained how a very small minority of people resorted to violence. Although ‘honour killings’ were said to have been done because of family shame, they felt these killings actually brought shame onto the community and culture.

There were concerns raised amongst the Indian mothers and the professional and community representative group about the prevalence of STIs within the Indian community. It was felt that STIs remained untreated because there was often denial that sex was taking place. There were also concerns from the mothers about the HIV epidemic in India and the possibility that this epidemic could affect the UK Indian community.
The Indian young men thought that the cocooning of young ‘Asian’ women could have negative effectives in the long-term. If young women had less knowledge of how to protect themselves, they could be at greater risk of pregnancy when they finally did have sex.

5.4. Jamaican young people

The sexual experiences of the Jamaican respondents also varied, between those who were sexually active and had engaged in sexual practices, vaginal and/or oral sex, and those who were not.

The Jamaican respondents were generally sexually active at a younger age than either Bangladeshi or Indian young people. One male respondent suggested that his first experience of sexual intercourse was when he was eight years old.

The Jamaican young women generally talked about having vaginal sex between the ages of 14 and 16. However prior to this some suggested they were engaging in other sexual practices, such as masturbation at 12 years old. On the whole, those Jamaican respondents who were sexually active had vaginal sex only, although some had also engaged in oral sex.

Although the sexually active female respondents suggested they were happy about having had sexual intercourse, some wished they had waited as:

- They felt they were not emotionally ready:
  
  Emotionally no I wasn’t [ready to have sex]. I wasn’t, maybe physically I was, because I was well developed for my age, but mentally I wasn’t, and emotionally I don’t think I was.

  (Jamaican young woman, Aged 16-18, London, In-depth interview)

- They valued their virginity and wished they had kept it for longer; and

- They had experienced physical pain during sex.

The young men appeared to be sexually active earlier than the young women. They generally had their first sexual encounter by the ages of 12 or 14. As with the female Jamaican respondents, the males were also engaged in other sexual practices, such as kissing and masturbation, prior to actually having sexual intercourse.

For both the Jamaican young women and men, sex tended to occur both casually and within longer-term relationships. The number of sexual partners respondents had varied and was obviously related to their age at interview. The number of sexual partners reported did generally exceed those of either the Bangladeshi or the Indian respondents. A few Jamaican male and female respondents suggesting they had multiple partners, for example one respondent suggested they had up to 14 partners and another suggested they had seven or eight.

The Jamaican young people used a wider range of contraceptive methods, and although these included standard methods, such as the pill and condoms, they also used other
methods, such as the withdrawal method, judging the menstrual cycle, and anal sex. Respondents suggested they had used the withdrawal and menstrual cycle method as friends had used it and found it to be effective. Anal sex was being used as a form of contraception by one respondent who suggested she had been using this method for three months rather than using a condom or the pill, as they did not want to go on the pill and had used condoms in the past that had split.

The pill was said to be used as it was thought to be effective. Some respondents did raise concerns about the longer-term impacts of the pill on the body, such as reducing future ability to conceive and disrupting periods. They also expressed fears they would forget to take it.

The condom was thought to be an effective and convenient method, although as with the other groups, the fear of splitting was highlighted.

5.5. Similarities and differences between the groups

Context of sexual activity

There was a general feeling across the Indian and Bangladeshi groups, particularly those with young people, that times were changing and more young people were having sex before marriage. However, young people kept any sexual activity, and even non-sexual relationships, very hidden:

There are people, Asians, who are having sex before marriage… Asians in our religion are not supposed to drink or have drugs. But you go into a club you see a lot of Muslims doing it. So yeah, they are starting to lose touch with their religion slightly. I would say there are a lot more (young) people having sex than back 10 years ago.

(Bangladeshi young man, Birmingham, Focus Group)

Club culture was seen to have had a huge impact on sexual activity, and young people generally thought that the older generation were unaware of what went on in clubs.

There was some discussion around the fact that young Asian people were more likely to start having sex once they were at college. This was because at this stage they had much more freedom and did not have to explain to parents why they were not at home by 3.30pm. Some of the Indian young women expressed their shock when they started college and realised that the girls that they thought were 'good girls' were sexually active.

Gender differences

There was general agreement in the focus groups with Indian and Bangladeshi young people, that young women from these BME groups were still less likely than young men to have had sexual intercourse. In terms of casual sex, the young men were more likely to be having sex with women from other ethnic groups. The Indian young men explained there were a number of reasons to explain this. First, young Indian women often have curfews and would not be allowed to go out at night to, for example, a pub. Asian
women are subject to much more discipline at home. Second, attitudes were more liberal within some other ethnic groups. They felt that White women “haven’t got so much attitude”, meaning they have fewer inhibitions about sex. And finally, ‘you don’t have to deal with the family’ of women from other ethnic groups.

Generally, all agreed that the consequences of having unmarried sex were far greater for young women than men. Young women who were discovered to be sexually active would often be forced to marry or would be disowned.

Prevention of pregnancy and sexually transmitted infections

Most of the young people were more concerned about teenage pregnancy than STIs. A few of the professionals were very surprised to hear that anal sex was being used as a method of pregnancy prevention. Some of the Jamaican young women were disgusted by the thought of oral or anal sex.

The reasons given for young people’s lack of contraceptive use included: poor communication, an assumption that contraception is a women’s responsibility, unfounded trust, naivety, the thought that pregnancy or acquisition of an STI is something that happens to someone else, and men thinking that condoms are not manly and reduce sensation. Interestingly some of parents felt that it was important that adults also looked at their own behaviour and not just criticise the young.

Key points

♦ Although Bangladeshi young women and men’s views on sex before marriage were similar, there were gender differences in the levels of sexual experience. The women had very little experience pre-marriage, but some of the men were sexually active.

♦ There was more variation in terms of sexual experience amongst the Indian young people in comparison to the Bangladeshi young people. However, it was generally felt that there was more pressure on women to avoid sex before marriage and some women explained how relationships were hidden to avoid negative consequences, such as shame brought to the family. Indian participants mentioned that because sex was not openly discussed young people could be putting themselves at greater risk of pregnancy and STIs.

♦ Jamaican respondents tended to be sexually active at a younger age, which is in line with Natsal 2000 data.

♦ All groups agreed the negative consequences of sexual activity were greater for young women. Club culture and starting college were felt to have a huge impact on sexual activity.
6. Teenage Pregnancy and Parenthood

6.1. Background

Information on ethnicity is not routinely collected for national conception, abortion and birth data. Data from Natsal 2000 show that there are variations between ethnic groups in the proportion of people who have a child before they are 18 years old. Amongst the general British population the proportion reporting parenthood before 18 years was 4.9% (95% CI 4.4-5.6) for women and 0.8% (95% CI 0.6-1.2) for men (Wellings et al, 2001). Teenage parenthood was most common amongst Black-Caribbean people (12.8%, 95% CI 8.3-19.7 for women and 3.9%, 95% CI 1.1-12.5 for men) and least common amongst Indian people (0.5%, 95% CI 0.1-2.2 for women and none of the Indian men reported having a child before they were 18 years old) (unpublished Natsal 2000 data). Less variation is observed in the proportions of women reporting abortion before the age of 18 years, 4.0% (95% CI 3.5-4.6) amongst the general population (Wellings et al, 2001), 4.7% (95% CI 2.7-8.2) amongst Black-Caribbean women and 2.1% (95% CI 0.5%-7.9%) amongst Indian women.

The majority of the Jamaican participants in ExES described how they had either had direct experience of a teenage pregnancy or a member of the family had been pregnant as a teenager. A few described becoming pregnant very early on in a relationship and were relatively sexually inexperienced. The women often ended up bringing up the children by themselves. This sometimes led to a negative attitude towards relationships, one woman described feeling ‘betrayed’. A couple of women also described how they had tried to hide the pregnancy from their family, one woman succeeded until two weeks prior to the delivery of her baby. Some of the men also described how they were no longer in a relationship with the mother of their child and would describe themselves as the “baby father”:

She’s carrying a baby for nine months, when he’s ready he can duck out the door. I’m not saying I teach my son them things there, but that’s how it is, all a man’s got to do is juice, she’s got to carry the baby, .... It’s not being sexist but you’ve got to teach girls to be more aware and be more open because there’s a lot of girls out here at a young age, boys will tell them what they want to hear and get what they want to get and then they’re gone.

(Jamaican Male, ExES)

For some women seeing other women having to bring up children by themselves acted as a deterrent. They described how they had waited to have children until they were in a committed relationship or marriage. One woman explained that she felt children should be brought up within committed relationships as she had seen the negative consequences of having a child without a partner. There was general agreement that there were cultural expectations to have children. Traditional Caribbean pro-fertility beliefs have been described as an influence on young British-born black Caribbean women’s attitudes to having children (Low, 2001).

The majority of the Jamaican ExES participants were against abortion:

Abortion would be a disgrace, shameful in the community. If people have one, it’s very secret and private.

(Jamaican Male, ExES)
A combination of moral, ethical and religious reasons were provided as reasons for being against abortion, but there was acknowledgement by some that it was sometimes necessary. Although the men described disapproval of abortion some did report casual partners of theirs had had an abortion. It has been argued that Black-Caribbean young people's attitude towards teenage pregnancy and abortion may be more to do with deprivation than ethnicity as there are similarities in the attitudes of Black (mostly born in the UK) and White working class women (Low, 2001).

Young Asians are more likely than non-Asians to say that child bearing will be a feature in their lives within the next five years (Brady and Williams, 1999). However conception is a consequence of marriage and only acceptable within this framework (Katbamna, 2000). This was consistent with what the Bangladeshi participants in ExES described. A pregnancy out of wedlock would have dire consequences on any marriage prospects. Parents described how they would worry about their daughters in particular. One young woman described how her mother would always check to see if she had her period each month. Abortion was seen as a sin, although one woman acknowledged there might be no alternative for unmarried women. Once married, pregnancies followed very quickly. Some women mentioned that if they had known about contraception prior to marriage they would have preferred to delay their first child.

The Indian participants generally felt children should be within marriage. They were also against abortion, but again recognised there might be circumstances where unmarried women may have to have an abortion. The importance of birth spacing for financial reasons and to prevent jealousies between children were emphasised by some.

6.2. Bangladesh young people

There was very little direct experience of teenage pregnancy or parenthood among the Bangladeshi young people outside of wedlock. Some respondents suggested they knew of people at school who had become pregnant and in some cases had an abortion. On the whole, respondents felt these experiences had given them the opportunity to observe the impact of teenage pregnancy and had discouraged them from becoming pregnant themselves. In contrast teenage pregnancy within wedlock was often seen as acceptable:

My friend who got pregnant at school, it ruined her chances of anything because she was Asian as well. She did not come to school after that. It was really tough. She did keep the baby. It is really terrible.

(Bangladeshi young woman, Aged 19-21, London, In-depth Interview)

Teenage pregnancy and abortion were not generally thought to have been openly talked about or discussed within the Bangladeshi communities, rather it was felt they were kept within the family in order to avoid gossip. One Bangladeshi respondent said that she had heard that teenage girls who became pregnant were either forced to have an abortion or were told to return to Bangladesh with their child to avoid negative attention.

Disapproval of teenage pregnancy and parenthood by both the family and by the wider Bangladeshi community acted as a deterrent to becoming pregnant as a teenager. Some respondents also talked about the influence of Islam on their attitudes towards teenage pregnancy and parenthood out of wedlock, believing that pregnancies at a young age
were unusual in the Muslim community and also at odds with Islamic values. One respondent said that it would be difficult to be a single Muslim mother and expect to find a husband within the Muslim community:

"Well there are a lot of single parents around. They get benefits and they get family help. But say it was a Muslim, say girl as me, it would be really difficult because society would not like that at all. If you did interview an Asian guy the same age as me he would probably say he would not want to marry a girl who has got a child. A single man would not want to marry a girl with a baby because that is quite difficult as well. He would have to be married with kids as well. May be he has broken up with his wife, it would be one of them."

(Bangladeshi young woman, Aged 19-21, Manchester, In-depth Interview)

In the event of a young unmarried woman becoming pregnant, the Bangladeshi young men explained that a man would probably have to marry her, they would go to 'hell' or the woman might be sent abroad to marry. They said they would not go to their family, a pregnancy outside marriage "would just kill your family’s reputation, and everything you’ve built for the last 20 to 30 years plus, would all just go down".

Generally, Bangladeshi respondents were overwhelmingly against abortion for religious reasons, abortion was thought to be against the teachings of Islam unless the life of the mother was endangered. In particular, the male respondents were often strongly anti-abortion, with one suggesting that it was akin to murder:

"I mean like it is from God isn't it? That this new person is coming along, and you are actually killing it. It is just like murder isn’t it, because like you are classed as a murderer in our religion. So, I don’t think it is allowed."

(Bangladeshi young man, Aged 19-21, Manchester, In-depth Interview)

Where pregnancy was a result of people not using contraception, then abortion was generally seen as wrong, as it was felt that people were shirking the responsibilities of having sex outside of marriage. However, some said that although they recognised the religious teachings, they would still consider having an abortion under certain circumstances for instance, if pregnancy was a consequence of rape.

Some Bangladeshi respondents, particularly the young women, suggested they would not tell their family if they or a partner fell pregnant and they would have an abortion without their parents’ knowledge:

"I wouldn’t tell my parents because they would see me differently. They’d be more protective and I would hate that. They would like cage me up. I really need my freedom."

(Bangladesh young woman, Aged 16-18, London, In-depth Interview)

In contrast, some respondents said they would discuss their situation with family members and would keep their child even if their parents disapproved of this decision. The young men were more optimistic of parental support, expressing their confidence that they would receive both financial and emotional support once the situation had been accepted.

Participants in the Bangladeshi focus groups did not perceive teenage pregnancy to be a huge problem in their community. They were more concerned about drugs, high
unemployment and poor educational achievement. There was no consensus on whether or not the Bangladeshi community needed to be targeted in terms of the prevention of unintended teenage pregnancies.

The Bangladeshi young women felt that many young women from their community would not know where or who to turn to for help.

The Bangladeshi young men and women were asked if a young person was married and had a child whether or not attitudes would be different. It was felt that even if there was security, in terms of a home and career, that it was also important to be mature enough to have children. The young men felt they would not be mature enough at 18 years, but thought this age was alright for women to start having a family. The young women felt that once you were married, whatever your age, there would be pressure to get pregnant, ‘every mother-in-law will think marriage equals pregnancy’.

6.3. Indian young people

The Indian groups, like the Bangladeshi groups, felt that teenage pregnancy was not a major concern within the community. Teenage pregnancy and parenthood was generally seen as undesirable. Participants in the Indian Professionals focus group explained that attitudes to teenage pregnancy varied across the country. In Oldham a young pregnant unmarried woman would be ostracised, but not in Leicester, for example.

A number of the Indian respondents suggested that teenage pregnancy was not only ‘wrong’ morally, but they felt a teenager would also lack the financial stability and maturity to look after a child. Moreover, it was thought that teenage pregnancy and parenthood could impinge on a person’s ability to achieve good educational qualifications and this was seen as being particularly problematic by some of the female Indian respondents who placed a high value on education:

Someone in school, she got pregnant. She lost the baby, she left school a couple of months back and she’s not coming back to school … And I thought she’s like, ruined her education and you need qualifications to get a job, can’t do anything without qualifications. So she’s ruined her life basically.

(Indian young woman, Aged 16-18, Birmingham, In-depth Interview)

For the most part, Indian young people felt their opinions, regarding teenage pregnancy and parenthood, had been influenced by the negative views held by their parents, who they believed would be ‘disappointed’ and ‘ashamed’ if they were to become pregnant. Generally they felt that the ‘right age’ to have children was between 25 and 30 years of age, after they had completed their education, established financial security and were married.

Among the young male respondents, the responsibility and change in lifestyle they believed teenage parenthood would bring was viewed negatively. They spoke of a loss of freedom; having to stop socialising with friends; and having to establish themselves in a new home away from their parents.
The young people felt their parents would strongly disapprove if they were to become teenage parents, as a consequence of the embarrassment the family would face within the community and also because they would be disappointed they had not fulfilled their parents’ aspirations or expectations:

“They would see it as something, it would be like ‘How could you be so stupid as to fall pregnant, did you not take precautions?’ And also it would also hurt her parents and my parents. They’ve both got high hopes that we’re going to do well and it wouldn’t fit into the plan.”

(Indian young man, Aged 19-21, London, In-depth Interview)

Despite this disappointment, generally young people felt their parents would ultimately be supportive and would offer both emotional and financial assistance if they could. However, some, particularly female respondents, expressed doubts that family members would support them. One said that she would expect to be ‘disowned’ if she fell pregnant outside of wedlock. Others described how a young women would have no one to turn to if she found she was pregnant as the pregnancy would bring great shame to the family:

“She wouldn’t be able to speak to her cousins. She wouldn’t be able to speak to her sisters. Because it is a bad thing. The parents disown them and you don’t talk about them. You don’t even mention their name in the household. All the pictures are taken off the mantelpiece.”

(Indian young man, London, Focus group)

The Indian young men said they knew of Indian girls who had had to run away from home because they were either pregnant or they wanted to be with someone. One young man described a female family member who ran away and was disowned by her family. She contacted her mother two years later to tell her that she had a grandson. The mother was delighted to hear this news as it was important that the family line continued.

The Indian mothers also agreed that a pregnancy outside marriage would be a great shame to the family, particularly to the mothers. They explained in the event of an unplanned pregnancy the young couple would have to get married or the woman would have to have an abortion. Although they were against abortion for religious reasons, they agreed it may be the only option, particularly if this meant a young person could continue their education. But they did express concerns that abortion was being used as a form of contraception.

The more utilitarian views on abortion were seen in all groups. For instance, by young people abortion was sometimes seen as an acceptable way to protect themselves and their family from the community’s judgement of teenage pregnancy:

“I think the older generation they would sort of, look at me in a bad way … Probably think I was a dirty girl.”

(Indian young woman, Aged 16-18, Birmingham, In-depth Interview)

The female respondents exhibited a strong element of independence in their views regarding abortion, with a number suggesting they would terminate a pregnancy if they believed the end was justifiable. For instance, some young women would have an abortion rather than hinder their educational and professional opportunities, although, they stressed this decision would not be taken lightly.
Among the young men there were mixed views on abortion, with some feeling that the woman should be allowed to make the final decision:

I wouldn’t force her into anything. The first person I’d probably, I’d have to discuss it with my parents because I’m guessing they’d advise me on the best course to take, what they’d advise me on, I don’t think they’d force me into doing anything.

(Indian young man, Aged 19-21, London, In-depth Interview)

Indian young men felt that abortion would be easier for parents to cope with than a continuation of pregnancy as at least both families could keep it quiet. One Indian young man described how a member of his family in India had an abortion because she was having a little girl. Although not talked about everyone knew it had happened and there were no repercussions.

6.4. Jamaican young people

In contrast to either the Bangladeshi or Indian groups, Jamaican young people had more exposure to teenage pregnancy and parenthood. However, the level and types of experience varied. The group was divided between:

- Those who had very little awareness of teenage pregnancy;
- Those who had friends who had become pregnant or had children while they were teenagers;
- Those who had experienced teenage pregnancy themselves; and
- Those whose own parents had become a parent while in their teens.

Those respondents who were teenage parents themselves, described the conflict of priorities they faced between caring for their child and pursuing their own educational or career goals. One teenage mother felt strongly that people should consider more carefully the realities of becoming a teenage parent.

A number of Jamaican respondents spoke of their ‘shock’ at learning of friends who had become pregnant and this had seemed to encourage some respondents to use protection.

Between 16 and 17 a lot of my friends had children then and they weren’t ready for children because they were so young themselves. It shocked me and scared me from the age of like 17. That’s when I started – when I was young I didn’t really use protection too much. I did used to use it but not all the time, but from the age of 17 I started using protection all the time.

(Jamaican young man, Aged 16-18, Manchester, In-depth Interview)

In cases where the younger respondents had been the child of a teenage parent, they had generally been warned by their parent about the disadvantages of having a child at a young age, and suggested they had heeded the advice given. Many of the older generation, who had perhaps had children when they were teenagers, wanted their children to learn from their mistakes and get a good education. There was also concern
raised that, as a parent, by supporting your child in pregnancy and parenthood, you would be helping them “throw their lives down the drain”. The Jamaican fathers expressed concerns that some men saw teenager mothers as ‘easy’. These women are often isolated and therefore are pleased to have some attention, but end up getting pregnant again. However, one young woman described how she and her partner were trying for a child, and she was reassured by the knowledge that her mother and other members of her family had children at the same age.

A number of younger respondents did express concerns about the impacts of having a child at a young age. These concerns focused on a general change of lifestyle, problems achieving academically and professionally, and also the financial problems this would bring. Also some young people viewed teenage pregnancy negatively, as a result of the stigma this would bring onto them, as they suggested they would not want to be viewed in this way. As one young person explained, they did not want to be part of the ‘buggy crew’.

In contrast, some young people were more open to the idea of becoming a parent at a young age. One respondent felt it was better to have children when you were young to reduce the age gap between mother and child, which they believed would increase the bond between them. Others felt that as long as the child was wanted, then teenage parenthood was acceptable.

The Jamaican respondents expressed mixed views about abortion. Generally, views on abortion seemed to be informed by the experiences of others and perceptions of parental reactions, rather than strong religious or cultural factors. Although the Jamaican young people felt that their views did not necessarily reflect those of their grandparents, who were more likely to have religious objections. Some people were pragmatic in their views explaining that while abortion was not desirable, it would be the most sensible choice when considering the longer-term implications of teenage parenthood on both the parent and the child.

Others were fervently against abortion, regarding it as ‘wrong’ in all circumstances, with one young respondent describing it as ‘killing my flesh and blood’. Overall, young women were less accepting of abortions, with some stating that people should take responsibility for their actions rather than terminate a pregnancy. One respondent was ‘devastated’ after she had an abortion but did not tell her parents for fear of disappointing them. However, the Jamaican mothers felt that it was often the Jamaican men who had stronger objections to abortion than the women:

..they see it as their seed….that you’re destroying their seed…. even if they had no intention of looking after the child…

(Jamaican mother, London, Focus Group)

The young people were asked about the emotional and financial support mechanisms they had used, or would expect to use in the event of teenage parenthood. They generally thought they would get emotional support from family and friends, who they believed would help with childrearing and childcare. Although they expected parents to be initially disapproving, the young people were confident that this would eventually be overcome. In cases where the respondent was a teenage mother, they had generally received support from family and friends, but stated that support had predominately come from their
mother. It was agreed that although parents can be supportive, young people do have to take responsibility for their actions:

_She [a daughter] needs to understand exactly what she is getting herself into. People are misinformed. Young people have this concept about love. You can get into bed with a woman and have fantastic sex, but the consequences of this could be a child. They need to know what having a child is all about. They need to be responsible._

(Jamaican father, London, Focus Group)

In terms of financial support, respondents mentioned both social services and family members as sources of support. One respondent who had a young child explained that without their mother's financial assistance they would not have been able to afford to work part time and would have had to have increased their working hours. This financial input was thought to have a real impact, as it enabled them to spend more time with their child and it also allowed them to continue with their education. Another respondent spoke of their friend's experience of teenage parenthood and how financial support from their parents had enabled them to pay for childcare while they went to work.

Although, it was agreed that it was more culturally acceptable for young Jamaican mothers to remain single, there was much debate within the groups about the consequences of single parenthood. Jamaican women were seen as independent and it was felt they were brought up not to rely on men. In Jamaica there would be support from other females in the extended family, but this support network was not necessarily available in the UK. It was argued that young mothers do want love and attention from the father of their child, and become bitter when he does not get involved. Often this is a repetition of their experience with their own fathers. A young man may get some ‘grief’ from his family because of an unintended pregnancy, but then things settle down and he can avoid much of the responsibility. However, some described how men were sometimes actively excluded from any involvement in the pregnancy or child-rearing. Some of the healthcare workers mentioned how they would encourage young mothers to bring in the father of the child so that they did not feel shut out. Even if men wanted to be around their partner and child, often their partner’s family would say that they did not want them around. It was also felt that women had to take some responsibility for men’s attitudes as they were the ones who often reinforced the stereotypes and gave boys negative messages:

_Some of the young women I see are quite angry. One woman said to her young boy, “Your father’s a sperm donor.” I was thinking she doesn’t like men. She has sex with men because they can give her something. She said, “I’m not going to have a relationship. I’ve got my child. I don’t need anything else”. She was quite bitter and I’m thinking if you are only 17 and you feel like that, it is very harsh._

(Professional and Community Representative Group: Jamaican)

The ‘anger’ of young men was also raised and the fact that great consideration needs to be borne in mind when challenging their attitudes and behaviours towards parenthood:

_There are a lot of angry young men and a lot of them are angry because they don’t have a positive relationship with their father or any other male role model. So a lot of them learn to survive. They learn to cope and some of the strengths we would look at that are quite negative are their means of coping and surviving in the environment they are in. Some of that is about_
being hard, uncaring, inability to be nurturing, not engaging at an emotional level because that is
very difficult. If you haven’t got the emotional capacity to cope, if you don’t have the emotional
skills, life skills, educational prospects, then to engage at that level and take on responsibility of
being a father... it is easier to walk away. It is easier not to face the pain and the hurt you went
through in your own childhood of not having a father than to try to actually live up to the
responsibility and what you should know. With a lot of these young people it is not about giving
information, it’s about looking at whether they have the capacity to cope with the information
that they are given. Going in and challenging at one level is not the answer.

(Professional and Community Representative Group: Jamaican)

This rejection was also expressed in the fathers’ group:

The women get pregnant. They get a flat. They get a job. They get paid more than the men. They
think they can take over and look after the kids without the men. You see them driving a nice
car. The man is not involved.

(Jamaican father, London, Focus group)

The Jamaican mothers did not totally accept some of the feeling of rejection expressed
by men. They felt that they were often left in difficult situations and worked hard to do
the best for their children. As a consequence they felt that they did have closer
relationships with their children and better jobs, but it was as a result of their hard work.
They felt that in many cases the relationship between Jamaican fathers and their children
resulted from the fathers not acting responsibly and so their children did not have as
much respect for them:

Sometimes I just cringe the way I hear her talking to her dad. I know she would never be like
that to me.

(Jamaican mother, London, Focus group)

It was felt that it is important to look at the culture and imagery that surrounds young
Jamaican men. They may associate images around parenting and nurturing as ‘soft’.
Parenting skills should be taught to young men, as well as young women, so that they are
aware of what is involved in bringing up a child and the role of the father is shown as a
positive one. The Jamaican fathers also felt that men should be educated about women’s
experiences of pregnancy, so that they could be more supportive.

6.5. Similarities and differences between the groups

According to some respondents, teenage pregnancy was not viewed as a serious concern
for the Bangladeshi and Indian populations, rather it was perceived to be an issue for
other communities, specifically black and white people. For example, one respondent
suggested they only recalled Black and White young women becoming pregnant at
school.

The consequences of teenage pregnancy were greater for Indian and Bangladeshi young
people, and particularly young women. Although teenage pregnancy was not necessarily

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viewed as a positive outcome in the Jamaican groups because of its effect on educational and career prospects, it was not viewed as being ‘the end of the world’.

There was a marked difference in views on abortion according to the ethnic and religious background of respondents. There was general agreement across all of the focus groups that abortion remained a huge stigma and was generally not talked about. There did appear to be differences in the reasons focus group participants said they were against abortion, and these were consistent with the findings from the in-depth interviews with the young people. Those participating in the Jamaican and Indian focus groups tended to object to abortion for moral reasons, while those in the Bangladeshi focus groups objected for more religious ones. However, these attitudes, whatever influenced them, did not necessarily reflect behaviour. For some women, particularly Bangladeshi and Indian women, having a baby outside wedlock was not even an option. The attitudes of family or the wider community just ensured that abortion happened in secret:

...they are so scared of actually being disowned by their family. They don’t even tell a friend sometimes, they’re that scared.

(Bangladeshi young woman, Birmingham, Focus Group)

Another problem raised by health care workers was that abortions tended to take place at the local hospital. This meant that women would often seek abortion services from outside the area they lived as they were so concerned their confidentiality would be broken. The fact that young people do not necessarily know how to access abortion services and that abortion is so secretive means that by the time young people finally reached services they are at crisis point:

They are not coming to us for prevention. They come in crisis and it is easier to opt for an abortion than to go home and say “I’m pregnant”. The majority of young women who come to us and are pregnant choose to terminate.

(Indian Professional Focus Group, Manchester)

Both health care workers and parents raised concerns that all the secrecy meant young women who opted for abortion often received little support after the event. This lack of support or follow up meant young women often experienced depression afterwards. One Jamaican father explained that, although he could understand why parents were often left in the dark, he would want to know if his daughter was thinking of having an abortion, because “after the abortion there has got to be someone there to pick up the pieces”.

All groups agreed that the consequences for young mothers were far greater than the consequences for young fathers.

The Bangladeshi and Indian young men felt they generally had much more choice than young women, for example if they really did not want to marry a woman because of a pregnancy they would not necessarily be forced. The women on the other hand were more likely to be forced. Their parents may even be put into the position of having to ‘beg’ for marriage if the young man was not keen.

All of the young people agreed it was important to have financial security before thinking about having children. This meant finishing one’s education, getting a good job and setting up home. It was felt that a pregnancy at an early age would ruin your chances of
achieving this. The parents felt that young people had little understanding of the pressures of bringing up a child; even the cost of nappies was a complete unknown. Some were concerned that young people see a young mother with a flat, a baby and a boyfriend, and think they want the same. The parents felt that young people needed to realise that more often that not this 'domestic bliss' would not last.

Key points

♦ Bangladeshi participants had little direct experience of teenage pregnancy. Teenage pregnancy outside of wedlock was therefore not seen as a huge priority. Other health and social issues, such as drugs, high unemployment and poor educational achievement were of greater concern. The influence of Islamic values shaped their beliefs towards single parenthood and abortion. However, it was recognised that for those who did become pregnant the fears and difficulties were great, including possible forced marriages here as well as being sent back to Bangladesh to marry.

♦ Indian respondents’ views against teenage pregnancy tended to arise more from cultural rather than religious influences. Teenage pregnancy was felt to impinge on educational and employment prospects. In addition, it was felt that generally a pregnancy outside wedlock would bring shame onto the family. Although abortion was frowned upon, there was consensus that it may sometimes be the only course of action in order to, for example, protect the family’s reputation or to ensure that young people can meet the high expectations of their parents.

♦ Jamaican participants had more experience of teenage pregnancy. There were more positive views of teenage pregnancy expressed in comparison to the other ethnic groups. On the whole Jamaican respondents felt there would be support from family and friends if a young person decided to continue with a pregnancy, although there were concerns expressed about the social, educational and financial constraints of having a child as a teenager. There was more debate on the consequences of single parenthood and the role of fathers. It was felt important to address young men’s attitudes and behaviours towards parenthood, and provide them with more positive messages.

♦ Views on teenage pregnancy and abortion do not necessarily mirror behaviour. Young people, particularly Bangladeshi and Indian young people, who find they are pregnant are often in crisis by the time they access services. Due to the fact that the pregnancy is often kept secret they may receive little emotional support from family and friends.
7. Sexual and Reproductive Health Services

7.1. Background

Little research has evaluated the use of sexual and reproductive health services amongst people from BME communities. Routine data collected at a national level, such as KT31 returns (which provide data on family planning clinic attendance figures, the age and sex of attendees, and the contraceptive method provided) do not report on the ethnic origin of attendees. Neither is the ethnicity of attendees collected for national routine data purposes in GUM clinic or primary care settings.

The TPU has produced guidance for developing contraceptive and sexual health services that target young people, as well as guidance for developing these services to reach BME young people (TPU 2000a and 2000b). A summary of the recommendations from these documents is provided in Table 4.

The TPU recommends that services should monitor their success in reaching BME young people through indicators such as ‘the number of young people accessing the service and increases in the ratio of these young people compared to other groups of young people’.

A recent audit of contraceptive and sexual health services in England found that many are not currently meeting the TPU recommendations (French et al, 2002b). Around a quarter of services monitored service access by BME young people. Only 6% of all services specifically targeted BME young people, with regional variations ranging from none of the services in the Trent region to 16% in the South East. Under a third of services said they had evidence of imagery reflecting BME groups and 18% provided training on working with BME young people. Another survey of GPs found that those who trained in the Indian sub-continent were significantly less likely to say that they would provide contraceptive services to females under 16 (Sengupta et al, 1998).

The few studies that have looked at access, use of services and ethnicity have had conflicting results. Hennick and colleagues (1998) investigated Asian women’s use of contraceptive services, and found that level of education influenced fertility decisions and use of services more than ethnicity. A study conducted in a London family planning clinic found that attendance from BME women was greater than their profile in the local community would suggest (Christopher, 1999). However studies that have just focused on younger women have found the opposite. Garg (1998) found that sexually active Asian women aged between 16-25 years were less likely to be accessing family planning services in comparison to non-Asian women. The school nurse has been identified as an important contact for those young people who may find it difficult to access services outside of school hours (TPU, 2000).
For many Asian women their first contact with contraceptive services is through maternity services (Prasad, 1994). ExES found that this was particularly common amongst Bangladeshi women. Even married Bangladeshi women reported problems in accessing services:

<table>
<thead>
<tr>
<th>Area of guidance</th>
<th>All young people1</th>
<th>Additional guidance for delivering services to BME young people2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involving young people</td>
<td>Services planned and evaluated in consultation with young people.</td>
<td>Gender specific, as well as mixed, forums for consultation on full range of contraceptive methods, refer to NHS abortion and antenatal care, do chlamydial testing and partner notification in collaboration with local STI services.</td>
</tr>
<tr>
<td>Age specific services</td>
<td>Upper limit of 25 years.</td>
<td>Developing skills and confidence of less assured and non-assertive BME young people, so they take part in advisory boards, etc.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Services should have explicit confidentiality policies that young people are made aware of.</td>
<td>Awareness that chronological age may not reflect level of sexual health knowledge, e.g. for small minority withdrawn from SRE for religious or cultural reasons.</td>
</tr>
<tr>
<td>Staff attitudes</td>
<td>Non-judgemental approach</td>
<td>Ongoing staff support, training and adequate supervision to ensure confidence in working with BME young people.</td>
</tr>
<tr>
<td>Atmosphere</td>
<td>Non-clinical and comfortable</td>
<td>Training of interpreters.</td>
</tr>
<tr>
<td>Location</td>
<td>Sufficient anonymity with easy access. Consideration paid to transport links, accessible from schools, colleges, etc and accessible to those with pushchairs or those with learning or physical difficulties.</td>
<td>Recruitment of staff that young BME people can relate to.</td>
</tr>
<tr>
<td>Opening hours</td>
<td>Ideally open every day</td>
<td>Imagery and information materials need to reflect the ethnic diversity of the local community.</td>
</tr>
<tr>
<td>Contraceptive and sexual health advice</td>
<td>Young people need time and support to make effective decisions.</td>
<td>May be more appropriate to have services in generic youth settings (e.g. in schools and colleges) rather than in traditional sexual health clinics.</td>
</tr>
<tr>
<td>Publicity</td>
<td>Publicity materials should have resonance with the target group and should highlight that services are ‘free’ and ‘confidential’.</td>
<td>Need to be aware that some BME young people may not be able to access services after school or at weekends.</td>
</tr>
</tbody>
</table>


Table 4. Summary of TPU Guidance for Contraceptive and Sexual Health Service Delivery to all young people and to BME young people
Some people don’t go to their doctor or clinic or anybody else, probably cause they’re embarrassed or your husband might be strict. And cause our religion says not to do things like this. We Bangladeshi people don’t usually ask men things [about contraception]. Husbands don’t usually approve of you going. They’d say things like ‘other men would see you’ and ‘men will touch you.’

(Bangladeshi female, ExES)

An area that all the women interviewed in ExES felt strongly about was the importance of having female staff available. The Jamaican women also felt that it was important to have an ethnically diverse mix of staff.

There were differences in the type of service preferred. The Indian women generally said they would go to their GP for contraceptive advice or supplies, while the Jamaican women tended to prefer a more specialist service. The reason they gave for this preference was concern about the lack of confidentiality in primary care. Men were unlikely to access either of these services.

Women were nearly always the ones who obtained contraceptive supplies. One woman described how she was responsible for getting the condoms as her husband would not access services:

I was surprised, the whole clinic was full of women, not a single man. I can't see anyone there, they are sitting outside in the car waiting for wives to come out and they can take them home.

(Indian female, ExES)

Her husband was not keen on using condoms, but she was able to persuade him saying the doctor said they must.

A criticism of reproductive and sexual health services has been their reliance on husbands, and even children, for translation as there are often difficulties in getting interpreters (Prasad, 1994). The ExES interviews found this was more likely to be a concern for Bangladeshi women. Leaflets were popular as they allowed women to go through the information in their own time in the privacy of their own home.

7.2. Barriers to sexual health services

Many of the barriers to sexual health services described by the young people during interviews and focus groups were relevant to all young people, irrespective of their ethnic origin. However, outlined below are some of the issues raised that need to be addressed in order to make services more accessible to BME young people.

Lack of knowledge

Lack of knowledge about local services was a problem particularly amongst the young men. The young men felt that they did not come into contact with any advertisements about local services. The young Indian men, for example, explained that most of their sports activities, such as basketball and football, were connected to the Temple, a place where information about services would not be made available. The men said that word
of mouth was the best way of informing young people about services, although if they wanted any specific information they would probably go to the library or access the Internet.

Confidentiality

A number of the concerns expressed by respondents were related to confidentiality and privacy. The main concern among both Bangladeshi and Indian respondents seemed to be the potential for embarrassment at being seen by someone they knew and assumptions being made about their sexual activities, rather than concerns about the prospect of visiting the service itself:

I'd probably feel like, if someone I know saw me, I would probably feel embarrassed. But if no-one saw me and I just went in and wouldn't feel embarrassed.

(Bangladeshi young woman, Aged 13-15, London, In-depth Interview)

The Bangladeshi young men explained that they would prefer to use services where it was not possible to identify the reason for their visit. Therefore general practice was seen as the preferred service. Although they did acknowledge that it could be difficult to talk to the family GP who you have known all your life.

Conversely, concerns around confidentiality were also given as reasons not to go to the GP for information about sexual health, as people who shared the GP with other members of their family sometimes felt inhibited about discussing sexual matters in case the GP divulged personal information to their family. One respondent said they would not go to the GP for advice as a family member used to work at the surgery and they feared that any information might get back to their family:

It would be confidential but knowing him he would probably go blabbing to my Mum.

(Bangladeshi young woman, Aged 13-15, Birmingham, In-depth Interview)

This was particularly evident amongst young Indian people, whose GPs were often also Indian, and either friends of the family or well known within the local community:

I don't know of any services. If I go to my doctors around the corner, before you get home there would be a phone call come from the doctor. The doctor he knows everyone .. and the girls that work there, they know everyone as well. They know my mum and they know my family. Everybody knows everybody. If I went to an Indian doctor and even mentioned anything related to [sex] the gossip would be unbelievable. There is no where to go.

(Indian young man, London, Focus group)

One of the Indian young women (whose father is a GP) felt that most Indian doctors after training go back to their local communities and practice there. To these doctors community values were often more important than anything else.

Interestingly, the Indian mothers confirmed the young people’s fears, and agreed that GPs would contact them if their child attended the surgery. One mother gave an example of how the family GP would still tell her when and why her 30 year old son had been to
see him. The mothers also explained that in Indian culture under 20 years was considered ‘under age’ and therefore a young person under this age would not be given any contraception. The professionals working with Indian and Bangladeshi young people spoke of GPs in their area who would not see people under 16 years without a parent present. It was felt that GPs often held much power and respect, and that GPs had to recognise that young people may be concerned about their relationship with parents and other family members. It was suggested that training days may help address some of the communication issues with BME young people. As there were no GPs in the focus groups we were unable to explore the problems around confidentiality in primary care with the profession itself.

**Language**

Another barrier to services mentioned during the focus groups was for those people whose first language was not English. It was felt that for the majority of young people this was not a problem, although there would be some young women who had come from abroad for marriage whose English would be limited. However, even young people who are proficient in English may find they have a limited sexual vocabulary or may find it difficult in front of a doctor to use words referring to sexual intercourse. It was felt by some, that this problem was not just confined to young people and many professionals, particularly those from the Asian communities, may find it difficult to use words related to sexual intercourse. One respondent said his doctor would not talk to him in English because they shared both a cultural and religious background:

> I don’t feel comfortable talking to him and his accent to mine is different. He likes talking, every time he doesn’t like speaking English he likes talking our language. I just don’t understand it.

(Bangladeshi young man, Aged 16-18, Birmingham, In-depth Interview)

**Fear of judgement**

A number of respondents talked of their discomfort discussing sexual matters with health professionals and their fear of being judged as a consequence of being from the same religious or ethnic background. This is further explored in Section 7.3. *Sexual health service staff*.

### 7.3. Expectations and use of sexual health services

**Knowledge and experience of services**

There was a widespread awareness of the role of sexual health clinics, although there were some, particularly Bangladeshi young people who were unfamiliar with what was on offer. Some respondents had direct experience of sexual health services, some had visited the service for their own needs and others had attended in order to accompany friends or family. Use of these services was low among the Bangladeshi respondents, whereas, a
number of young people from both the Jamaican and Indian groups mentioned having used this type of service, particularly the female respondents.

Mainstream sexual health services were often used as an alternative to the GP where respondents felt that the anonymity offered by clinics meant they were more confident that information would not be fed back to their families. Some people also attended services to protect their sexual health information from GP records. One respondent admitted that they had lied to their doctor about their sexual history, but did not feel the need to do so at the clinic:

*They make sure that no one, nobody knows. You’re talking to them and you feel comfortable talking to them because you know that what you say to them isn’t going to go any further than the four walls that you’re in.*

(Indian young woman, Aged 19-21, London, In-depth Interview)

Other benefits of mainstream sexual health services described were the way people were separated by gender in the waiting area and were called up by number rather than name, thereby preserving anonymity.

The young people did talk about services outside of the health sector. School was identified as a useful advice and information source. This was primarily the case where respondents were undertaking PSHE lessons at the time of the research. For these respondents, teachers were seen as a less formal but equally reliable source of information as their GP or other health providers.

Some of the younger respondents highlighted the advice columns and articles in teenage magazines such as ‘Bliss’ and ‘Just Seventeen’ as information sources. Helplines were also highlighted as a preferred source of advice on sexual and reproductive health as a consequence of the anonymity and confidentiality it offered. Other respondents mentioned using the Internet for seeking information, particularly information on STIs or the location of sexual health services:

*Well the thing is I would not go to Brook clinic like the one here. I would find out on the Internet somewhere far. And then go to one where I don’t know much people or, like, not like Asian community, and go there.*

(Bangladeshi young woman, Aged 16-18, London, In-depth Interview)

**Location of sexual health services**

Even walking into the sexual health service was problematic for many young people. The Bangladeshi young people explained that there would be no way they could go to a Brook Centre, for example, because the negative consequences would be too great if they were seen going in. It would be against Islam. The young women explained that they would have to go to a service far away from where they lived. The Bangladeshi professional and community representatives explained that setting up a sexual health service in areas with a high Bangladeshi population would be counterproductive due to the backlash.
The location of the service impacted on the young people’s decision about whether or not to attend, where some of the respondents favoured clinics situated outside their locality, others preferred using local services. Bangladesh and Indian respondents were more likely to say they would want to use a service situated outside of their local area. The reasons given for this were that they did not want to be seen by people they knew and they wanted to avoid gossip among members of their community:

“I would not like it in my area. I would not like it near my house. Say I went in that place and some other people would see me and I would not like that at all.”

(Bangladeshi young woman, Aged 19-21, Manchester, In-depth Interview)

Some Jamaican respondents also expressed a preference for services to be situated away from their local area. However, this seemed to be in order to avoid embarrassment about being seen entering a sexual health clinic, rather than a strong desire to protect their confidentiality for fear of being judged by their community.

Others thought the service should be located centrally in the town centre rather than locally, to increase its accessibility and to raise its profile as a source of advice and information on sexual health.

Respondents who expressed a preference for locally based services tended to do so as they believed this was more convenient, particularly in case of emergencies. One young person said that having a service in the town centre away from the local community would make little difference to their anonymity, as the town centre was also ‘full of Asian people’. Therefore there would still be a good chance they would see someone they knew, despite it being further away.

A number of suggestions were made regarding the location of sexual health services, including the idea to situate services:

- In schools and colleges in order to encourage young people to access their services;
- Near local hospitals, in order to make it easier for people to locate them; and
- In ‘good areas’ to make people feel comfortable and to reassure them of a high quality service.

**Imagery**

It was felt that any images in sexual health services, such as posters, should be “a mirror image” of the local population. It was felt that young people should be able to walk into a service and identify with what they see. However, the Jamaican fathers pointed out that it was important campaigns do not stigmatise any particular ethnic group. For example, in terms of education about STIs, advertisements need to include Black people as well as other ethnic groups, but should not imply that it is just Black people who have the STIs. One of the health care workers described how the Sex Lottery campaign had been hugely successful in getting young people, irrespective of their ethnic background, into services for Chlamydia testing.
Sexual health service staff

Respondents had strong views about what staff they believed they would feel most comfortable talking to about their sexual health. These views were generally related to demographic factors, such as gender, ethnicity, age and religion.

The ethnicity of the staff member did not appear to be important to Jamaican respondents, with a number of young Jamaican people suggesting they would be happy to speak to a person about sexual health issues regardless of their ethnicity. However, having staff from a range of BME backgrounds was said to be important in order to demonstrate that services were not racist and that they welcomed Black people:

*I think it’s really important because the black community might feel more confident to speak to somebody if they see more black people in the service.*

(Jamaican young woman, Aged 13-15, Manchester, In-depth Interview)

In contrast, one Jamaican respondent said they would not visit a sexual health service if there were Black staff as they would be concerned that staff members would either know them or one of their friends, and would therefore only talk to a White or Asian person.

The Bangladeshi young people’s opinions on the ethnicity of staff were diverse. Although the ethnicity of staff was not seen as being of direct importance, it was felt that staff should have an understanding of the cultural, and in particular, the religious issues faced by the Bangladeshi community. For example, one respondent suggested staff should be aware of cultural and religious views on abortion. Another talked about wanting staff to be aware that some cultures do not allow abortions and for this reason this person said they would feel more comfortable talking to an Asian worker with the same religious beliefs.

Conversely, some people felt uncomfortable at the idea of talking to staff of the same religious background as they thought people would be more likely to make judgements based on religious beliefs:

*Usually, people of the, you know, own background usually look down on the same background. It’s just natural thing really, thing to …and so, it would make life easier if they weren’t from the same background.*

(Bangladeshi young man, Aged 16-18, Birmingham, In-depth Interview)

There was a general acknowledgement among this group that it was beneficial to include Bangladeshi staff in sexual health services, in terms of overcoming language barriers and raising awareness of sexual health issues within the community.

Ethnicity was an important issue for the Indian respondents who generally suggested they would not want to see staff of the same ethnic background as they believed shared cultural norms and values would make them feel they were being judged:

*They might think, “Okay, naughty girl, what has she been up to.” But if it was White or Black or something like that they wouldn’t have problem. They do a job, they are there to help you.*

(Indian young woman, Aged 19-21, Birmingham, In-depth Interview)
Moreover, it was felt Asian staff may have links with their local community and this would undermine feelings of confidentiality and privacy. Although some young people did say that they were relieved when they saw a member of staff who is of the same ethnicity, in each of the focus group discussions concerns were expressed regarding confidentiality and being judged by staff of the same ethnicity. This was of particular concern in general practice settings, where many GPs are Asian. The young people explained that even if the doctor they saw was very professional and nice, they would still be worried about what the doctor was really thinking.

All groups agreed with the findings that it is important to have staff that are representative of the local ethnic population. However, it was often very difficult to recruit staff from some BME communities to work in contraceptive and sexual health settings, particularly from the Bangladeshi community. The Bangladeshi community representatives and those professionals working with the Bangladeshi young people felt it would be more viable in the first instance to recruit Bangladeshi youth workers or lay health professionals. Resources should be put into getting Bangladeshi workers involved in outreach programmes. Some of the community representatives spoke of the difficulties of working with sexual health workers from different ethnic groups. For example, Asian communities did not have much trust of the non-Asian workers.

Age of staff was seen as important with some people suggesting they would feel more comfortable speaking with someone of the similar age about personal issues, such as sexual health. As one respondent explained:

When they’re older than you that it’s like talking to a teacher or your parents. You just don’t want to do it. You don’t want to talk to them … you feel that they’re going to say “don’t do this”, “you shouldn’t do that”.

(Jamaican young man, Aged 13-15, London, In-depth Interview)

The gender of the member of staff was generally seen as more important than ethnicity, particularly for the Bangladeshi and Indian young people. On the whole young people felt they would feel more comfortable discussing sexual health issues with a member of the same gender.

There was a fair amount of discussion in the focus groups about the fact that there tended to be few men from BME communities in the sexual health field. Those who did work in the area were often gay and many young heterosexual men were not going to identify with these workers:

I think traditionally the image is that male sexual health workers have been gay. People who do that work are open and liberal. The guys that you are working with are homophobic and quite the opposite. In order to connect with them you need to have that cultural learning experience. You need to have people they look up to or who understand where they are coming from, who can challenge that, because they will expect everyone else outside of that experience to disagree with it. The barriers go up and then they learning doesn’t take place.

(Professional and Community Representative Group: Jamaican)
Some professionals also felt this reinforced the message that heterosexual men were not interested in or took responsibility for their own sexual health. Men from BME communities needed to be actively encouraged to get involved in sexual health services and programmes. The professionals thought that this would make a big difference in attracting young BME men into services.

### 7.4. Delivering services

All groups agreed that there is a need for variety and that creative thinking in terms of service delivery is needed.

The young people were asked to draw their ideal sexual health service and nearly all of the pictures were of a nondescript house. Surrounding buildings included chip shops and the local library. Inside a variety of services were provided; many young people described a one-stop shop service where they could be tested for STIs and obtain contraceptive supplies (including emergency contraception). A variety of condoms should be provided. Integration with information services, for example, was recommended.

Services, such as general practice, where the reason for the visit is not obvious, were popular. One professional described how she had been working closely with practice nurses on issues related to young people’s sexual health with great success. Schools and colleges were also seen as useful venues for the delivery of sexual health services. One professional described how sessions to help with college work were also used to discuss and deliver sexual health services, “They can walk out with contraception and college information”.

Health buses were popular with some of the young people. Those who had worked closely with the Bangladeshi community described how literally going from door to door was a good way of accessing women, and in particular young mothers. The Internet and email groups was also described as a method of targeting more ‘hard to reach’ groups. Outreach into venues that young people access was recommended. These venues included:

- Hairdressers and barbers
- Night-clubs (including under 18 discos)
- Snooker halls
- Fast food restaurants
- Computer cafes
- Youth services
- Events, such as the Notting Hill Carnival
- Sports centres
- Music shops
- Churches

Whatever the service or venue it was agreed that time was required to build up good working relationships between young people and providers. It was also felt that service providers should not just be focusing on increasing BME young people’s knowledge about sexual health, but they should also be focusing on confidence, self esteem, gender,
race, emotions, relationships, negotiation skills, personal development, social skills and aspirations.

It was agreed that reproductive and sexual health services needed to link in with other agencies, such as social services and youth services. Participants also felt strongly that reproductive and sexual health services need to create partnerships with community groups and not just work with other statutory organisations. It was felt that often there was little engagement between these sectors and ways of debating the issues needed to be explored. It had to be recognised that this process is a slow one, more of a ‘dripping tap’ effect:

…Slowly people are coming to us. It’s about building up a trust with us. … It’s taken a long time. It is 2 years down the line. At the same time we didn’t want to go in feet first and the doors close on us.

(Professional and Community Representative Group: Indian)

The other problem raised during the groups was that those working with young people often acted as the ‘gate keepers’:

Our main block wasn’t the young people. They wanted it. It was the people actually working with young people that are the barrier to get into the young people. They had huge fears. We can’t do that. We need parent’s consent.

(Professional and Community Representative Group: Indian)

One participant explained that rather than ‘diving straight in’ and trying to work with community groups around sexual health, it was sometimes useful to focus on other issues that were related, such as the law, and young people’s rights and responsibilities.

Concerns were raised in each of the professional and community representative groups that there needs to be a commitment to delivering services to BME young people. Resources and commitment were required, not just words. Short-term grants did not work. It was also mentioned that sometimes more of a concern was paid to numbers rather than the quality of work. Much effort was often put into finding out about what was needed at a local level and then it was not followed through. Some felt, for example, that there were insufficient resources to offer support for young women who would want to carry on with their pregnancy. However, it was felt that there were many examples of good practice across the country and it was important that successes were publicised more broadly to avoid “reinventing the wheel”.

The Indian professional group felt that little work around reproductive and sexual health had been done with Asian communities. Projects with Asian communities tended to focus on coronary heart disease and smoking cessation, but other ‘health’ issues were not being addressed. For example, they felt that drugs and sexual health were a huge problem. However, including drugs and sex into more general health projects could jeopardise them. It was agreed that much sensitivity was required and that caution was needed when piggy backing sexual health services for young people onto other services or settings as parents may stop their children from attending. Therefore was it better to carry on with the small amount of sexual health work that is happening in some areas rather than jeopardise everything? Fear was responsible for this lack of change.

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In terms of service delivery to BME communities, targeting of both services and health promotion needs to be very flexible and use many different approaches. However, the messages need to be the same irrespective of ethnicity. The Indian professional group also explained that it was also not feasible to deliver services to meet such a wide variety of needs. For example, it would not be possible to have different packages of care for Hindu young people, Sikh young people and so on. It would also be wrong to assume that all Indian Hindu young people, for example, have the same beliefs. Individuals will all interpret the effect of ethnicity, culture and religion differently.

Key points

♦ There has been little research into BME young people’s use of sexual health services and routine data on ethnicity is not consistently collected within these services.

♦ The major barrier young people described in terms of accessing services was that of confidentiality. This was particularly evident amongst Indian young people whose GPs were often also Indian.

♦ Use of services was extremely low amongst Bangladeshi young people. Those that participated in our research did not feel they needed to access services at the point of interview.

♦ The benefits of mainstream sexual health services described by young people included gender specific waiting rooms and being called by a number rather than by name when in the waiting room. Others preferred their GP because the reason for their visit was unknown.

♦ In terms of location, Indian and Bangladeshi young people said they would be unlikely to use local sexual health services, because of a perceived lack of privacy and confidentiality.

♦ Imagery, such as posters and leaflets, should reflect the local population.

♦ It was felt important that staff should be representative of different ethnic groups and that all staff members should have an understanding of the cultural and religious issues faced by these young people. Although these young people were concerned that if staff were of the same ethnic origin or religion they would be judged. For many young people seeing a member of staff of the same gender was more important. Professionals spoke of the difficulties of recruiting staff from some groups, particularly Bangladeshi and male BME health care workers.

♦ Outreach into venues that BME young people access, e.g. clubs, hairdressers and barbers and places of worship, was suggested. Greater links with community-based organisations and more inter-agency working was also recommended.
8. Lessons from the Research Process

The research process itself was very informative. Young people who participated in the in-depth interviews were asked about their experiences of the research process (See Topic Guide, Appendix 2). Much was learnt by the research team over the course of the study through feedback from participants. This information was not only useful in research terms, but much would be applicable when working with BME groups in the setting up and development of sexual health programmes or services.

8.1. Recruitment

The research team felt that it was the young people who should define their ethnicity rather than anyone else. As the Background Section, shows how people define their ethnicity is often multi-faceted. It was important throughout the research process that the team was very clear about how young people’s ethnicity was defined for this study as definitions obviously varied at group and individual levels. The focus group discussions illustrated that people’s definitions often conflicted.

Much of the recruitment for both the in-depth interviews and focus groups was done through community-based organisations. With the recruitment of participants for the focus groups contacts were first made with those working in the health, social and voluntary sectors. The identification of relevant groups and the recruitment of participants was a slow process, and at times an unfruitful exercise. A number of reasons were given as to why groups could not or did not wish to be involved with the research. It was felt that certain groups were not used as they:

- **Did not respond to the contact.** Some organisations did not respond at all to the contact and others did not respond following initial contact they had from BMRB or UCL. Lack of response was (according to the subjective views of the research team) thought to be a consequence of groups either not wanting to take part or simply being too busy to become involved or even respond.

- **Were not thought to be appropriate following discussions with the organisation.** For instance, some identified groups were located in the wrong geographical area for this study (i.e. not in Birmingham, London or Manchester), or were not focused on young people from the BME groups being explored in the study; and others were specialist groups - such as lesbian and gay groups, which again were not deemed relevant for this study.

- **Thought they were unable to assist, as they did not have the required information.** General contacts in large organisations, such as NHS trusts, were not only difficult to get in touch with in the first instance, but once contacted were often also unable to provide the relevant information for the appropriate community groups. It was felt that in order to utilise contacts effectively, a named contact, rather than a general number, was required as it was too difficult to identify the correct person to speak to.

- **Did not want to be involved.** Some groups, particularly some of the Bangladeshi contacts, suggested they did not want to be involved, as they did not think the issues
covered in the study were relevant to their community. Others felt, that although worthwhile, they did not believe the parents would ever agree to the young people taking part in the research. As one contact explained: This is much too difficult for the Bengali community to handle, Bengali children would never be affected by teenage pregnancy while they are still at home.

Another problem that became apparent when trying to recruit for the focus groups was that some Bangladeshi participants thought that the groups had been arranged to discuss health in general rather than sexual health. Although written invitations had been prepared, it became evident that people had been invited by word of mouth. Some left the group once they learnt what it was really about.

Many community group workers were obviously the gatekeepers to young people and the researchers were reliant on them to identify young people who would meet the inclusion criteria for this study and, in the case of the in-depth interviews, to ensure that the necessary quotas were filled accurately. Although willing to assist, they were less focused on finding young people who fitted the criteria exactly. As a result a number of the interviews organised had to be re-arranged. Furthermore, some of the young people had not received written parental consent, as the gatekeeper had not organised this. Again this resulted in interviews having to be postponed or re-arranged. Negotiating access into community groups can be a very complicated and sensitive process that takes time to organise: In order to recruit via community groups, it was essential to identify a gatekeeper in the organisation who understood and believed in the purpose of the research and was also willing and able to organise the recruitment or provide information or contact details of other groups. It was felt that identifying these gatekeepers was often down to good fortune as well as perseverance, and depended on such things as ‘who answered the phone’ or ‘who was working when the recruiter visited the group’. It is worth noting that in this study that the vast majority of gatekeepers were overwhelmingly sympathetic to this subject matter and tended to be fairly young (in their twenties or early thirties).

The other recruitment problem was that sometimes the necessary links or networks were not there. This was a particular problem for recruiting parents. Although many local groups and organisations had an established working relationship with young people, parents were rarely engaged in any formal way. In the end the research team had to abandon attempts to recruit parents through conventional statutory links. The Indian mothers, for example, were recruited from a sewing group. Recruiting the Jamaican mothers was also difficult because although they were sympathetic and enthusiastic about the research they often could not participate because of the demands on their time. For example, one Jamaican mother was a single parent with five children and two jobs.

The team had to be flexible in its recruitment approaches and different strategies were used. For example, with the Bangladeshi community, researchers had first to establish links with the main community leaders and ‘elders’ in order to gain their respect and trust. It also became apparent that those representing the community were not necessarily representative of it. For example, although the ‘middle generation’ were often happy to talk to researchers at an individual level, they were not happy to attend groups with elders where they perhaps felt that they could not express themselves so freely.

For logistical purposes and to try and provide a context for the discussions, the focus groups for each BME group were held in a different city: the Bangladeshi groups were in Birmingham, the Jamaican groups in London and the Indian groups in Manchester. The
Indian community in Manchester was seen as relatively small in comparison to other BME groups in the area. Therefore links between health and Indian community groups were not strong, making it was difficult to recruit young people and parents. Due to time constraints and the fact that the research team were based in London, recruitment for the Indian young people and parents groups had to take place in London. This illustrated that in areas where certain BME communities are relatively small, people within those groups can be fairly isolated. The need to learn from other areas that may have more experience in working with specific communities is therefore required.

The research team endeavoured to ensure that there was diversity in the characteristics of the research participants that would reflect the diversity in the community. The secondary selection criteria for the in-depth interviews included migration history, religion and sexual experience. However, those who participate in sexual health research, as with those who are likely to get involved in programme development in the sexual health field, are not necessarily representative of their ethnic group. Work with the Bangladeshi community in Birmingham illustrated this point. When asked if they thought their views were representative, the Bangladeshi young men participating in the focus group said that they were probably more open, confident and ‘chilled’ in comparison to other Bangladeshi young men. In fact the original group of young men recruited for the focus groups thought the group had been arranged to talk about general health issues and left when they realised the discussions were about sex. The researcher was able to recruit some other young men at short notice. This group had left school at 16, were more ‘streetwise’ and were probably more able to speak about sex than the original group. The Indian mothers who participated in the focus group may not have been typical of all Indian mothers. They described how they were proactively engaged in all sorts of community work and were comfortable vocalising their opinions. They also explained they had no difficulties in talking about sexual health.

Another group of people who were for the most part excluded were non-English speakers. This was a concern that had been raised by the Ethics committee that reviewed the research proposal. Although there was one non-English speaker who was interviewed on a one-to-one basis with an interpreter, it was not feasible to conduct focus groups in different languages. Some parents and carers, in particular, may have been excluded from contributing.

The recruitment process illustrated the need for flexibility and adequate time when working with community groups, health services, youth services, the voluntary sector and so on. Often the research team felt they had some good leads and then found these fell through at the last minute. The recruitment process also showed that what works in one city or with one BME group does not necessarily translate to other areas or communities. It is important to listen to people working in the local area and to avoid acting on assumptions.

8.2. Attitudes to taking part in the study

There were many benefits described to taking part in the research. Overall, young people said they were very willing to take part in the study as they felt that raising awareness of sexual behaviour and health in their communities was both necessary and worthwhile:
Especially in the ethnic minority, you know, groups because they won’t get that kind of support from their parents and family. See with a White girl or a White boy, I think they hear a bit more about it compared to us whereas we don’t get to hear anything about it. So we need to hear about sex from somewhere, learn about it from somewhere.

(Bangladeshi young woman, Aged 19-21, London, In-depth interview)

Young Bangladeshi men and women involved in the focus groups mentioned that the research methods used, i.e. the small group discussions, were an excellent way of providing information and support. They enjoyed the discussions as well as some of the debates around the issues. It was also widely felt that this study would allow a greater understanding of sexual health by young people from BME communities by prompting more discussion about sex. In particular, respondents identified teenage pregnancy and the risks of unprotected sex as issues that could begin to be tackled by this kind of study by encouraging people to talk more openly. The young women who participated in the Bangladeshi group told one of the research team that they had talked to their mothers about what was discussed in the groups. The mothers were very interested to hear what was talked about and told their daughters that they wanted to know more but felt unable to come forward.

A few respondents took part in the study because they wanted to learn more about sexual health, such as contraception and STIs and felt it would be of educational benefit to themselves and others. Others felt the study would facilitate access to sexual health services by addressing concerns around judgement and confidentiality. The Indian young men who participated in the focus group explained that they had learnt more from the presentation of in-depth interview results than they had learnt from school or their family.

Generally, young people said that they did not have any concerns about participation. However, some admitted to feeling “embarrassed” and “scared” at the prospect of having to talk about sex. One respondent was worried that she would be judged by the interviewer, but felt she was put at ease and was able to talk openly during the course of the discussion. Conversely, some respondents from the Indian and Bangladeshi groups said that the prospect of talking to a stranger had encouraged them to participate in the study, as any fears of being judged by someone that they knew were immediately allayed.

However, there were concerns raised about involvement in research that was focusing on specific ethnic groups and sexual health. Researchers have a duty to ensure that research does not create further stigmatisation. For example, concerns were expressed by those working with young Jamaican people that much of the research targeting Jamaican young people in recent years had focussed on crime, gang culture and STIs. This focus could reinforce negative messages to and about young people from these communities. A “Frequently Asked Questions” (FAQ) sheet was produced to address some of the concerns (see Appendix). This sheet was written in response to queries from those working in the field. This was a lesson learnt by the research team that sensitive issues need to be addressed right from the start. How the results are disseminated also needs to be addressed. Those working with Bangladeshi young people, for example, mentioned concerns around misrepresentation in the media. An issue could be blown out of proportion with negative repercussions for those in and working with the community.

The ethics of coming into a community, and building trust, whether for research or service provision purposes, and then withdrawing as quickly as entered, were raised. It
was felt important that researchers and service providers are clear about the potential gains and losses for those who participate, and that any work is a continuous and consistent process.

8.3. Expectations and views on questions asked

Many young people said that they felt “awkward” and “nervous” at the start of the in-depth interview as they did not know what subjects would be discussed or how personal the questions would be. In the main, respondents felt comfortable with the questions and some said they had found the experience “enjoyable”. Some respondents said they had found it difficult recalling the development of their sexual knowledge, and had therefore found it challenging to pinpoint the age at which they became aware of certain issues.

Interestingly, some respondents said they were surprised at how much they had to say, particularly those who had little or no sexual experience. However, one respondent said he felt “shy” answering personal questions as it was the first time he had discussed sex with anyone. A few people who said they had little or no sexual experience found questions about sex difficult as they felt they did not have sufficient knowledge about it. In particular, these respondents found the visualisation exercise of contraceptive services challenging, as they had never considered their own use of contraception or what their needs might be. Some people wondered how “useful” their limited knowledge would be to the study, and felt the interviews should have been conducted with people who had direct experience of the issues addressed, such as teenage parents or those who had used contraceptive services. One respondent said that he had felt “dodgy” answering questions about gay sex because he did not agree with it.

Generally, respondents thought that the subjects covered in the interview were appropriate, particularly the questions on teenage pregnancy and contraceptive services. One respondent suggested some questions about how young people socialise would have been helpful as a way of understanding sexual behaviour, mentioning “clubbing” as a topic that could have been explored in more depth.

*Clubbing is where you are more likely to meet boys. You get into the drugs or the alcohol and all of that dancing business, bodies touching together. And then there’s all this about ‘Oh let me have a dance with you’, and then it leads to a kiss … Then it’s all about, ‘Oh, do you want to go back to my house?’ So I think clubbing is a big thing.*

(Indian young woman, London, 19-21, In-depth interview)

8.4. Views on type of interviewer: in-depth interviews

Many respondents expressed preferences of the type of interviewer they would have felt most comfortable talking to about their sexual knowledge and behaviour. For some, the interview was the first time they had discussed sex with anyone, therefore the role of interviewer had an added significance.
**Bangladeshi respondents**

Overall, the Bangladeshi respondents expressed a preference to be matched by gender with the interviewer. Many said they would feel more comfortable talking about issues concerning sex with someone of the same gender as there would be an implicit understanding between them, and it would be less embarrassing discussing such personal matters. The female respondents felt particularly strongly about this, with many admitting that they would have been "uncomfortable" talking to a man and would therefore have divulged less detailed information. One respondent said she would have walked out of the venue if her interviewer was male, and expressed her relief that this was not the case. Another respondent said that she would have found it difficult talking to a male interviewer because she did not socialise much with men.

However, one male respondent said he would have preferred talking to a female interviewer. In this case, the respondent explained how the familiarity of talking to another male would have made him take the discussion less seriously:

> No, I wouldn't take him seriously. Oh, I don't know, it is just, I don't respect guys as much as I respect women, if you know what I mean … Because guys are just guys, isn't it? You see them as your pal, your buddy, you know?

(Bangladeshi young man, Aged 19-21, Manchester, In-depth interview)

Generally, the ethnic background of the interviewer was not important to respondents in this study, with many people saying that they would have responded in the same way regardless of the ethnicity of the person they were talking to. However, there were exceptions. In these cases, people felt that someone of the same ethnicity would be more judgmental of their sexual attitudes and behaviour. One male respondent said that he would not have wanted to talk to a Bangladeshi man, as he feared the interviewer would "look down" on him. Another person said that they would not have talked to an Asian interviewer from the same area for fears that their confidentiality would be breached. Conversely, one respondent felt that talking to an Asian person enabled them to be more open as the interviewer had a better understanding of their culture.

In terms of religious preferences, a few people said that they would have been inhibited to talk openly if the interviewer had been a Muslim because they would be familiar with the Islamic teachings around sex and may try to influence their behaviour:

> I wouldn't prefer a Muslim because they actually like, you know, when they try and help you they're also like telling you that you're supposed to do this or that.

(Bangladeshi young woman, Aged 13-15, London, In-depth interview)

The age of the interviewer appeared to be an influencing factor in how comfortable people were in talking about sex. A number of respondents said they would have been 'intimidated' if someone older interviewed them and consequently felt their responses would have been different. One respondent feared negative judgement from an older interviewer:
If it was a young Asian woman it wouldn’t matter. But if it’s like an old Asian woman you’d think, ‘What are they thinking inside their heads?’ They must be thinking, ‘What a slut’.

(Bangladeshi young woman, Aged 16-18, London, In-depth interview)

**Indian respondents**

As with the Bangladeshi sample, there was an overwhelming preference for gender matching of interviewer among the female Indian respondents. The reasons given for this were also very similar, with many stating that they felt more comfortable talking about sex with another female and that they would be able to be more open about their views;

*If you were a male then I don’t think I’d be saying half the things that I’ve been saying.*

(Indian young woman, Aged 19-21, London, In-depth interview)

A few male respondents expressed reticence in talking to a female interviewer about sex, fearing that they may ‘offend’ her. One respondent, who was interviewed by a female researcher, said that he would have been less hesitant and expressed himself more clearly if he had spoken to a man.

There were mixed preferences about the ethnicity of the interviewer. In the main, the male respondents said that this was not important to them, and felt that their responses would have been consistent regardless of the ethnic background of the researcher. However, some female respondents seemed to be concerned about being judged for their views and behaviour, and expressed a degree of discomfort about talking to someone who was familiar with their cultural values.

As with the Bangladeshi group, the age of the interviewer was significant to respondents, with many suggesting that they would have been more “cautious” if they had spoken to someone a lot older than them. One respondent said that talking to an older researcher would be akin to discussing sex with his parents, and this would have made him more hesitant in answering personal questions. Some people expressed satisfaction that the researcher was around the same age as themselves, as they felt the interviewer was a contemporary who would relate to their attitudes about sex;

*I don’t think he would really understand you know. I don’t know. When you’re older it’s not like bad or anything, but I don’t think he would know as much. You don’t really know as much what kids think.*

(Indian young man, Aged 13-15, London, In-depth interview)

**Jamaican respondents**

Among the Jamaican respondents there was more ambivalence towards the characteristics of the interviewer. Unlike the Bangladeshi and Indian groups, many Jamaican respondents said that they had no preferences at all for who they would feel
most comfortable talking to. A few people felt it was more important that the interviewer was well trained than being matched on any demographic basis.

The ethnicity of the interviewer did not seem to be a significant concern, with many people stating that this was 'irrelevant', and that they would have been as comfortable talking to someone from the same or different ethnic background. Generally, respondents expressed a preference for talking about sex with a researcher of the same gender. Again, this was explained by people feeling embarrassed and uncomfortable when discussing personal matters with someone of the opposite sex. One respondent said that although she would have talked to a male interviewer, she would not have been as open about her views and behaviour. Another said that he would have felt 'shy' talking to a female about sex and would have to think more carefully about how he expressed himself:

'Talking to a man about things like this, it's just like talking to your mate, this is a normal chat. I don't have to think, 'Oh, does she want to hear this?' But when you're talking to a woman, you have to talk to her different.'

(Jamaican young man, Aged 19-21, Birmingham, In-depth interview)

8.5. Working with groups

Use of participatory methods

Many of those participating in the groups described how getting together and having a debate had been a very useful exercise. For some of the professionals and community representatives it was the first time they had discussed issues relating to sexual health of the BME young people they work with or within their own community. By presenting the findings from Natsal 2000, ExES and the young people's in-depth interviews to the groups of young people, parents, and professional and community representatives we were able to get a greater understanding of the influences on attitudes and behaviour and to create further debate. This was key in coming up with the final recommendations for the report.

Conflicts within the groups

As well as the bringing people together, the groups also identified conflicts, reaffirming the point that BME groups are not homogenous communities.

One of the most obvious potential conflicts within a group was that of gender. On the advice of those working in the field, most groups with parents and young people were run separately for men and women. If the groups had been mixed it is doubtful participants could have been so open. The professional and community-based organisation groups were mixed. However, in the Bangladeshi group all the community leaders were male. It was felt that female community representatives would not have discussed issues related to reproductive and sexual health in front of men as the implications in terms of shame and loss of respect were too great.
The views expressed in the professional and community representative groups were often diverse. These viewpoints were often influenced by factors outside direct professional experiences. These included influences from participants’ own culture, religion and ethnicity, and involved their own experiences growing up as a teenager or as a parent. One participant felt that it was important professionals and community representatives address their own views and the reasons for them as young people need to respect the people who may be challenging them.

*It's a mirror. These young people are a mirror of us. Sometimes we don’t like what we see in the mirror.*

(Professional and Community Representative Group: Jamaican)

The other concern was that some participants may not have felt comfortable expressing their opinions or ideas in front of others. For example, the health care workers may have felt uncomfortable expressing their views on the sexual health needs of young people for fear of offending the more traditional community representatives.

**Confidentiality**

There are potential difficulties in working within small, tight communities where everyone knows each other. It was not only important that confidentiality was adhered to within the individual groups, but the researchers had to ensure that confidentiality outside of the group was maintained. For example, community leaders helped with the recruitment of young people for focus groups and would therefore know the identity of those who participated. This had implications for the way research was written up and disseminated.

Like the in-depth interviews, young people seemed to prefer that the person running the focus groups was not from the same ethnic background.

*It's easy to talk to you (the focus group leader), it's much easier because we don't know you and you're from a different community. But if I was to sit with a group of girls I work with and asked them to talk about sex, they wouldn't. You wouldn't get a response. We’re from the same community and probably I know their parents so it would be very difficult. But because we know you won't feed back to anyone we can talk. We're strangers talking, so it's much easier.*

(Bangladeshi young woman, Birmingham, Focus Group)

**Other Practicalities**

There were many practical factors that had to be considered when organising the focus groups. Working with communities at a local level helped ensure the setting up and running of the focus groups went more smoothly. The most appropriate environment for the each of the groups had to be considered. For example, some of the Bangladeshi participants would not have attended a focus group if it had been set in a sexual health service.
For the Bangladeshi groups timing had to be flexible. Many of the respondents turned up late, which was explained to be normal, ‘it’s just the way’.

Refreshments were provided in each of the groups. Again consultation was required. The young people tended to prefer take-aways from fast food restaurants. It was also important that consideration was paid to any dietary requirements from religious perspectives.

Religious festivals also affected the organisation of groups. Initially five Indian mothers were expected and only two turned up. When asked why the others had not turned up, it was explained that they were still busy celebrating Diwali.

Both researchers and service providers need to be aware that there are specific ways of doing things within different communities and etiquette that needs to be followed. It is sometimes not possible or appropriate to adhere to traditional research methodologies. Working with community groups needs adequate resources. Unfortunately due to various constraints, such as small budgets and little time, the work is done too quickly and therefore does not succeed in meeting its objectives.

Key points

- Recruitment was often difficult because of the sensitive nature of the research topic, in some cases there were no established networks (e.g. parents) and concerns about expressing oneself freely in front of peers, community elders or colleagues. Those who agree to talk freely about sex may not necessarily be representative of their ethnic group.

- The young people found the interviews and focus groups enjoyable and informative. For many it was the first time they had ever talked about sex and relationships.

- The focus groups helped generate debate and discussion. Gender specific groups provided a safer environment for some.

- The setting for the research was an important consideration. For example, Bangladeshi participants would not have taken part if the research had been held in a sexual health clinic.
9.1 The Study

There has been very little research on ethnicity and teenage pregnancy published in the UK to inform policy and the development of sexual health services. Much work looking at ethnicity, young people and reproductive and sexual health has been conducted in the US, and may not be transferable to this country. As Singh et al (2001) comment, “Race, ethnicity and immigrant status do not translate easily or directly into comparative measures of disadvantage, because minority groups in the study countries and cultures may differ in values, attitudes and behaviours and may or may not be socially or economically disadvantaged relative to the majority group”. Much of the UK published literature has focused on married, Asian women, and studies that have looked at ethnicity and sexual behaviour and contraceptive use have tended to recruit people who are already accessing services and therefore not necessarily representative of the community, in particular young people. The strength of this study, and the others used to inform its methods (i.e. ExES and the Natsal 2000), is that they were community, rather than service, based.

As discussed in the previous chapter, we endeavoured to ensure there was diversity in the characteristics of young people that participated in the study. In practice, the research tended to attract young people who were, or had aspirations to be, high achievers, and the vast majority of participants were fluent in English. All the young people who participated lived in urban areas. The experiences of BME young people living in cities are likely to be very different from those living in more suburban areas. For example, those living in cities may be more likely to come from an ethnically diverse community and may have easier access to a variety of reproductive sexual health services.

We used qualitative techniques for this study, as in-depth and flexible questioning in individual interviews and focus groups are particularly suited to exploring the reasons why people behave in a certain way and the factors that influence them. This approach is unique in its ability to provide a greater depth of understanding of the full range of experiences and attitudes. It is particularly appropriate for exploration of sensitive topics, the success of which depends on building rapport with, and gaining the confidence of, the interviewee. This approach can operate at different levels, exploring not only sexual lifestyles themselves, but how people respond to talking about such attitudes and behaviour.

As with all qualitative studies, our results may not be applicable to all young people in the three BME groups we focused on. However, the strength of this study was its use of three stages in the research process, i.e. 1) establishing priorities and themes; 2) the in-depth interviews; and 3) the focus groups to present preliminary finding, and to explore their meaning and discuss the way forward. Using this approach we could compare the findings with previous qualitative and quantitative data, and explore the results of the in-depth interviews across and within different target groups. This methodology also allowed us to ascertain where there were consistencies, as well as variations, in the data.
9.2. Consistencies and variations in attitudes and behaviour

Knowledge

Young people participating in this research were more likely than the previous generation (i.e. the ExES participants) to have had SRE in school. Young people today also have more access to alternative information sources, such as the television and the Internet. Therefore there was greater knowledge about sex amongst the young people compared with their parents when they were a similar age. However, compared to the Indian and Jamaican respondents, the Bangladeshi young people in our study, as with ExES, knew the least about sex.

Interestingly, participants in our study and ExES felt they would be better at discussing sex and relationships with their children than their parents had been with them. However, there was little difference between the two studies in child and parent communication about sex and relationships. This suggests that the different generations may always have some difficulty talking about sex, despite the good intentions of parents.

SRE is often criticised for being too ‘biological’. This was something on which parents and young people agreed. Those participating in the professional and community representative focus groups were concerned that not enough emphasis was placed on SRE in schools – often the only source of information for Bangladeshi young people in particular. Everyone wanted more information to be provided on relationships and more discussion around the context of sex, for example behavioural influences, such as taking drugs and alcohol, and attitudinal influences, such as influence of family, culture and religion. The in-depth interviews found that young Jamaican men knew the least about contraception despite being the most sexually experienced. The Natsal 2000 data illustrated that Black-Caribbean young people were less likely to use any contraception at first sexual intercourse than the general population.

Sexual relationships and experience

There was evidence that attitudes and behaviours towards sex and relationships are changing. For example, the Bangladeshi women described how it was less common to see women married at 16 as more emphasis was being placed on having children after the completion of one’s education. Unfortunately there are no data available to confirm whether there is a downward trend in terms of teenage pregnancy rates within this group.

More young people in the Asian groups, particularly Indian young people, are having sex before marriage. However, behaviours may be changing faster than attitudes in some respects. So, for example, although some young people are having sex before marriage they are still keeping these relationships secret because of the potential shame that could be brought on the family.

The Jamaican young people and the Jamaican parents generally had more liberal attitudes towards sex. Sex outside marriage was more frowned upon within the Bangladeshi groups and to lesser extent Indian groups. Strategies were described for ‘protecting’ young people, such as ensuring that young women came straight home from school. However, it was also apparent that, for some, sex was taking place within ‘hidden’ social worlds outside of the home environment, for example at clubs, or once young people
had left home and were socialising with people from different backgrounds. Some of the Bangladeshi and Indian men spoke of having sex with women of different ethnicities to avoid the perceived difficulties of having sex with women from the same ethnic or religious group.

**Teenage pregnancy**

Data from the Natsal 2000 show that under 18 year old motherhood and fatherhood are far more prevalent amongst Black-Caribbeans in comparison with other ethnic groups. ExES and our study showed that attitudes towards teenage pregnancy and parenthood were more liberal amongst Jamaican participants, and most had either direct or indirect experience of teenage pregnancy. Although there were practical reasons given during the study for delaying starting a family, such as waiting until you are more financially secure, the positive benefits of having children at a young age were also described amongst some Jamaican participants. This was not apparent amongst participants from other ethnic groups. In the Indian community where teenage pregnancy outside of marriage was viewed as ‘shameful’ and more emphasis was placed on delaying child-rearing until completion of your education, the proportion of teenage parents is significantly lower. Less emphasis was placed on age amongst the Bangladeshi participants. It appeared to be more important that pregnancy happened within marriage. There were some young women who mentioned that they would prefer to complete their education before having children, but it was acknowledged that once married there would be pressure to start a family fairly quickly.

There were notable differences between the three BME groups in how a teenage pregnancy would be ‘dealt with’, although there was generally consensus within the groups. Both the Jamaican young people and the Jamaican parents agreed that although parents would be upset and angry in the first instance, ultimately they would be supportive in both emotional and financial ways. The Indian young people and the Indian parents explained that a teenage pregnancy would usually be hidden, with young people encouraged to marry or have an abortion. The consequences of a teenage pregnancy outside marriage were the most negative for Bangladeshi young people. They may be forced to marry or disowned from their family and community. Under 18 year old marriages were rarer now and therefore pregnancies amongst the under 18s were felt to be less common. These factors are likely to affect the decisions young people make if they find that they are pregnant, and, in fact, whether they have sex in the first place.

The views on whether or not specific BME communities should be targeted with respect to pregnancy prevention sometimes varied between professionals and parents or community representatives. This illustrated the sensitivity required when providing information or delivering services to young people. For example, teenage pregnancy was not generally seen as a problem amongst the Bangladeshi and Indian communities. Although teenage pregnancy is not common, in the cases where it does happen a huge amount of additional support may be required to address some of the cultural and religious taboos. As more young people from Bangladeshi and Indian communities are having sex before marriage, the numbers experiencing unplanned pregnancy may increase if messages about pregnancy prevention are not targeted at them and services are not made more accessible.
There were also examples where attitudes and behaviours of individuals were not necessarily consistent. However, these inconsistencies were sometimes logical. For example, the vast majority of Bangladeshi young people were firmly against abortion for religious reasons, but because the consequences of a pregnancy out of wedlock were so great, most agreed that an abortion would probably be the only course of action they could take.

9.3. Factors influencing attitudes and behaviour

Acculturation

Greater acculturation (i.e. the adoption of a different culture) was observed in the Jamaican community in comparison to the Bangladeshi community. This was also observed in ExES and reflects the length of time each of the communities has been established in the UK. Young people, particularly those born in the UK, may not necessarily identify with a particular community. This was particularly evident amongst Jamaican young people, many of whom had never been to Jamaica, and described a variety of cultural influences on their attitudes and values around sex and relationships.

Amongst the Indian community there was more diversity. The authors of ExES commented that differences in the attitudes and behaviours between the generations were starting to become evident. Our study shows that this is an evolving process, and that attitudes and behaviours can change fairly quickly between generations. For example, most of the Indian adults in ExES had had an arranged marriage, while the parents in our study said they would be happy if their children chose a ‘suitable’ partner. However, definitions of what is ‘suitable’ may still vary. The Indian mothers spoke about the importance of ‘caste’ when choosing a marriage partner, while the younger generation thought factors more associated with the British class system were of greater importance.

The Bangladeshi community is more recently established in the UK, and the need to protect cultural identity and values was something highlighted amongst all Bangladeshi participants, irrespective of age.

Religion and culture

Teasing out what was influenced by religion and what was influenced by culture was often difficult.

The data in our study and ExES related to the Bangladeshi community was consistent in highlighting the importance of faith on attitudes and behaviours. This was seen across the different generations. Religion was central to shaping young people’s views on sex and relationships. Even amongst the Bangladeshi men who were sexually active, Islamic teaching influenced their views on relationships.

Amongst the Indian participants, cultural values appeared to be more central to influencing attitudes and behaviours than religious ones. Although, there was more diversity observed amongst this group in terms of both religious beliefs and cultural
influences. Value was placed on social standing and respect within the community; therefore the weight placed on education and job prospects was high. Generally teenage pregnancy was more of a taboo because of the shame it would bring to the family rather than because of any religious objections.

The religious and cultural influences that directly affected Jamaican young people’s attitudes and behaviour seemed the most tenuous. There were differences observed amongst Jamaican young people and older people, or more specifically those brought up in the UK, compared with those brought up in Jamaica. The impact of the Church was far greater in Jamaica, although, unlike the Bangladeshi community, the influence of religion did not necessarily affect sexual behaviour. Objections to sexual activity outside committed relationships, for example, were for moral rather than religious reasons. The Jamaican young people described a variety of cultural influences, which influenced their attitudes and behaviour, ones that were not necessarily about being ‘Jamaican’. The Jamaican young people were more likely than the other participants to mix socially with young people from other ethnic groups and some had a non-Jamaican parent.

There was agreement in all groups that religion should not be used as a barrier to communication around sex and relationships.

**Gender**

The influence of gender on attitudes and behaviours was very strong amongst all three BME groups. There was agreement between the genders that the consequences of an unplanned teenage pregnancy were far greater for young women than for young men. The message that women received, particularly the Bangladeshi and Indian women, was the importance of protecting one’s virtue, while it was often accepted that men would be sexually active. Even the young Bangladeshi and Indian men described how they would ultimately like to have a ‘traditional’ wife, even though they were having sexual relationships prior to marriage.

The discussions about gender roles in the Jamaican focus groups were at times emotive. There was general agreement that many Jamaican mothers ended up bringing up children by themselves. The fact that men are often not directly involved in child-rearing was backed up by young people’s experiences in the in-depth interviews and focus groups, as well as recent census data. The repercussions of this varied between the different groups. Mothers were described as being ‘betrayed’ and ‘isolated’, fathers were not encouraged to get involved and felt pushed out, and the young men and women described the lack of positive male role models. The young men, in particular, received negative messages, resulting in low self-esteem. Although some of the Jamaican ExES participants described how in Jamaica women were often solely responsible for the bringing up of children, the role of the extended family in supporting mothers in Jamaica was far more evident. In the UK, young mothers were often isolated without a wide family support network.

**Education and economic status**

In communities where high value was placed on education and getting a good job, young people were more likely to want to delay pregnancy. High educational achievement is
observed amongst Indian young people, and the Natsal 2000 shows that age at first intercourse and rates of teenage pregnancy are low within this group. There was consensus amongst the Indian young people and parents in our study about the value of education and the importance of establishing a good career before having children. Although the Jamaican and Bangladeshi young people also spoke of the need for a good education and career, there was an acknowledgement amongst some that there were often barriers that prevented them from achieving these goals. The Jamaican parents agreed with this. It was clear from the study that Jamaican young men, in particular, lacked confidence and self-esteem in terms of educational and employment prospects. Many of the professionals felt these issues had to be addressed alongside SRE in order to reduce higher rates of teenage pregnancy and STIs (see Section 9.4. Education). Although census data shows the educational and employment prospects for Bangladeshi young people are often poorer (see Chapter 1. Background) it appears that currently the effect of religious beliefs on behaviour and attitudes towards teenage pregnancy is greater than the effect of lower educational achievements and unemployment.

9.4. Policy implications

Education

Our findings back up the criticism of current SRE programmes in that they rarely take account of cultural and religious influences on sexual attitudes and behaviour. Young people and parents were keen that these influences were discussed. They felt that it would help put sex and relationships into context. The young people who took part in the focus groups particularly enjoyed the debates about how factors, including culture and religion, influenced their attitudes and behaviours. For some it was an opportunity to share experiences, and for others it was an opportunity to learn about what influences other people’s beliefs. The young people enjoyed the small group discussions and felt that group work should be used more in school and other settings. However, those running SRE sessions need to be aware that where specific ethnic groups are in the minority they may feel uncomfortable vocalising their views and beliefs.

Another important message that came from the focus groups is the importance of discussing how young people can act on or use the information they are given, rather than just providing information. Telling a young person that their local sexual health service is open in the late afternoon is not useful for those who have to be back at home at 3.30pm. Alternatives need to be discussed. Topics such as career aspirations and life skills need to be discussed alongside talks on contraception, STIs and pregnancy. SRE needs to be linked into the wider PSHE programmes in schools rather than being viewed as an isolated lesson. For example, it became evident from the in-depth interviews and focus groups that the negative images portrayed in the media of drug and gang culture, and the lack of positive male role models could ultimately lead to low self-esteem or confidence amongst some Jamaican young men. Addressing these issues within SRE programmes is likely to help young people reflect on the values they place on their sexual behaviour, and even the values they place on parenthood.

Some aspects of SRE need to be discussed in single gender groups. The young people, in particular the Bangladeshi young women, felt very uncomfortable discussing sex in mixed gender groups. The data from this study illustrate that young men often have little access to SRE outside school settings. Sex and parenthood was less likely to be discussed at
home with young men in comparison with young women. Single gender groups would allow men to explore factors that influence their attitudes and behaviours in a safer environment.

There were many innovative suggestions during the focus group discussions on how to reach young BME people in the community. However, for many young BME people, the provision of SRE in schools is crucial, as it is often the only accurate and objective information source that is available to them. Some young people participating in the in-depth interviews and focus groups described how it was difficult to get messages about SRE in settings outside of school. For example, Bangladeshi and Indian young people described how their social lives evolved around the mosques or temples, and many had little social contact with other ethnic groups until they left home.

Parents were keen to be involved, although our experiences illustrate that parental involvement can be a slow and time consuming process. Some parents described how they felt ill equipped to discuss sex and relationships with their children, as their own knowledge was often poor. Group sessions with parents in community settings may be a way of providing them with SRE in a culturally appropriate manner and a forum for discussing issues, such as communication with children. Community leaders emphasised the need to educate young Bangladeshi mothers in order to improve prospects for better communication with children in the home. Interestingly, some young people explained that the poor communication with their parents was because of language barriers within the home itself. Involvement of extended family members, such as aunts and sister-in-laws, in community education programmes should be considered, as many young people said they would prefer to talk to other family members rather than their parents.

SRE should not stop at 16 years. For many of these BME young people SRE was not relevant during their early teens. Although they welcomed the information at this stage, it was sometimes difficult to put it into context. Therefore it is essential to provide further information to some groups to fit in more with their sexual and reproductive careers. For example, many of the Indian young people described becoming sexually active once they had left home and started college. Freshers' Fayres are excellent venues for providing health education materials and for letting people know where local services are situated. Some young people, in particular Bangladeshi young people, explained that they did not intend to have sex until after they were married. So for this group it may be more appropriate to have further discussions about sex and parenthood prior to marriage.

Reproductive and Sexual Health Services

When describing their ideal service, factors such as open access, non-judgemental staff and age specific sessions were identified as being important by the young people who participated in this research. These factors have been described in previous research with young people, and are relevant to all young people irrespective of their ethnicity (Harden and Ogden, 1999; French, 2002a). More specific suggestions for improving service delivery to young BME people included ensuring that the décor was culturally appropriate and that staff from different ethnic groups were employed within the service. These are aspects of service delivery that were also mentioned by the ExES participants, and are therefore not necessarily age-specific.
TPU guidelines (2000b) recommend that ethnicity of staff within reproductive and sexual health services reflect the ethnicity of the local population. For many services situated in areas with fairly large BME populations, this will have to be a long-term objective. Many of the Bangladeshi community described the difficulties of walking into a sexual health service. Working in one would be near impossible, due to cultural opprobrium. Qualified professionals, such as nurses and doctors, may not be adequately represented across all BME groups. Encouraging people from BME communities to train and apply for these posts will take time. However, there are goals that may be more realistic in the short-term.

It may be more feasible to recruit professionals from BME communities in settings outside reproductive and sexual health services, such as focusing on youth services or generic health settings, and provide them with training in sexual health. Partnerships could be established between these different types of services to ensure that young BME people can be quickly linked into sexual health services when appropriate.

As discussed in chapter 7, less than 20% of services provide training for staff on working with young BME people. This proportion needs to be increased dramatically. Staff must have the awareness and skills to understand some of the dilemmas young people from BME communities may be facing, e.g. a Bangladeshi woman accessing the service for an abortion. The training should ensure that staff do not make assumptions – factors other than ethnicity often have more influence on attitudes and behaviours. Also, BME staff need to be aware that young people from the same ethnic community as themselves may be very concerned about being judged and fearful that their confidentiality will be breached.

Confidentiality within primary care needs to be addressed. This was of particular concern to Indian young people when their GP was Asian (and often a friend of the family or a well-known, respected figure within the local community). Discussions with parents and professionals seemed to confirm that young people’s fears were sometimes warranted. Further research needs to be conducted with Asian GPs to assess whether or not issues around confidentiality and the provision of contraceptives to under 16 year olds are problematic.

**Targeting BME young people**

Education and health service programmes need to ensure that they are reaching young BME people. In many cases it will be appropriate to target particular communities. However, providers need to be sensitive when targeting specific ethnic groups. Where this sensitivity is lacking - negative consequences may result.

There were concerns raised about stigmatising and stereotyping certain ethnic groups. For example, any imagery in the form of media campaigns needs to ensure ethnic diversity and should not focus on one group. Messages need to be consistent across all groups.

Although it is important to assess local priorities, this should not be to the exclusion of other groups. For example, there may be implications for ethnic groups that are not well represented in the local area. The Indian community in Manchester is relatively small. It may not be appropriate or realistic to establish strong links with the Indian community.
and specifically target Indian young people. However, providers still need to ensure that services are accessible to all Indian young people by ensuring access to mainstream services that are culturally appropriate.

Ongoing training, support and supervision for all staff will be essential to ensure good quality, anti-discriminatory service provision. Equally important is the need to develop collaborative partnerships with community and voluntary organisations working with BME communities so that limited resources can be utilised effectively and outcomes maximised for these young people around maintaining and preserving their sexual health.

Another problem with targeting specific groups is that definitions of ethnicity change and young people may have a variety of cultural and religious influences that impact on their attitudes and behaviours. Therefore young people could be inadvertently excluded if they do not necessarily identify with the targeted group.

It is important that there is diversity in the services provided to match the diversity of the local population. One programme or type of service targeting a specific ethnic group will not suit all its members.

**Community involvement**

Consultation with and involvement of the local communities is seen as a requirement of any work with BME groups and was a recommendation made in all the focus groups with professionals and community representatives. However, this may be easier said than done and presents a number of challenges. Identifying and working with community representatives can be time consuming and requires much sensitivity. It cannot be assumed that a community is a homogenous group. There are often different agendas and conflicts within it, due to differences between generations, genders, religions and so on. The focus groups also illustrated that definitions of ‘community’ vary. ‘Community’ may be defined by where a person lives rather than by their ethnicity. Interestingly, many of the young people did not even see themselves as part of a ‘community’. Despite the challenges raised by ensuring community involvement, it is essential if good quality sexual health services are to be provided for young people from a range of different BME communities.

**Key policy messages**

1. **Research, policy and the development of sexual health services require long-term commitment and adequate resources in order to address the needs of BME young people successfully.** It is important that goals are realistic and sustainable. Local services need to meet the requirements of the local BME population. Ascertaining the needs of the population and establishing the necessary partnerships with community groups takes time. Service providers and policy makers need to think about the quality of their service. Focusing on numbers of young BME attendees may not be informative. It may be more appropriate to provide a quality service to those who need it.

2. **Do not reinvent the wheel.** Professionals may need to look in other geographical settings where for historical reasons services and support networks may be more
‘advanced’. A database of relevant projects would help professionals learn from other people’s successes and identify areas for further development.

3. **Any consultation exercises and partnerships set up with community groups need to ensure there is wide representation across the community.** It is important not only to acknowledge that there is diversity within all ethnic groups, but also people within the same group may have conflicting views and different agendas. These need to be addressed from the beginning.

4. **Information about reproductive and sexual health needs to be provided via a variety of sources and formats which are accessible to young BME people.** For many young people school is the setting where most SRE is received, and for Bangladeshi young people in particular this may be the only source. However, it is important that other sources are used to reach young people, such as youth services. The Internet was particularly popular with young men. SRE needs to look at the context of sexual experiences and address cultural and religious influences on attitudes and behaviour. Small group discussions were a popular vehicle for such debates. Education should continue post 16 years, particularly for communities where first sexual intercourse is stated to happen later.

5. **Support needs to be given to help families provide SRE within home or community environments.** Involvement of parents, particularly mothers, and members of the extended family (e.g. sister-in-laws, aunts and cousins) in the delivery of SRE should be encouraged. However, many of the older generation spoke of their own lack of knowledge and some of those who had recently come to Britain were unaware of the services available. Community programmes could be established to provide support and link people into local services.

6. **Stigmatisation of particular BME communities must be avoided.** Professionals must work with and take advice from local community groups and young BME people. There must be consistency in all sexual health messages, i.e. the messages about unplanned pregnancy and STI prevention are the same whatever the target group. Imagery used for health education purposes should reflect the diversity of the local minority ethnic population, and not just focus on one minority ethnic group.

7. **There needs to be ethnic diversity in the staff employed within reproductive and sexual health services.** This may be a long-term goal within some communities, e.g. it may be difficult to recruit Bangladeshi people to work in sexual health services. In the short-term services need to ensure that staff receive ongoing support, training and supervision on working with young BME people. Staff need to be aware of cultural and religious factors that may affect young people’s values and behaviours, while at the same time avoiding stereotyping.

8. **Those working with young BME people in the community should be offered training on sexual health and they should provide a link to local sexual health services.** Partnerships need to be established with sectors, such as the youth service, voluntary and community based organisations where there may be greater representation of people, and particularly men, from BME communities. Professionals working in the community, particularly youth workers, have a key role in addressing sexual health alongside, for example drug and alcohol use, and emotional issues such as low self-esteem.
9. Additional reassurances around confidentiality and the right to freely available contraception without their parents’ knowledge may need to be given to BME young people. In particular, this was a concern of young Indian people whose GP was also Indian. Further research and training is needed in this area.

10. Health care workers providing pregnancy counselling to young BME women may need to offer ongoing support. Young BME women who find themselves pregnant, particularly those from Bangladeshi and Indian communities, will often keep the pregnancy a secret. Therefore support from family or friends may be lacking. Whether they decide to continue with the pregnancy or have an abortion, health care workers need to offer ongoing care.

9.5. Conclusions

This study illustrates the multifaceted influences on young Bangladeshi, Jamaican and Indian people’s attitudes and behaviours with regards to sexual health and teenage pregnancy. Although many of the issues raised were relevant to all young people, there were often specific values influenced by culture and religion that shaped views and behaviours of the young people within these communities. A theme that was consistent throughout this research was that young people (whatever their ethnic background) who were confident and had high educational and career aspirations were keen to delay pregnancies until they were independent, older and financially secure. Some BME communities have higher levels of unemployment and are at a disproportionate risk of poverty. It is therefore not just a case of focusing on health services when trying to improve the reproductive and sexual health of some BME groups. Inequalities elsewhere need to be addressed, such as improving education and employment opportunities.

Many of the recommendations made by the young people, parents, health and education professionals, and community representatives were consistent with recommendations made in the guidance documents produced by the TPU on working with young people and young BME people (Teenage Pregnancy Unit, 2000a and 2000b). Yet, there is still evidence that some young BME people have poor knowledge of reproductive and sexual health, find it difficult to access the appropriate services and are putting themselves at risk of unplanned pregnancies and STIs. Professionals and community representatives felt there were examples of exciting and innovative projects with young BME people going on. However, much of this work was done in isolation at grass root levels, was poorly funded and not widely disseminated. There would be significant value in setting up a national database of projects, so that professionals can seek advice and support from others, learn from their successes and be able to address any challenges. Also, it is very early days. It has been stressed throughout this report that setting up sustainable, effective and acceptable programmes with young BME people takes time. Therefore, adequate time and resources are needed to allow quality programmes to develop and flourish and to undertake meaningful evaluations.
References


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VERSION 3

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Job Number: 1156 - 846

Hadley House
79-81 Uxbridge Road,
Ealing, London,
W5 5SU

BMRB International
Job Name: Sexual Health

Date:

PLEASE WRITE IN BLOCK CAPITALS

Mr/Mrs/Miss/Ms: Initials: Surname:

First name: 

Address: 

Post Code: 

Telephone: 

QUOTAS:
SEE RECRUITMENT SPECIFICATION

Region
- London
- Birmingham
- Manchester

Sex
- Female
- Male

Age
- 13-15
- 16-18
- 19-21

Ethnicity
- Jamaican
- Bangladeshi
- Indian

Sexual health knowledge
- 1
- 2
- 3
- 4

Depth Details: 

Research Areas:

Variable times

Face to face recruitment: 1
Telephone Recruitment: 2
Delivered Invitation: 3
Sent Confirmation: 4
Confirmed Attendance: 5

IMPORTANT: PLEASE REFER TO INSTRUCTIONS FOR COMPLETE STUDY

RECRUTER'S DECLARATION

The person named above has been recruited by me in accordance with the instructions and within the Market Research Society Code of Conduct.

Signed: ____________________________ Date: ____________________________
Print name: ____________________________ 

BACKCHECKED

Signed: ____________________________
Print name: ____________________________ Date: ____________________________

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“Good morning/afternoon, I’m from the British Market Research Bureau. We are carrying out a research project among young people to find out their views on sexual issues, such as contraception, pregnancy, young parenthood and sexual activity. The project is being funded by University College London (UCL) and the Department of Health.

Do you or any of your close friends or relatives work in any of the following industries or professions?

<table>
<thead>
<tr>
<th>Industry/Profession</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Research / Journalism</td>
<td>1*</td>
</tr>
<tr>
<td>Central government department or agency</td>
<td>2*</td>
</tr>
<tr>
<td>Health profession</td>
<td>3*</td>
</tr>
</tbody>
</table>

If any marked (*) professions mentioned close.

Explain as appropriate

- The nature of the methodology – Depth interview
- Confidentiality and anonymity of respondents
- About BMRB and UCL
- Explain purpose of study
- Explain and hand-out information letter
Q.1 Note Respondent’s (young person’s) sex

Male
Female

Q.2 How old were you last birthday?

Write in ____________ and then code:

Under 13 1
13-15 2
16-18 3
19-21 4
22 or over 5

Q.3 For this study we will be carrying out depth interviews with young people from minority ethnic communities. I am going to read out a list—please tell me which best describe you

Read and code

BOX 1
If people only choose ‘British’ ask: Any other?
If answer is ‘no’, close

British 1
White 2
Black-Caribbean 3
Black-African 4

Black-Other, write in ___________________________ 5

Indian 6
Bangladeshi 7
Pakistani 8
None of the above 9

If none of the above, how would you describe your ethnicity?

CONTACT OFFICE
Write in: __________________________

Q.5 Which Caribbean Island(s)?
- Jamaica 1
- Trinidad & Tobago 2
- Barbados 3
Other, please write in __________________________ 4

SHOW CARD A and ask Q.6

Q.6 Which of the statements on ‘show card A’, best describes your knowledge of sexual/sexual health issues?

Show Card A
1. I don’t feel I have any knowledge of sexual/sexual health issues
2. I have a little/some knowledge of sexual/sexual health issues
3. I feel knowledgeable about sexual/sexual health issues
4. I am very knowledgeable about sexual/sexual health issues

We would like you to take part in an interview. The interview would be confidential and would take place at a time convenient to you and the researcher will visit you at home or another convenient location.

Would you be willing to take part? Yes 1
No 2

The interview will be held on:

………/………/……….. (Date), at …………. (Time)

THANK AND CLOSE
Sexual and reproductive health of young people from Ethnic Minority communities

Overall Aim:

- To gain a better understanding of the attitudes and behaviour of Bangladeshi, Indian and Jamaican young people relating to sexual behaviour, contraceptive use, pregnancy and young parenthood.

1. INTRODUCTION

- About BMRB and UCL

- About the research
  - It is about young people’s views on sexual behaviour, contraceptive use, pregnancy and young parenthood.
  - There has been some research into the views and experiences of adults from ethnic minority groups, but very little on the views and experiences of young people from ethnic minority groups.
  - This study will provide further information on the views of younger people from Bangladeshi, Indian and Jamaican communities.

- Commissioned by Teenage Pregnancy Unit (part of DH)

- Length of interview

- Confidentiality

- Tape Recording

2. PERSONAL CIRCUMSTANCES

- Can you tell me a bit about yourself
  - Age
  - Who live with respondent (relationship)
  - Family/carers/siblings (ages)
  - School/employment
  - Where born
  - Parents: where parents born/how long they have lived in UK (if born outside UK)/occupation
  - Languages they speak – different language spoken at home and/or with Parents/carers’
- Religion / beliefs - how different from religion / beliefs of parents/carers and peers
- Friends – how know: probe – school, family, work
  - probe: ethnicity, religion, culture of friends

3. LEARNING ABOUT SEX

*Note to researcher: See matrix one ‘Learning about sex’. Go through and complete Matrix with respondent.*

4. SEXUAL HISTORY

*Note to researcher. See matrix two 'sexual History'. Go through and complete with respondent. Reassure respondent of confidentiality at this stage.*

5. ATTITUDES TO SEX AND RELATIONSHIPS

- Explore respondents attitudes towards the following:
- Sex before marriage / cohabitation
- Casual sex e.g. one night stands / number of partners
- Arranged marriage
- When to have sexual relationships or encounters –probe: age and point in relationship

*Not to researcher: Can use body map to help uncover respondents' views of type of partner
- Type of partner: probe - choice of partner, age, sex, race preferences, religious preferences
- Explore how their views of sex and relationships differ to those of their: partners; friends; parents and parents’ generation; and culture in general

6. PREGNANCY AND PARENTHOOD

**Teenage pregnancy**

- Explore respondents experience of teenage pregnancy –probe: Personal experience, experience of friends, family and any other
- What do they think about teenage pregnancy
- What impacts on respondent’s attitudes towards teenage pregnancy – probe: parents / carers, friends, family, culture, religion
- Explore what they would do if they thought they (or their partner) might be pregnant
- Explore views on abortion
- Explore the perceived differences between their views and the views of their: parents and parents’ generation, family, friends, religion and culture in general.
• How ‘typical’ do they believe their views are compared to other people of their own age group

Parenthood
• Explore the respondents experience of teenage parenthood - **probe:** Personal experience, experience of friends, family and any other
• Explore their attitudes towards teenage parenthood
  • What impacts and influences their beliefs and attitudes towards teenage parenthood
  - **probe:** parents/ carers, friends, family, culture, religion

• Who would provide the support network if they had a baby - family, friends, health services
  • Explore emotional support and practical support (e.g. who will help bring up / look after the baby, provide financial support)

• Is teenage parenthood a problem in their area and within their ethnic community
• When do they perceive it to be the ‘right time’ to have a baby
• What influences this view
• Explore the perceived differences between their views and the views of their: parents and parents’ generation, family, friends, religion and culture in general regarding teenage parenthood
• How ‘typical’ do they believe their views are compared to other people of their own age group

6. CONTRACEPTION AND CONTRACEPTIVE SERVICES

Contraceptive methods
**Explore:**
• Knowledge of different methods
• Attitudes towards contraception (including emergency contraception)
  • What factors influencing preferences and those that put interviewee off using a method
• Importance of cultural, religious factors on contraceptive choices
• Views of safety, efficacy and acceptability of methods; double protection (from STIs and pregnancy)

Contraceptive services

*Note to researcher: get the respondent to visualise a visit to the family planning clinic and get them to talk through their imagined experience of attending step by step. For instance, get them to describe: what it would look like, how they would feel and who would be there.*
Probe:

- Where it would be located
- What would it look like from the outside
- What would it look like inside - big/ small
- Who would be there - receptionist, nurse, doctor, other people
- Where would they wait
- Would it be private/ confidential
- How would they feel
- What concerns would they have
- Would there be any posters or leaflets available

- Explore if visualisation based on perception or experience
  - Briefly explore respondents actual experiences and opinions of services (those who have accessed services for advice or supplies)
    - How many times have accessed services
    - What service did they access
    - Who did they see
    - Any problems with service
    - Any improvement that could be made

- Explore where they would obtain contraception or advice about contraception – probe: informal information from friends, family V formal information from health professionals
  - What would prompt them to seek advice
  - Would anything influence their choice – probe: gender, culture, religion, views of others - family, friends, health professionals
  - Would anything hinder access to contraception services (if expressed any concerns/fears during visualising exercise explore if these would hinder)
    - Possible ways could be overcome

- Knowledge of media campaigns connected to teenage pregnancy/sexual health – probe: TV, radio, magazines, leaflets
  - Explore views and opinions of these campaigns – how appropriate to them, imagery
  - How could they be improved

Explore the following:

- What the word ‘confidentiality’ means to them
- How important it is for services to reflect needs of black and ethnic minority communities, e.g. staff representation, imagery, language
- What improvements should be made to information available about sex / sexual health / contraception / pregnancy
- Who should be targeted / ages / type of information required
- What improvements should be made to services providing contraceptive advice and supplies - what should be done differently
7. ATTITUDES TOWARDS BEING QUESTIONED

- Explore respondents attitudes to taking part in the study:
  - How the respondents felt about taking part in the interview
  - What do they think about a study like this being carried out
  - Their reaction when initially introduced to the study on the doorstep
  - Reactions to letters and leaflets

- Explore views on types of questions being asked:
  - subjects
  - language
  - difficult / embarrassing questions / not understood
  - Any better ways of being asked and responding to certain questions
  - How easy is it to be accurate and honest

- Type of interviewer -:would it make any difference based on: gender, age, ethnic group
  - Anything the respondent did not talk about - probe: as were unsure about relevance, too embarrassed

- Are their any other issues the respondent wanted to discuss
- Check if any questions for the researcher regarding the study

THANK AND CLOSE
Appendix 3: Body maps

Some of the body maps drawn by the young people during the interviews are included below.

Body map 1
Body map 2

IDEAL PARTNER

Religious

Don't mind

Look like jews, in the back

Not smart, needs IQ

Body map 3

Good dress sense

Sense of humor

Nice, well done

Good looking

Asian
Appendix 4: Life matrices

Focus the discussion

The matrices were felt by researchers to have focused the respondents’ minds on specific issues or questions that were written down on the matrix, as not only did the researcher tend to speak the question aloud, but the respondent could also take their time and read the question, which was written clearly on the paper.

Aid recall

Moreover, by dividing the responses by age (11 or under; 12-15; 16-17; 18 plus), it was thought to have helped the young person to think about what they knew or had learnt at specific stages of their life. Linking the age stages to school years was thought to be a particularly effective way of helping the young person to remember what they knew or what experiences they had at any given stage. For instance, you could ask ‘what did you know about this before going to secondary school?’, or ‘what did you know during the first couple of years at secondary school?’.

Reduce the pressure

Using the matrix was also thought to reduce some of the pressure the young people may have felt as a result of discussing sensitive issues, such as sexual experience with the researcher. As it was felt that by focusing on the paper matrix some of the potentially confrontational contact between the respondent and the researcher was removed. For example, it removed some of the eye contact between the researcher and the respondent which may have made the respondents feel uncomfortable and also meant that where appropriate, the respondent was able to read the questions for themselves, rather than being asked directly by the researcher. For sensitive questions, for instance, the researcher was able to adopt a more flexible approach by either asking the question verbally; pointing to the question and asking ‘what about this question?’; or using a combination of the two approaches.
Matrix 1: Learning about sex

At these different ages:

<table>
<thead>
<tr>
<th>Aged 11 or under</th>
<th>Age 12/15</th>
<th>Age 16/17</th>
<th>Age 18 plus</th>
</tr>
</thead>
</table>

What sort of things did you know/learn about sex (helpful? anything misleading?)

Probe for:
- physical (oral sex, vaginal sex, anal sex, other)
- relationships
- marriage
- contraception
- communicating with a partner
- infections and diseases
- safer sex

How did they feel about talking about sex at age … (dependent on who with? …)

Who did you find things out from?

Probe for:
- family (including extended family, family friends, grandparents, other carers)
- friends
- school (eg sex and relationship education)
- media eg magazines, TV, internet, cinema
- other (eg faith leaders, cultural events/rites)

What else influenced their learning and views towards sex

Probe for:
- Attitudes and behaviour of other people (parents, other young people, people within the same ethnic group)

Religious influences
- The media
- Cultural factors
- Friends and peers group

What influences do they believe were most important

Looking back, anything they weren't told / wished they had known earlier

Preferred sources of information

What should people know at certain ages …
Matrix 2: Sexual experience
At these different ages:

<table>
<thead>
<tr>
<th>Age 11 or under</th>
<th>Age 12/15</th>
<th>Age 16/17</th>
<th>Age 18 plus</th>
</tr>
</thead>
</table>

What sexual experiences have you had, probe - on first time had sexual intercourse and any subsequent experience

Can you give some details about the experience, for instance what happened

Probe for:
- Details of partner and type of relationship - how met, how long, whether relationship was casual or it continued
- Decision making process - any reasons, how it came about
- How did you feel about these experience - did you feel ready/ happy. If felt unhappy, explore what they felt unhappy about
- Whether used contraception: extent of use, what used, explore reasons (any emergency contraception)

Whether discussed contraception with anyone - who discussed with: Family, partner, friends, GP, nurses and how felt about this

Focusing on your current partner (if applicable), can you tell me about your

Probe for:
- How met, length of relationship, type of relationship - casual/ serious
- Importance of sex to the relationship - when first had sex, how often do you have sex
- Do you communicate about sex; do you talk about sex, do you initiate sex (how feel about this)
Exploring the attitudes and behaviours of Bangladeshi, Jamaican and Indian young people in relation to reproductive and sexual health

Frequently Asked Questions (FAQ)

1. Why have young people been targeted in this piece of research?
   ♦ The UK has the highest teenage pregnancy rate in Western Europe.
   ♦ Sexually transmitted infections are particularly high amongst 16-19 year olds.
   ♦ Young people often find it difficult to access sexual health services. Therefore research is needed to investigate ways of making services more attractive to young people.

2. Why people from Black and ethnic minority (BME) groups?
   ♦ There is some evidence from research that some BME groups have poorer reproductive and sexual health.
   ♦ There are concerns that current sexual health services are not accessible to people from BME groups.
   ♦ Very little research has looked at the concerns of young people from BME groups with regards their reproductive and sexual health, and how services could be improved to meet their needs.

3. And why Bangladeshi, Indian and Jamaican people in particular? Won't focusing on the three groups just stigmatise people from these communities?
   ♦ This research is focusing on individuals' ethnic or cultural identity and its effect on sexual health beliefs and behaviours. It is not focusing on their racial identity (e.g. White, Black, Asian).
   ♦ Previous research, conducted by one of the research team members (Dr. Kevin Fenton), focused on the sexual health beliefs and behaviours of adults from Bangladeshi, Jamaican and Indian communities. Participants in that study identified themselves from these ethnic groups and were happy to be included in the study on this basis.
   ♦ We will therefore be able to compare these previous findings with those obtained from young people in this study to see if there are any differences between the age groups.
   ♦ We will be looking at the findings across the ethnic groups for the purpose of providing recommendations for policy and sexual health service delivery. The aim is to improve health care for young people from BME communities.

4. But don't young people from these groups see themselves as British?
   ♦ Ethnicity is a fluid concept - a person may identify themselves as being Jamaican among predominantly black friends, but as Black British or Afro-Caribbean among a group of white British colleagues. Our previous work suggests that people are comfortable with assuming particular ethnic identities and do so with relative ease.
   ♦ At recruitment young people and parents of young people will be asked how they define their ethnicity. People who define themselves as only British will not be invited for interview or participation in the young people’s/parent’s discussion groups as the focus of this research is cultural and ethnic identity.

5. What methods are being used in this research?
   ♦ The research will take place in three cities: Birmingham, London and Manchester.
   ♦ 75 interviews have been carried out with young people aged 13-21 who identified themselves to be Bangladeshi, Indian or Jamaican.
   ♦ These interviews will be analysed to provide a better understanding of what influences young people’s beliefs and behaviours around their reproductive and sexual health.
   ♦ The results will be presented back to local groups of young people, parents, and health care and community workers so that discussions about the way forward can be held.
6. **Is this study ethical?**
   - This research has been independently assessed by an Ethics Committee to ensure that it is ethical.
   - All those who agree to take part will be informed of the purpose of the research and will be asked to sign a consent form.
   - Any participant can agree to withdraw from the study at any stage without giving a reason.
   - All of those agreeing to participate will remain anonymous.

7. **But what about young people aged under 16?**
   - In addition to the young person’s consent, parental consent will be sought for this age group.

8. **What are the results going to be used for?**
   - The results will be written up for a report for the Teenage Pregnancy Unit (based at the Department of Health).
   - Papers will also be written for academic journals.

9. **Will participants have access to the results?**
   - A summary report of the results will be made available on the Teenage Pregnancy website – [http://www.teenagepregnancyunit.gov.uk](http://www.teenagepregnancyunit.gov.uk)

10. **Is this project going to make a difference?**
    - This piece of work is part of a wider research programme that is linked into the Teenage Pregnancy Strategy.
    - The research findings will help inform national policy on how best to ensure sexual health services are meeting the needs of young people from BME communities.
    - As the findings are also being fed back to local individuals and groups, it is hoped that the information could be used to help young people and services at this level.

11. **What experiences do the research team have in this area?**
    - The research team has a wide range of expertise and experiences that are relevant to this study. These include research into ethnicity and sexual health, sexual health service evaluation, and working with community-based organisations and young people.

If you would like any more information about this research, please contact Rebecca French on 020 387 9300, Ex.8190 or by email on rfrench@gum.ucl.ac.uk