An assessment of the fertility control health needs of women from Eastern European countries requesting abortion in Aberdeen/Aberdeenshire

A report for NHS Grampian

January 2008

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Acknowledgements

The present health needs assessment formed part of the public health module of subspecialty training in Sexual & Reproductive Health Care for the Royal College of Obstetricians & Gynaecologists.

Dr Diana Webster, Professor Cairns Smith, and Dr Padam Simkhada from the Department of Public Health, University of Aberdeen gave advice and guidance on undertaking a health needs assessment and performing research on ethnic minorities and where English is either a second language or not spoken.

Mr. Nigel Firth, Equality and Diversity Manager, NHS Grampian and Barney Crockett, Director of Grampian Racial Equality Council, provided service data and statistics and commented on the questionnaire and study protocol. We would like to thank them for their interest and willingness to share information and experience working with ethnic minorities.

Professor Siladitya Bhattacharyya, head of the Department of Obstetrics & Gynaecology, gave his support to the project and peer reviewed the project protocol and questionnaire.

Helen Strachan, Service Manager, Department of Obstetrics & Gynaecology, gave her support to the financial implications of the assessment and NHS Grampian acted in the role as sponsor.

Dr Gillian Flett, head of service Centre of Sexual & Reproductive Health Care, also supported the project and gave comments on the questionnaire and report.

Kathleen Sommers, clinic coordinator, and medical and nursing staff from the pregnancy advisory service assisted by identifying potentially suitable women and promoting the project.

John Cooknell, Resource Manager- Language Line, provided information to the local ethic's committee.

Above all we would like to thank the women from A8/ Eastern Europe who unanimously agreed to being interviewed during what would have been a particularly difficult time. Their cooperation was much appreciated.

Susie Logan, November 2007
EXECUTIVE SUMMARY

1. Background

This health needs assessment project grew out of observations made by the pregnancy advisory clinic’s staff about a rise in the number of women from a8 & Eastern European countries requesting termination of pregnancy (TOP). Many were perceived to have limited English proficiency (LEP) and this was felt to impact negatively on the overall running of the service.

Since joining the European Community in 2004, it has been estimated that 1200 migrants from a8 & Eastern Europe come to Grampian each month. The workers and their families now make up 8.4% (46,108) of Grampian’s population, the largest change in its history. Approximately half are Polish, averaging 25-30 years in age, and most are settling permanently in Grampian.

Migration is recognised to increase both vulnerability and risk, with access to health care a challenge. Those with LEP constitute a particularly vulnerable group. The last ten years have seen increased female migration, with sexually transmitted infections (STI), unwanted pregnancy, and poor knowledge, access, and advice on contraception, common among migrant women. Risk factors such as social pressure, cultural naivety, and more immediate priorities such as employment, increase a migrant’s vulnerability to sexual ill health. Furthermore, almost half of all pregnancies in Eastern Europe end in abortion, with rates four times that in Scotland in 2003.

2. Research

This health needs assessment examined the fertility control health needs of women from a8/Eastern European countries requesting abortion in Aberdeen/Aberdeenshire. Our research was guided by the following three questions:

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1. Eight countries from Eastern Europe who joined the European Union- Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, & Slovenia
2. Russia, Romania, Moldova, Transdniestria, Belorus, Bulgaria, Ukraine, and the Balkans minus Greece
1. Are there inequalities of access to fertility control services for women from a8/Eastern European countries?
2. What are a8/Eastern European migrant workers perception of needs and priorities for fertility control?
3. What are the priorities for the most effective service planning and resource allocation for fertility control in female a8/Eastern European migrant workers?

The assessment combined both qualitative and quantitative methods of investigation. It piloted the use of a semi-structured questionnaire, administered by an interviewer, to both English-speaking and non English speaking a8/Eastern European women requesting abortion. Ten women were recruited between November 2006 and February 2007. Telephone interpreting, where appropriate, was performed using Language Line.  

3. Findings

General
The ten women ranged in age from 18-43 years, with a mean age of 27 years. Five different countries of origin were reported- Lithuania, Latvia, Poland, Slovakia, and Czechoslovakia. Most had lived in Scotland for less than a year (range 1-24; mean 10 months). Russian was the most common language spoken and read at least “a little” by the participants. Only three of the ten women reported that they spoke English well or very well and Language Line was required for 7/10 interviews. Employment and financial opportunities were the most commonly reported reason for migration and all were employed in unskilled jobs. The majority resided in Aberdeen City (6/10), with the rest residing in Peterhead (3/10) and one in Huntly. For the majority (6/10), their partner was from their country of origin, having either come to Scotland together or met whilst here. Two had Scottish boyfriends and two pregnancies resulted from casual encounters.

Fertility and Fertility Control
For six women, this was their first pregnancy. Four women had children and three gave a history of previous abortion. These three women were the eldest in age and this one in three rate is similar to UK statistics. The majority stated they would have to pay for an abortion in their country of origin. Responses were mixed when asked if they would have requested an abortion back home with replies

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10 Language Line (www.languageline.co.uk)
11 Birth Control Trust. Abortion Provision in Britain – How services are provided and how they could be improved. London: Birth Control Trust; 1997.
influenced by the vulnerability of their migrant status and the prescriptive moral climate they had left behind.

When questioned about past contraceptive use, the majority reported use of “pills” and condoms for which they had paid. Many had arrived in Scotland with contraceptives but ran out of supplies. As such, contraception at the time of this pregnancy consisted of either no method or one associated with higher failure rates (condoms or withdrawal). Post abortion, again, the majority thought they would opt for short-acting methods with 7/10 and 2/10 thinking they would use “pills” and condoms, respectively. There was little pre morbid knowledge about the Long Acting Reversible Contraceptive (LARC) methods, which are more effective in preventing pregnancy than those associated with user failure. As such, only a minority considering using depo medroxyprogesterone acetate (DMPA) (2/10), intrauterine (IUD)/intrauterine system (IUS) (2/10), or the progesterone only implant (POI) (1/10). Three women commented that they had never heard of these method options.

Use of Health Services
Overall, the women in this study were more likely to visit the library, supermarket, or chemist than their general practitioner (GP). This reflected the priority that work had over health. Appointments with healthcare providers meant loss of earnings and perceived employer discouragement and job insecurity. Some women were clearly discriminated as, unlike their Scottish counterparts, they were asked for written verification of their healthcare appointments. Eight out of the ten women were registered with a GP, with one unsure and one unregistered. Half, however, registered in response to the pregnancy and for the majority (6/8), first contact was to discuss the pregnancy. Two had attended within the previous six months with flu-like symptoms and irritable bowel symptoms, respectively, but contraception had not been discussed. No other healthcare staff had been seen during this time. Only a minority (3/10) of women knew where the nearest Sexual & Reproductive Health Care (SRHC) Service was located. One had a Scottish boyfriend and the other had contacts who had lived longer in Scotland.

Regarding informal sources of information on contraception, none of the women mentioned Local Authority/voluntary sector agencies or drop ins/community groups/clubs. Most reported knowledge of condom availability from pharmacies (9/10) and grocery stores (8/10), but 8/10 did not know where to access free condoms. Of those that did, one had a Scottish partner and the other had only become aware of this when her GP told her at the time of her pregnancy test. Similarly, only two were aware

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that contraception was free in Scotland. Regarding emergency contraception (EC), while 9/10 women had some knowledge of its existence, only a minority (4/10) knew where to obtain it in Scotland. Again, the two women who mentioned SRHC services and their GP had Scottish partners. Pharmacies were mentioned by two women, with one having previous purchasing experience. One couple had seen an advert in a toilet and searched the Internet for information and a phone number. Two had brought supplies from home but run out. NHS 24, Accident and Emergency, community hospitals, gynaecology and genitourinary medicine (GUM) services were not mentioned.

Experience of Health Services
Only three women received any health advice on arriving in Grampian. One had a Scottish boyfriend, one had contacts who had lived in Scotland for a longer time period, and one reported advice when she started work.

For those who did access primary care under a non crisis situation, the opportunity to provide information and/or advice regarding fertility control issues appeared to have been missed at the time of registration, within waiting areas, and during consultations for non contraceptive health matters. Communication difficulties were anticipated by the women and strategies taken to overcome these included taking an English speaking partner/friend with them specifically to interpret or asking them to write a note. In some cases, unavailability of an English speaking/writing advocate delayed access to an appointment. No woman who required Language Line for the study’s interview was offered an interpreter in primary care. Comprehension was also a problem for those who did not speak and/or read English well. Friends/partners translated but not all the information was understood. Regarding the provision of information on abortion and contraception, only information on date, time, and place of pregnancy clinic appointment was given to these women. This contrasts with written information usually provided to English speaking patients. Reactions from the women were mixed and included frustration due to a lack of comprehension and appreciation for the effort made by the primary care staff to aid understanding by speaking slowly and using diagrams.

Only a minority had attended a SRHC service, with all requesting a pregnancy test and/or pregnancy advice. In contrast with primary care, the drop in service was universally utilised at a time that did not impact on work, a telephone interpreter was offered appropriately, and written information in English was given, though inconsistently. A negative comment was made regarding staff attitude.

The majority of women did not experience any delay in referral to the pregnancy counseling service, taking the traditional route through primary care or the SRHC service. The remainder relied on
assistance from friends and employers. In two cases, the pregnancy counseling service was not alerted to the patient’s language difficulties by primary care.

The majority (6/10) reported that any **oral or written information** on birth control method(s)/abortion care was preferred in their mother language. Even those with some knowledge of another Eastern European language stated that understanding would be compromised if only that language was available. This contrasted with the advantage of having an English proficient advocate who would translate. The Internet was mentioned as an information source that women accessed to back up information given during a consultation. There appeared to be benefit in obtaining a female interpreter when discussing fertility control issues.

4. **Policy Implications**

All Health Boards are required to monitor and evaluate the use/non-use of health services by ethnic minorities and there is good evidence that NHS Grampian has embraced the principles of equality and diversity. However, local clinical teams must also be proactive in developing and improving clinical practice in relation to their own areas of expertise. As such, the present study sought to examine the fertility control and service needs of a8/Eastern European women requesting abortion. It was the intention that the findings would inform NHS Grampian’s SRHC Department and its wider clinical network about how best to engage with this vulnerable group of women and guide policy at both strategic and operational levels. Furthermore, general conclusions and recommendations could also support the development of guidance and standards in other areas of Sexual Health and general health service delivery.

*What does the research imply?*

Extrapolating the clinic data suggests that a larger proportion of a8/Eastern European women are requesting abortion compared to their Scottish counterparts. Furthermore, consistent with average fertility rates, the majority will present within the first year of moving to Grampian.

**As such, local pregnancy counseling services should encourage NHS Grampian to take into account such patterns of “illness” in the planning and delivery of abortion services, assisted by prioritising the collection of ethnicity data for future monitoring.**

Prior to their unplanned pregnancy, fertility control needs were not deemed a priority. This reflected a combination of the precedence of work or study, financial pressures, insecurity associated with unskilled labour, vulnerability of migrant status, and instability of sexual relationships.
Accordingly, the local Equality and Diversity team and the Racial Equality Council should liaise with both employers/higher learning institutes and a8/Eastern Europeans to highlight the health and “business” gains from effective fertility control. The NHS Grampian Workplace Team should be approached for advice. Sexual & Reproductive Health Care services, Health Promotion, the Equality Diversity team, and the Racial Equality Council need to develop a language appropriate communication strategy highlighting sexual health matters and promoting the health benefits from learning proficient English. Furthermore, any approach must include Aberdeenshire, in view of the number of residing migrants.

This study found clear sets of empowering and hindering factors around personal fertility control for a8/Eastern European women.

Empowering factors included the following:

- Aids for those with limited English proficiency
  - Language Line availability and lack of cost
  - Scottish partner or English proficient friend/relative/work colleague
  - Effective communication between referring services regarding language needs
- Service organisation that reduced time off work
  - Drop in appointments
  - Fertility control provision from pharmacies and supermarkets
  - Longer prescriptions for “pills” and availability of LARC methods
- Information sources
  - Efforts made by workplace
  - Formal and informal information sources from local healthcare staff, even in English
  - Access to the Internet in libraries
  - Adverts placed in public toilets
  - Female interpreters
- A non judgemental and caring attitude by healthcare staff

As such, the local Equality and Diversity team, Racial Equality Council, and SRHC services should reinforce to NHS Grampian and Local Authorities, works and actions that benefit this vulnerable group. In particular, there is potential for expanding the current delivery from community pharmacies, libraries, and health promotion and extending the network to community hospitals, casualty departments, job centres, community centres, and supermarkets, to name a few.

With respect to barriers, the following was identified:
- Limited English proficiency
  o Contact with healthcare staff deferred until English speaking/writing advocate available
  o Peer groups/partners/work colleagues usually from similar ethnic background
- Financial priorities
  o Loss of wages attending appointments
  o Perceived employer discouragement to take time off work
  o Financial responsibilities in the UK and in country of origin
- Lack of awareness of contraceptive choices, availability, and lack of cost
  o Only a minority were aware contraception was free
  o Little to no knowledge/experience of LARC methods
  o Little or no knowledge of community sexual health services
- Lack of awareness of interpreter rights, availability and free provision
  o No Language Line usage in primary care
- Cultural issues around expertise in fertility control
  o Role of GP versus gynaecologist
- Lack of language appropriate written information sources throughout health services
- Within primary care:
  o Loss of self management opportunities
    ▪ Lack of information at the time of registration with a practice
    ▪ Lack of information in primary care waiting rooms
  o Loss of opportunistic discussion during other consults
    ▪ Extended role of the practice nurse
  o Long waiting times for appointments

Accordingly, the SRHC services should work with the local Equality and Diversity team, Racial Equality Council, NHS Grampian and Local Authorities to address deficits in locally relevant web based information sources and promote Equality and Diversity training for staff. Work with locality leads in primary care should prioritise awareness and use of Language Line and migrant issues in relation to service redesign. Within the SRHC core service, priorities include the translation of patient information on abortion, database collection of data on nationality and need for interpreter, increased LARC uptake in this group, and a telephone follow up to provide advice and support. Finally, the National Sexual Health Strategy Group should task the Sexual Health and Wellbeing Network to gather language relevant information sources and translate generic contraception and sexual health related leaflets as these will be required by all Health Boards.
Finally, in agreeing to take part in this study, these women have demonstrated their enthusiasm and willingness to provide patient representation and work effectively with local NHS services. 

*As such, NHS Grampian should be encouraged to proactively seek the views of A8/Eastern European migrants by commissioning research and development and involving representation from the Racial Equality Council when reviewing or designing services.*

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Section One: Introduction

Background

What is the problem?
The suggestion to undertake this health needs assessment project came from the pregnancy advisory clinic’s staff who had noted a rise in the number of women from a8 & Eastern European countries requesting termination of pregnancy (TOP). The service runs to a Royal College of Obstetricians & Gynaecologist’s (RCOG) standard that, as a minimum, “no woman need wait longer than 3 weeks from her initial referral to the time of her abortion.” In practice this means that access is stretched by demand and clinics are always booked to capacity. Staff were concerned that the service was becoming flooded by an ethnic group who used abortion as a form of contraception. There was also concern regarding the number of these women presenting with little or no English. This effected the running of the service, as interpreter assistance was required at all stages of the patient journey—medical history, examination, swab-taking, blood taking, trans vaginal ultrasound scanning, consent, priming, medical treatment, anaesthetic review, recovery, post operative review and care, blood and swab results, follow up, and readmission. It was perceived that consultations with a8/Eastern European patients took were much longer and impacted negatively on the overall running time of the clinics.

WORLDWIDE:

Migrants and health inequality:
As many as 190 million people are thought to cross borders every year. Poverty in one’s home country pushes people to look for opportunities elsewhere. Traditionally, migration is recognised to increase both vulnerability and risk, with access to health care a constant challenge. Even when health provision is available, perception of services and staff, cultural attitudes to health and healthcare, and communication problems, intervene. Confidentiality issues, shame, and alienation can further limit health care opportunities. In Moray, for example, migrant workers don’t routinely register with a general practitioner (GP) as many are resident for only three months before returning to their own country (personal communication, Andrew Fowlie, Moray Community Health & Social Care Partnership). Migrants may not be eligible for National Health Service (NHS) care or may simply not know where and how to seek help.

Female migrants and sexual health

The last 10 years have seen increased female migration. In 2005, women were estimated to make up 95 million of 191 million migrants worldwide.¹⁵ Unwanted pregnancy, poor knowledge, access, and advice on contraception, and STIs are common among migrant women.⁴⁻⁷ Policies such as single sex labour migration force people to migrate without their partners and increase recourse to casual sex. Risk factors such as social pressure, cultural naivety, and more immediate priorities such as employment, increase a migrant’s vulnerability to sexual ill health. Screening and health promotion programmes also tend to have a low uptake.⁵,¹⁶ Locally, discussions with a Latvian female representative about this project, found a perceived high prevalence of sexual & reproductive ill health as migrant workers are often separated from their partners back home and live in cramped, rented accommodation (personal communication, Barney Crockett, Director, Grampian Racial Equality Council).

a8/Eastern European women and abortion:

Accurate data on the number of induced abortions performed is difficult to collect in many parts of the world. In 2003, the most recent date for worldwide estimates, it was reported that about one in five pregnancies are terminated, with approximately 42 million abortions performed worldwide.⁸ Eastern Europe was the highest sub region (44 per 1000 women aged 15-44), four times that of Scotland.⁸,⁹ This equates to almost half of all pregnancies in Eastern Europe ending in induced abortion.⁸ The reasons for these high rates include scarce and expensive contraceptive services and supplies, free abortion services, financial incentives through private abortions for gynaecologists, lack of professional training & poor knowledge of contraceptive choices among consumers, health professionals, policy makers, and media representatives, and a lack of sex education in schools.¹⁷,¹⁸,¹⁹ As a result, couples had come to rely on abortion for control fertility. Compared with 1995 figures, however, Eastern Europe has shown worldwide to have the sharpest decline (90 to 44 per 1000 women aged 15-44) in abortion rates.⁸,²⁰ It is not clear is whether this decline represents the effects of under reporting through increased private sector services, more restrictive abortion laws, or improved access to contraception from international and national agencies.¹⁷,¹⁹,²¹

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Language barriers

People with limited language proficiency constitute a particularly vulnerable group for health service disparities. A detailed survey by GPs published by the Health Policy and Economic Research Unit of the British Medical Association (BMA) identified lack of a common language as the greatest barrier to delivering effective healthcare. Compared with English speakers, people with LEP are less likely to receive the care they need, have a poorer understanding of their care, are less likely to follow up recommendations for treatment and follow up visits, and be less satisfied with their care. Interpreting and translation are the terms used to describe the processes of changing spoken and written words, respectively, from one language to another. Research suggests that health care consultations requiring telephone interpreters are longer, more costly, and less satisfactory compared to face-to-face interpreters.

Health Needs Assessment definition

A health needs assessment is the systematic method of identifying unmet health and healthcare needs of a population, and making changes to meet those unmet needs.

LOCAL ISSUES:

a Eastern Europeans in Grampian

The last Scottish Census (2001) reported that ethnic minorities comprised an estimated 19,000 of Grampian’s population, with two thirds located in Aberdeen. Since joining the European Community in 1 May 2004, however, there has been a large influx of migrant workers into Grampian from Eastern European countries. The main countries of origin are Poland, Lithuania, Latvia, and more recently Estonia. While the Immigration Service and Practitioner Services are unable to provide statistics, some information has been gained from National Insurance numbers issued from job centres in Aberdeen and Peterhead. It is estimated that there are now 1200 migrant workers and their families coming into Grampian per month. These figures include only those in registered employment and do not include non-working family members. As a result, it is estimated that Eastern European migrant workers and their families now make up 8.4% (46,108) of the population of Grampian, the...
largest population change in its history. Approximately half are Polish in origin with an average age of 25-30 years and the most are not "migrant" but are settling permanently in Grampian. In comparison, during 2006/7, approximately 20 asylum seekers per month came to Grampian.

What is the size and nature of the problem?
In order to investigate the staff’s concerns, the Aberdeen Royal Infirmary’s (ARI) IMT department was asked to provide information on patient ethnicity or primary language. They reported that the hospital database does not specifically collect either data. Hand written records from Clinic B, ARI, which undertakes centralised booking of all TOP requests, recorded 72 women with a8/Eastern European sounding names attending 116 clinics between January 4 and August 1, 2006 (30 weeks). This equated to one a8/Eastern European woman being seen every 1-2 clinics or 2 ½ women each week. In 2006, 1447 women attended the pregnancy advisory clinic (TOP database, 2006). Extrapolating, this means that during 52 weeks of clinical work, 130 or 9% of women currently requesting abortion in Grampian were from a8/Eastern European countries.

It was also not known what proportion of a8/Eastern European women requesting TOP in Grampian have limited or no English proficiency. Between 4/1/06 – 31/7/06, 69% (119/172) of “Language Line” total usage in the acute sector was for a8/Eastern European translation (personal communication, Nigel Firth, Equality & Diversity manager, NHS Grampian). During this time, the TOP service was responsible for 19% (22/119) of the a8/Eastern European translations. The interpreter calls ran for a total of 199 minutes, equating to cost of £298.50. The following languages were requested: Russian (11), Polish (6), Lithuanian (4), and Latvian (1). This data does not accurately quantify the number of patients requiring interpreters, as those who used family or friends are not recorded.

What are the current services?

Legal and policy framework

National:
The Race Relations Amendment Act 2000 and Fair For All policy initiatives place a duty upon NHS organisations to promote racial equality and to develop strategies to reduce ethnic inequalities in health. The Fair For All report expressed concern regarding the inability of the NHS to take effective action to ensure their services were open and accessible to minority ethnic communities. The Scottish

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Executive HDL (2002) 51 Fair For All: Working towards culturally-competent services requires Scottish NHS organisations to:

- make a clear commitment to address the challenge of ethnic minority health
- develop a local demographic profile to facilitate effective planning of services
- ensure equitable access to services by all ethnic groups
- include ethnicity in human resource strategies
- involve ethnic minority communities in service development.

Furthermore, the Scottish Executive has recently highlighted the sexual health needs of ethnic minorities as a priority area of work.

Local:

Any organisation undertaking work on behalf of NHS Grampian, or supplying any type of service, must comply with the racial equality and diversity legislation. NHS Grampian has an Equality and Diversity manager whose working group produces an annual Racial Equality Action Plan. In 2006, the plan identified seven priorities:

- Interpretation and translation services
- Training NHS staff to better understand the needs of the local ethnic communities
- Access and service delivery
- Racial equality for staff working within NHS Grampian
- Actively promoting health within the ethnic communities
- Meeting the health care needs of recently arrived migrant workers and their families
- Introduction of Racial Equality and Diversity Impact Assessment for all NHS-Grampian-wide strategies or policies.

Induced Abortion Provision

Induced abortion is one of the most commonly performed gynaecological procedures in Great Britain, with around 194,000 terminations performed annually in England and Wales and around 13,000 in Scotland.34

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Scotland. At least one-third of women in the UK will have had an abortion by the time they reach the age of 45 years. Within Scotland, over 95% of induced abortions are undertaken because of risk to the mental or physical health of the woman or her children, over 99% take place in NHS hospitals, and 67% are undertaken under 10 weeks gestation.

NHS Grampian is the fourth largest Health Board in Scotland and provides a comprehensive healthcare service to over half a million people living in Grampian. The Pregnancy Counseling Service of NHS Grampian sees women referred for TOP from Aberdeen City, Aberdeenshire, Orkney, and Shetland. The service runs a minimum of four weekly, dedicated clinics at Square 13 (Centre for Sexual & Reproductive Health Care) and Clinic B, ARI. Medical support is provided by four SRHC consultants and three staff grade/associate specialists. Two full time nurse specialists lead the service, supported by members of nursing staff from Square 13. Following national trends, the demand for termination increased in 2006 with 1,447 patients seen (TOP database, 2006). On average, 20 medical terminations and 16 surgical terminations are undertaken each week. Medical TOP requires a single room on the gynaecology ward and is primarily undertaken as a day case procedure, though longer stays are not uncommon with higher gestations. A minority of early pregnancies undergo “home” abortion, discharged home after receiving tablets from the gynaecology ward. Surgical TOP is undertaken on one of two weekly, dedicated day case operating lists. The majority of these are performed under general anaesthetic. In 2004, the RCOG published a national evidence-based guidance document “The Care of Women Requesting Induced Abortion.” The recommendations and standards reported by this document form the framework for the service. Within the UK, the unit is unique in having a database in place since 1997 that collects demographic and clinical activity data on every patient.

Interpreter Services

All dedicated contraceptive and abortion services in Grampian are staffed by English speaking professionals. To overcome communication barriers, NHS Grampian employs two interpretation services- “face to face” and telephone. At present, there are “face to face” interpreters for 35 out the 82 different languages spoken in Grampian, but few or no interpreters for the less common Eastern European languages. During 2006/07, this service cost NHS Grampian £11,600.

NHS Grampian has also employed the services of “Language Line” the UK’s largest provider of telephone-based translation services. In existence for over 25 years, Language Line is used by large
multinational companies, Health Authorities, Police Constabularies, and Central and Local Government organisations, from nine global centres. They have a worldwide database of over 3000 tested, monitored and scheduled Interpreters. Language Line is able to provide interpreters on the telephone for 170 source or target languages within 60-90 seconds. It is available 24 hours, seven days a week. Approximately 70% of the interpreters are female and all are enhanced Criminal Record Bureau checked and subject to a strict Code of Conduct and Ethics that prevents them discussing calls with any third party (personal communication, John Cooknell, Resource Manager, Language Line). All general managers have agreed to pick up the revenue costs for this service in their clinical area, which currently runs at £1.50 per minute. For 2006/07 the total expenditure was £23,974 and this is expected to double in 2007/08. The most commonly requested A8/Eastern European languages in 2006 were the following (rank overall): Polish (1); Russian (2); and Lithuanian (3) (Figure 1). There are over 289 Access Points throughout Grampian (personal communication, Nigel Firth, Equality & Diversity manager, NHS Grampian) and use had increased, reflecting the rise in numbers of migrant workers and their families. Roll out to Aberdeenshire Community Health Partnerships (CHP) was to be completed by February 2007.

Figure 1: Language Line demand For the Five Most Commonly Requested Languages, month by month, 2006

Translation Services
Currently used contraception and abortion leaflets are in English and the family planning association (fpa) only produces its fact sheets and leaflets in English (personnel communication, Margaret

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McGovern, Information and Library Manager, fpa). A total of £20,000 was spent in 2006/07 translating key pieces of local health care information and personal health care information such as reports or letters.37 The NHS Grampian website has an “Other languages” section which holds “key pieces of local health care information”, including ones on cervical smears in Polish and Russian, respectively. These are also available from the Department of Health website.39 A contraceptive choices leaflet was translated into Polish, Lithuanian, and Latvian in November 2006, but this was unknown to the SRHC services until September 2007. In compliance with the Race Relations (Amendment) Act 2000, upon request, any NHS Grampian produced material will be translated and there is no limit to this budget. Regarding demand for translation and interpretation, the most commonly requested a8/Eastern European languages are the following (rank overall): Polish (1); Latvian (5); Lithuanian (6); and Russian (7). It is anticipated that Latvian and Lithuanian will rise to second and third, respectively, in the next 12 to 18 months.37

Staff Training and Public Involvement
Half day seminars are provided by Grampian Racial Equality Council (GREC)40 for managers and front line staff. The Equality and Diversity training covers background information on the cultural, ethnic, and religious needs of each of the main ethnic communities represented in Grampian. To date, 220 NHS Grampian staff have undergone training (personnel communication, Nigel Firth, Equality & Diversity manager, NHS Grampian), but no frontline staff in SRHC have yet to be trained. The ethnic patient voice within NHS Grampian comes from GREC and they work closely with the Racial Equality and Diversity Manager and his team to implement and achieve the NHS Grampian Race Equality Scheme 2005-2008.41

Targeted Health Promotion
While NHS Grampian and Multi-Ethnic Aberdeen have mounted a campaign to raise awareness of sexual health and HIV in local ethnic communities, a8/Eastern Europeans have not yet been targeted (personal communication, Fiona Aitken).

Data Collection
Ethnic group is not routinely recorded in either hospital discharge or primary care databases. Ethnicity, nationality, migrant status, or the need for an interpreter is not currently recorded on the TOP database.

NHS Health Scotland’s national health demonstration project “Healthy Respect”\textsuperscript{42} and a systematic review from Aberdeen University\textsuperscript{43} have both reported concerns about the lack of data on sexual well-being of young people from ethnic minorities in Scotland.

Research Study

Research Objectives

The present health needs assessment aimed to determine the fertility control health needs of women from a8/Eastern European countries requesting abortion in Aberdeen/Aberdeenshire. Specific objectives include the following:

1. To identify inequalities of access to fertility control services by women from a8/Eastern European countries
2. To determine a8/Eastern European migrant workers perception of needs and priorities for fertility control
3. To determine priorities for the most effective service planning and resource allocation for fertility control in female a8/Eastern European migrant workers.

This assessment addressed priority areas of work for the NHS Grampian Racial Equality Scheme Action Plan\textsuperscript{34} and had strong backing from GREC and NHS Grampian Equality and Diversity team. It was the intention that the information gathered and understandings achieved would inform the work of NHS Grampian and the National Sexual Health Strategy Group (NSHSG), with respect on how to engage with this migrant group in this specific area of Sexual Health. Furthermore, more general conclusions and recommendations could also support the development of guidance and standards in other areas of Sexual Health and general health service delivery.

This assessment piloted the use of a semi-structured questionnaire, administered by an interviewer, on both English-speaking and non English speaking a8/Eastern European women requesting abortion.


Methodology

Null hypothesis: The null hypothesis was that a8/Eastern European women requesting abortion in Aberdeen/Aberdeenshire did not have specific health or service provision needs for fertility control.

Methodology: The study used a mixed quantitative/qualitative methodology. A semi structured questionnaire, comprising closed and open-ended questions (Appendix 1), was administered by an interviewer (SL, principal investigator) to both English speaking and non English speaking a8/Eastern European women requesting abortion. The questionnaire was critically reviewed by a multidisciplinary group comprising NHS and University consultants in SRHC and public health, the director of GREC, and, through GREC, three female Eastern European representatives from Poland (2) and Latvia (1). In response, it was revised to include a further 15 open ended questions.

Study population: The eligible study population included all a8/Eastern European women attending a pregnancy advisory clinic, requesting TOP. Initially, it was planned to include only those women who had moved to the UK less than a year ago, but this was removed as an exclusion criteria in order complete recruitment by the end of the principal investigator’s training. In response to the background information collected from the clinic coordinator and Language Line, we proposed to recruit ten women, of whom two to three were expected to require an interpreter.

Process: The pregnancy advisory clinic uses a central booking service with all referrals from general practice or Square 13 going through the clinic coordinator in Clinic B, ARI. She alerted the interviewer by email or telephone to the date and time of the a8/Eastern European woman’s appointment.

For those referred from Square 13, a patient information sheet (PIS) (Appendix 2) describing the purpose of the study and the importance of their views, was given out or translated by Language Line, when a woman first requested referral following a confirmed positive pregnancy test. For those referred by their GP, the PIS was given out when they attended the TOP clinic, approximately one week after their referral. The use of Language Line was offered to translate the PIS and the length of time required to translate the PIS recorded in minutes. Those approached were given the opportunity to discuss the PIS, or ask further questions about the study by the pregnancy advisory staff. There was a suggestion that the PIS could be faxed to the patient’s GP at the time of referral, but this was not possible due to staff time constraints and confidentiality concerns. Similarly, for reasons of confidentiality, no written information concerning the clinic is ever sent to a patient’s home address.
Within the clinic setting, eligible women were approached by the interviewer while they were waiting to be seen by medical staff. These women were taken into a private clinic room and their understanding of the PIS was checked. Assurances were given that the interview would be confidential and that responses would not affect their future treatment in any way. The interviewer was not involved in their clinical care. Use of Language Line involved simultaneous two-phone connection and was used instead of friends or family members attending with the patient. Since the introduction of Language Line, the pregnancy advisory service has not routinely organised face to face interpreters when referral letters alert communication difficulties.

Recruitment at their initial clinic visit was decided for a number of reasons. It was noted by the pregnancy advisory staff that time away from work was a huge concern for these women. It was perceived that the majority chose surgical TOP as it required one less hospital visit and none took up the offer of an additional follow up appointment. For those who did opt for medical abortion, there was the opportunity to interview them when they attended for the priming tablet, 36-48 hours before the abortion. This was offered to all women who opted for the medical method and who had not had an opportunity to receive the PIS prior to their clinic appointment. It was strongly felt inappropriate to interview on the day of the abortion.

Informed written consent to permit storage and use of the data collected from the interview was obtained by asking participants to sign a consent form (Appendix 3). No data was collected on those who declined to participate.

The semi-structured interviews took place in a private clinic room and were timed. The questionnaire was administered by interview as we were advised that the interpretation of self-completed forms could be adversely affected by illegibility and misrepresentation by those with poorer English reading and writing skills. The questionnaire comprised sections on demographics, country of origin and primary language; length of residence in Scotland; occupation; contraception; contact with primary care and/or family planning services, referral to pregnancy advisory clinic; overall experience; and views on improving access to and information about contraception. Where applicable, the interpreter was asked, at the conclusion, to comment on the salience and cultural acceptability of the words and questions used by the interviewer. This was in response to an African study that found that some contraceptive terminology could not be translated.44 Answers to the questions from the patient or through the interpreter were recorded manually by the principle researcher and written up in full

immediately afterwards. A separate sheet collected selected demographic and clinical data from the medical notes.

Answers to the closed questions were reported as frequencies. For responses to the open ended questions, a thematic data analysis was performed by identifying themes from reading and re-reading the transcripts. The written transcripts of the interviews were independently analysed by two researchers (SL & EvT) in order to distill the emerging analysis and check on major themes. Where an association is indicated in the text, the results are based on unpaired t test statistics with a p value of 0.05 or less.

The project was given favourable ethical opinion for conduct in the NHS by the Grampian Research Ethic’s Committee and Grampian Research and Development on and 2 November 2006 and 7 November 2006, respectively. The assessment was unfunded but sponsored by NHS Grampian.

The patient’s GPs were not informed of their involvement in this study, as it is assessed their referral experience.

Outline of Report
The report is divided into nine main sections. In Section 1: Introduction, the background to the health needs assessment is outlined, the research interests described, and the methodology used in the study explained. In Section Two: The Study Group, a description of the sample of A8 / Eastern European who took part in the study is offered in terms of their socio-demographic characteristics and migration circumstances. In Section Three: Contraception and Pregnancy, their experience of contraception and pregnancy is reported. In Section Four: Use of Health Services, the use of services providing fertility control methods is examined. In Section Five: Experience of NHS Health Services, access to consultation and treatment, factors which more or less facilitated access to consultation and treatment, and ways of improving services are discussed. In Section Six: Timing of assessment and interpreter’s comments, the length of time the translated and non translated parts of the study took and the interpreter’s comments on the reproducibility of the questions, are reported. In Section Seven: Conclusion, an attempt is made to answer the research questions that guided the study. Section Eight: Recommendations, lists a number of recommendations based on the conclusions reported. Finally, Section Nine: Resource implications and evaluation, examines the potential resource implications and evaluation strategy for the proposed recommendations.

Section Two: The Study Group

This section offers a brief description of the a8/Eastern European women who took part in terms of their socio-demographic characteristics, past obstetric history, country of origin, language capabilities, and migration circumstances.

Sample size: Ten women were recruited between 21 November 2006 and 22 February 2007. Four women were missed while the principal investigator was on annual leave over Christmas and one woman declined to participate.

Age: Age ranged from 18-43 (mean 26.8; median 26) years.

Country of origin: Five different countries of origin were reported (Table 1).

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Number of women (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithuania</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Latvia</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Poland</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

Residence: six of the women lived in Aberdeen City and four resided in Aberdeenshire- Peterhead (3) and Huntly (1).

Months in Scotland: The number of months living in Scotland ranged from 1-24 (mean 10.05, median 9), with most living in Scotland for less than a year.

Reason for migration: A number of reasons were given for moving to Scotland (Table 2). Employment and financial opportunities were most commonly reported.
Table 2 Reason for migration

<table>
<thead>
<tr>
<th>Reason for Migration</th>
<th>Number of women (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work/financial</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Follow partner</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Study</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Learn English</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

* Percentage greater than 100% as women could give more than one answer

Study no 9- “In Lithuania I could not manage to provide for my family.”

Language comprehension: Russian was the most common language spoken and read at least “a little” by the participants (Table 3). Only three of the ten women reported that they spoke English well or very well.

Table 3 Languages spoken and read at least “a little” by participants

<table>
<thead>
<tr>
<th>Comprehension</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Russian N (%)</td>
</tr>
<tr>
<td>Speak</td>
<td>7 (70)</td>
</tr>
<tr>
<td>Read</td>
<td>6 (60)</td>
</tr>
</tbody>
</table>

Occupation: all ten women were employed in unskilled jobs such as factory work (5/10), bar tender/waitress (2/10), cleaner/hotel housekeeper (2), and care assistant (1).

Study no 8 "I am a care assistant in a nursing home like everyone else from Poland."

Recruitment: Only two women reported that a recruitment agency had been involved in their move. In other cases there was informal assistance through friends or relatives or they simply made their own arrangements.

Study no 1 “(Her) friend helped her. No formal arrangement though.”
Study no 9 “I personally arranged everything and stayed with a friend.”
Partner: In six cases, their partner was from their country of origin and they had either come to Scotland together or met while here. Two women had Scottish boyfriends and two pregnancies had resulted from casual encounters.
Section Three: Contraception and Pregnancy

This section offers a description of the A8/Eastern European women's past, present, and future contraception use, opinions on different methods, past obstetric history, previous abortion experience, and knowledge of abortion in their country of origin.

Contraception:

At the time of conception: Despite 8/10 women reporting condom use, this was not always the case at the time of conception. All women were using either no method of contraception or one associated with higher failure rates. One used no method, two were caught out by a casual encounter, and one had been trying for a child but now was financially unable to continue with the pregnancy.

Study no 9 “My friend came and it was New Year. I did not think.”

Two used the withdrawal method, with one using EC as a back up. The remaining four reported condom use with no known mishaps.

Study no 7” Withdrawal method but if we were not sure morning after pill.”

Only one woman had followed up the episode of unprotected sex with EC to prevent the pregnancy and this had been supplied by her gynaecologist in Eastern Europe.

Past contraceptive use: The majority of women (7/10 and 8/10) reported prior use of “pills” and condoms, respectively. The IUD and EC had each been used by one and three women, respectively. One woman reported no prior contraceptive use as this was her first partner. The majority (8/10) stated that they had paid for birth control in their country of origin. The other two were unsure, due to inexperience.

Study no 8- “Pills bought in (Polish) pharmacy.”
Study no 5- “Doesn’t know, first time having sex.”

Choice for post-TOP contraception: Again, the majority thought they would opt for short-acting methods with 7/10 and 2/10 thinking they would use “pills” and condoms, respectively. Two women specifically commented that their partners were responsible for condom provision. A minority considered using DMPA (2/10), IUD/IUS (2/10), and the POI (1/10). As there was little pre morbid knowledge about LARC, all were given brief information by the principal investigator about these methods.
### Study no 3 - “Boyfriend looks after this (condom provision).”
### Study no 2 - “Hasn’t heard much about (DMPA and POI), but maybe yes if got more information.”
### Study no 6 - “(DMPA) Possible. Would have more information.”
### Study no 8 - (Regarding choice of IUD/IUS) “Long-lasting, easy, I can’t do anything wrong.”

<table>
<thead>
<tr>
<th><strong>Unacceptable contraception</strong></th>
<th>The women were asked which of the full range of contraceptives available in the UK they would not use. Condoms were most commonly mentioned (8/10).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study no 8</strong></td>
<td>“I wouldn’t trust anymore.”</td>
</tr>
</tbody>
</table>

Reasons given for the other methods will be familiar to doctors prescribing contraception routinely - previous side effects, preconceived notions on drug delivery, side effects, foreign body and needle phobias, wishing to keep fertility options more open, male vasectomy phobia, and lack of awareness of the range of contraceptive choices available in the UK.

#### “Pills” and the combined contraceptive patch

| **Study no 8** | “because of my previous problems... Took 3-4 (different) pills to find proper one for me - moods, swelling” |
| **Study no 9** | “Don’t like the idea of using tablets.” |
| **Study no 9** | “Used contraceptives (clarified meant pills). I haven’t used them for a while now. They made me put on weight so I stopped taking them ten years ago.” |
| **Study no 10** | “(Patch) Don’t like those sort of things.” |

#### DMPA

| **Study no 4** | “I don’t like injections.” |

#### POI

| **Study no 1** | “Doesn’t like the sound of it.” |
| **Study no 6** | “Doesn’t like an object in her body.” |
| **Study no 7** | “No, three years is a long time. I might wish to start a family in that time.” |

#### IUD/IUS

| **Study no 2** | “Because you can have a pregnancy outside the womb.” |
| **Study no 3, 4, & 6** | “Wouldn’t feel comfortable having something there.”; “No, don’t like the idea.”; “Doesn’t feel right, doesn’t like an object in her body.” |
Study no 7- "No, (five to ten) years is a long time. I might wish to start a family in that time."
Study no 9- "I had problems (with an IUD). It got stuck and had to be cut out. I had pain, it wasn’t sitting properly, wasn’t put in properly."

**Female and male sterilisation**

Study no 1- "He will never agree (to male sterilisation)."
Study no 1- "(I want a) child in the future, maybe."

Three women commented that they had never heard of DMPA, the POI and IUD/IUS.

**Pregnancy**:

**Past obstetric history**: For six women, this was their first pregnancy. Four women had children and three gave a history of previous abortion.

**Previous abortion**: Of the three women with a history of previous abortion, in two cases there were marital difficulties, contraception had stopped, and the couple briefly reunited. One woman had a history of two previous abortions, the last in Aberdeen nine months previously. All three women were the eldest in age- 30, 32, and 43 years.

**Abortion in country of origin**: When asked whether they would have had to pay for an abortion in their country of origin, 8/10 stated they would. The other two were unsure having never had to consider the option. Patient costs were estimated between £30 and £150. One woman stated that there was a free service, but inferred that care was poor.

Study no 2- "two types of services (in Lithuania), free and pay. She would rather pay (£100) because of the quality of the service."

A Polish woman stated that abortion was illegal in her country but could possibly be obtained through the right connections.

Study no 3- "Probably very expensive in a private clinic. Unsure."

When asked if they had used abortion as birth control in the past, the three with a prior history answered affirmatively.

Study no 9- "I had a micro abortion about 15 years ago. An early one sucked out. No, similar circumstances. Wasn’t using anything at the time."
Current decision to terminate the pregnancy: When asked if they would have requested an abortion in their country of origin, the responses were mixed. In some cases, the vulnerability of their migrant status or the prescriptive moral climate they left behind influenced their reply.

Study no 3- “Too hard to answer. I cannot answer what it would be like. Situation would be different (abortion illegal in Poland, steady partner).

Study no 7- “It would depend on timing. In this case we have financial difficulties (and) was using a lot of alcohol at the time I got pregnant.”

Study no 8- “Now very conservative government (Poland). Churches too powerful, very influential, making difficult. Would be afraid of privacy and reaction of society.”
Section Four: Use of Health Services

This section reports on sources of health advice, both generally and specifically around fertility control, and Eastern European women’s use of GP and SRHC services.

The women were asked if they had got any health advice when they arrived in Grampian. The majority (7/10) replied that they had not. Health and fertility control were low priorities.

Study no 8- “Just get a job and start work.”
Study no 2- “She (translated) didn’t know anything at all”

Of the three who received advice, one had a Scottish boyfriend, one had contacts who had lived in Scotland for a longer time period, and one reported advice when she started work.

Study no 3- “(received advice from) boyfriend. Attended Square 13 for pregnancy test and big hospital (GUM) for HIV and other blood and swab tests.”
Study no 5- “Given written information when started work at (shortbread factory). In English and Russian. (Staff were given) questionnaire and information on GP, birth control, allergies, drink, etc, (in English).”
Study no 7- “My friend (boyfriend) explained things. I also had a friend who was a patient in a psychiatric hospital and visited her.”

Many patients confirmed the pregnancy counseling staff’s impression that time off work was an issue. What wasn’t clear was whether this was truly an issue with the employer or just perceived by the women. However, two women were asked to produce documentation of their clinic/hospital attendances and the majority (7/10) reported that there would be a loss of earnings associated with the clinic and hospital appointments.

Study no1- "They (employer) might not like her being late. Time off was arranged through an agency as doesn’t speak English. She would normally work today and won’t get paid now. Wouldn’t lose her job though.”
Study no 5- “Had to produce a paper to say in hospital. She will get paid if she gets letter from hospital.”
Study no 9- “There are not many workers there and too much time off would not be looked on favourably because they need the workers. They (employers) don’t say anything but I know they are unhappy.”
When asked where they would buy condoms, the majority was aware of provision from pharmacies (9/10) and grocery stores (8/10). No patients mentioned vending machines or the Internet.

When asked where they could get condoms free, eight out of the ten did not know this service was available. One woman mentioned Square 13 and GUM, but she had a Scottish partner and had attended both. The other mentioned that condoms were available from her local hospital (Huntly), but had only became aware of this when her GP told her at the time of her pregnancy test.

Similarly, only two women were aware that contraception was free in Scotland.

Study no 6 “Learnt today (that contraception was free).”

Regarding emergency contraception, while 9/10 women had some knowledge of its existence, only a minority (4/10) knew where to obtain it in Scotland. The two women who mentioned Square 13 and their GP had Scottish partners. Pharmacists were mentioned by two women, with one having previous experience of purchasing. One couple had seen an advert in a toilet and searched the internet for information and a phone number. Two had brought supplies from home. NHS 24, Accident and Emergency, gynaecology and GUM services were not mentioned.

Interviewer: Where would you get emergency contraception?
Study no 4- "GP’s, here (Square 13), maybe. (Anywhere else?) No, I don’t know."
Study no 5- "‘From chemist, she paid for that before. (Also) Huntly hospital. Didn’t know before, told by GP (at time of pregnancy test)."
Study no 6- “I had tablets from Latvia, used them up. Doesn’t know where to get them in Scotland.”

General Practice:
Eight out of the ten women were registered with a GP and one was unsure. The remaining woman had been in Scotland five months. Over half registered in response to the pregnancy.

Study no 1“ Friend filled in papers at clinic. Unsure what papers were about. Unsure whether registered.”
Study no 2- "(Registered) one week ago in order to get an appointment to this clinic."

The women were asked if they had visited a GP or any other healthcare staff in the proceeding six months. Seven of the ten women had seen a GP for the first time to discuss the pregnancy. Two had attended previously with flu-like symptoms and irritable bowel symptoms, respectively. None had seen other healthcare staff during this time.
Sexual & Reproductive Health Care (Family Planning) Clinic:

Only a minority (3/10) of women knew where the nearest family planning clinic was located. One woman had been told by her mother and two had Scottish boyfriends.

Study no 3- “Square 13, boyfriend knew.”

Study no 10-“ Through her Mom. Mom in Scotland but has never been here.”
Section Five: Experience of NHS Health Services
Eastern European women’s experience of primary care, SRHC, and pregnancy counseling services are detailed. Areas specifically addressed include access to information, consultation and treatment, factors which more or less facilitated access to information, consultation and treatment, and ways of improving services.

General Practitioner:
An opportunity to discuss fertility control health needs appeared to be lost at the time of non crisis registration and when attending for non contraception related appointments.

Study no 4- Interviewer: what did you consult about? “Flu. Did not discuss birth control.”
Study no 6-“When I registered with a GP I wasn’t given any information, for example birth control for free.”
Study no 8-“No health check when registered with GP.”
Study no 8- Interviewer: what did you consult about? “Last year, constipation and diarrhea. Diagnosed Irritable Bowel Syndrome. No discussion about contraception.”

Regarding GP appointments, a number of issues were raised-

1. **Making appointments**- Many anticipated communication difficulties and took an English speaking partner or friend with them down to the surgery to interpret. One woman got her friend to write a note.

   Study no 1- “Friend wrote down a note and she took it to the practice and got an appointment. (The note) explained her problem.”

   Study no 2-“I went there in person and my female friend translated.”

2. **Attending the appointment**- Problems with taking time off work, loss of earnings, and difficulty finding a friend who could take time off work to act as an interpreter were reported.

3. **Understanding the staff and advice given**- Comprehension was considered a problem by many of those who did not speak and read English well. Friends/partners translated but not all the information was understood. Only one stated she had “no problem” despite speaking English “not well.” However, she was the oldest, had previous experience of abortion, and may have had more confidence to deal with the communication difficulties. One brought a piece of paper with “details” written by her friend for the GP. The note finished with “any advice/instructions could be written down and the friend would interpret later.” Other than date, time, and place of clinic, no other written information was given to the women. Lack of
understanding brought frustration to one woman, while another appreciated the effort made by the staff to try and make her understand.

Study no 1- "Understood half of it (previous abortion in Aberdeen nine months ago)."
Study no 2- "She would have (had difficulties understanding the GP) if by herself, but got help from a friend.
Study no 5- "They tried everything so I understand good. Slowly speak English. Showed pictures. Boyfriend helped because he was with her."
Study no 6- "Boyfriend translated. Hard to understand."
Study no 7- "I haven’t received any advice, they just made me wait."

Those with good English had no such problems.

Study no 8- "(Understanding advice) very clear. For particular words, asked for explanation."

No woman who required Language Line for the interview was offered an interpreter in primary care. Some women commented that an interpreter would have helped.

Study no1- "Couldn’t understand everything. Helped if interpreter."
Study no 7- "I am really grateful for Language Line interpreter (during interview). Nice and good feeling someone communicating with me. “
Study no 8- "No she didn’t ask. Don’t know about translators/interpreters."

Overall, however, the majority (8/9) rated the service from their GP as GOOD. Only one woman gave a rating of NOT GOOD due to perceived delays in referral.

Study no 1- "Nice to her."
Study no 7- "Because I feel I would still be waiting without the help of my boss."

Sexual and Reproductive Health Care (family planning) Clinic:
Three women had attended Square 13 for a pregnancy test and advice in this pregnancy.

1. Making appointments- No problems were reported with all utilising the drop in service for testing, advice, and clinic referral.

Study no 3- ""Took me straight away."
Study no 4- “Just dropped in, not a long wait.”

2. Attending the appointment- No problems were reported as all used the drop in facility.
3. **Understanding the staff and advice given**- Only one of the three women did not speak English. Initially her boyfriend translated, understanding “not everything, but most.” Later on in the consultation an interpreter was offered but declined by the patient.

Overall, the family planning service was rated as GOOD by two women and FAIRLY GOOD by the other.

**Study no 3-** “(Staff) a little bit cold.”

**Pregnancy Counseling Service:**

The majority of women found out about the abortion service through their GP or Square 13. In the other three cases, a friend had had a similar problem, a female employer assisted, and a friend spoke to the receptionist of her GP’s practice, respectively.

**Study no 10-** “From another clinic, Torry. My friend talked to her receptionist because she could speak English.”

The majority (8/10) of women only had one healthcare appointment before attending the clinic. One patient was seen twice, once for a pregnancy test and then to discuss the result. The final woman was seen three times and recounted a catalogue of delays. Eventually the patient, herself, took steps to speed up the process.

**Study no 7-** “I knew I was pregnant because I had a home test. I saw a GP first because I had an allergic reaction- whole body red and swollen. Second (different) GP for pregnancy test. A week later she was referred to gynaecologist by another GP. Boss at work phoned and arranged for her to be seen by a gynaecologist and not wait a week… it took three weeks to be seen by the specialist.”

Only two out of the ten women were given written information about the abortion service. Both had attended Square 13. One patient reported she was unable to read it, but that a friend translated. None were formally given written information on birth control. One woman was asked to return to her GP after the abortion and one (spoke English “very well”) picked up a leaflet from the waiting room in Square 13. One woman had already been given pills by her GP, but had never used this method previously and could not understand the accompanying instructions. The Internet was mentioned as an information source that women accessed following consultations.
Study no 2- “GP told her that after visiting this clinic she should return and she would be given information.”

Study no 3- “I took it (written information on birth control) from Square 13 from leaflet rack.”

Study no 5- “Given boxes of contraceptive pill but no leaflet.” Interviewer- Inside pill boxes is written information. Were you able to read it? “Some of it.” Were you able to understand it? “unsure of all understanding.”

Study no 8- “Got (written information about birth control) from Internet after discussion with GP.”

Patients were mainly referred by a GP or Square 13 nurse. In two cases, the pregnancy counseling service was not alerted to the patient’s language difficulties by primary care.

The woman who had had a prior abortion nine months previously reported not taking up the offer of a review appointment.

Study no 1-“Declined follow up as thought not necessary and difficulty getting time off.”

One woman was able to compare interpretation from her friend at the pregnancy counseling clinic with Language Line for the interview.

Study no 6- “I understood the doctor and my friend helped when I didn’t understand. Language Line was much better, though. I understood everything…much prefer translation over phone.” (Speaks English not well)

Overall, the majority (6/10) reported that any written information would need to be in their mother language. One woman could understand “some” Russian, but it was her second language, and information in Latvian would be better. Another commented that it could be in English as her partner would translate.

Study no 5-“ Lithuanian. English- boyfriend would translate most.”

Finally, the women were asked about what was good and what needed improving about fertility control services in Aberdeen/Aberdeenshire.

Positive experience:
Three women complimented the availability of Language Line. In one case, it had not been available/used when she had her abortion in February 2006.
A non-judgmental attitude and lack of charge was appreciated by a woman with a previous bad experience in her home country.

Areas to improve:

One woman commented on the lack of relevant health information at her GP’s surgery and the missed opportunity to access health needs when she registered.

There were comments relating to long waiting times and lack of information prior to the pregnancy counseling clinic appointment.

They were also asked on how information about and access to birth control could be improved for Eastern European women residing in Grampian.
Information about birth control:
Most women gave suggestions. Lack of information about where contraception could be obtained and that it was free was emphasised.

| Study no 6- “When I registered with GP wasn’t given any information ie. Birth control for free.” |
| Study no 8- “GP could have suggested …leaflets to read.” |

Similarly, information about obtaining and using interpreters was suggested, as was translated leaflets/booklets. The idea of being issued an information pack when arriving in Scotland or through work was thought to be reasonable— "Of course it would help" (Study no 2). Others thought the Internet was the best portal for disseminating information in their mother tongue.

| Study no 7- “I think the Internet would be best place for to place information.” |
| Study no 9- "I would suggest Internet, information in Lithuanian. (Have information like) where free contraceptives are available, telephone numbers and addresses. |

Opinions were mixed on whether health information should be displayed at work, with one women citing efforts made by her workplace. Less contentious was the suggestion of putting leaflets/posters up at the libraries and pharmacies.

| Study no 5- “(Was) given written information when started work at (shortbread factory) in English or Russian. (Her employers issued a) questionnaire in English. Everyone from Lithuania does it together (fills it in). Information in English (included) GP, birth control, allergies, drink, etc.” (Patient spoke English “not well”, lived in Scotland 7 months, was unaware of free condoms, EC, and contraception, interpreter service, nearest family planning clinic, and could not understand accompanying combined oral contraceptive pill (COC) instructions that was prescribed by her GP). |
| Study no 6- “They (workplace) have no business and shouldn’t care about people getting pregnant.” |
| Study no 8- “(Suggest) poster in staff room at work with phone number of clinic.” |
| Study no 9-“ Put leaflets in places where people congregate. ie Canteens in workplace- stands with information eg. how to avoid getting attacked, multilingual; pamphlets in the library where people go to use the Internet.” |

Access to birth control:
Comments again emphasised difficulties getting time off work to attend appointments. Suggestions to deal with this issue included “easier appointments”, giving out increased supplies of pills (patient ran out of three month supply of COC after first abortion in Aberdeen) and use of LARC methods. Again
access was compromised by a lack of knowledge of free cost, of where advice and supplies could be obtained, and their right to interpreters.

| Study no 1- | "Interested in (LARC methods). Did know about them but not specifics. Wouldn't know how to ask for them." |
| Study no 2- | "A good idea if easier to get an appointment with GP for explanation because employers wouldn't be bothered about that. Because when you go to doctor you aren't paid and you end up sitting for a long time." |
| Study no 5- | "Don't know where to go for help or get birth control. More information about interpreters. Didn't know they were available." |

Comments suggested that access was limited by lack of contact with a gynaecologist and not utilising practice nurses.

| Study no 7- | "It would help when registering with GP to be able to register with a gynaecologist." |
| Interpreter explained that in Czechoslovakia, every woman has direct access to a gynaecologist for yearly check-ups including smears. Patient concurred, "avoid long wait with GP" (patient reported waiting three weeks to be seen at the pregnancy counseling clinic). |
| Study no 8- | "GP could have suggested to go to nurse to discuss (Patient had attended GP in the previous six months with Irritable Bowel symptoms but was not asked about contraception)." |
Section Six: Timing of interview and interpreter’s comments
Language line was required for seven of the ten interviews. The time required to translate the patient information sheet and consent form ranged from 6-14 (mean 9.7, median 10) minutes. The time taken to interview those requiring translation and those not ranged from 23-46 (mean 35.4, median 35) minutes and 19-29 (mean 24.7, median 26) minutes, respectively. This was not significantly different (p= 0.07).

The interpreters were asked to comment on any areas of the interview that were difficult to translate. In one interview, a Latvian interpreter was not available through Language Line and a Russian one was used. The interpreter admitted that this had caused some confusion as Russian was not the patient’s main language. They also admitted to altering the wording of some of the questions.

| Russian interpreter study no 1- “Occasionally had to slightly change sentences to make more plain language.”
| Russian interpreter study no 2- “Some required more explanation than just direct word.”

Some medical words were reported as difficult to translate.

| Latvian interpreter study no 6- “Struggled with some medical words eg. intrauterine device. Coil OK.”
| Czechoslovakian interpreter study no 7- “Genito-urinary medicine difficult to translate.”
| Lithuanian interpreter study no 9- “Emergency, no such word. When patient says “contraception” (mean) pills or condoms, not definite.”

There seemed an advantage to having a female interpreter. In one case, the female Latvian interpreter was cut off and the only replacement was a male Russian interpreter who struggled to explain to the patient about DMPA.

Overall, though, the interpreters found the process straightforward.

| Russian interpreter study no 1- “Easy enough for most questions.”
| Russian interpreter study no 2- “Easy enough.”
| Russian interpreter study no 5- “Not very difficult.”

* Unpaired t test
Section Seven: Conclusion

Our study sought to understand the fertility control health needs of Eastern European women requesting abortion using a combination of objective and subjective measures. This conclusion highlights the main findings and policy implications and offers several recommendations.

To identify inequalities of access to fertility control services by women from Eastern European countries

One of the aims of this study was to find out whether Eastern European women faced barriers to fertility control services, either through the way the services were organised or delivered. The draft Scottish Sexual Health Strategy divided the provision of Sexual Health services into the following tiers (Figure 2): 47

1. **Tier One** includes formal and informal sources of information and advice, which can be accessed directly i.e. NHS, Local Authority and voluntary sector staff, peers, magazines, radio, television, Internet, and leaflets.

2. **Tier Two** includes services which incorporate sexual health into their remit, but it is not their primary role i.e. drop ins, community groups, youth clubs, community pharmacies, casualty departments, and community hospitals.

3. **Tier Three** includes services that provide basic sexual health and reproductive health needs i.e. primary care, community-based family planning clinics, and specialist voluntary organisations (Caledonia Youth, Terrence Higgins Trust Scotland).

4. **Tier Four** incorporates services that provide specialist sexual health and reproductive health needs i.e. City Clinic (GUM) and Square 13. General practices with a special interest in sexual health or local family planning/GUM clinics working in conjunction with primary care also provide services at this tier.

5. **Tier Five** includes such specialist services such as HIV treatment and care, contraception and reproductive health, co-ordination of partner notification, psychosexual medicine, termination of pregnancy, along with the prerequisite clinical governance, quality assurance, and health needs assessment, for all tiers.

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Figure 1: Tiered Approach to Sexual Health Provision

This report found inequalities of access to fertility control services by women from Eastern European countries at all tier levels. Most had immigrated for opportunity—work, study, language, or relationship. Only a minority came through a recruitment agency and that was not reported to confer an advantage in terms of gaining local or national health information. Regarding self management (Tier 1), the language barrier provided the most difficulties. After a mean length of just under a year in Scotland, the majority still had difficulties understanding, speaking, and reading English. Those whose partners were of a similar ethnicity or whose jobs required little contact with the Scottish public were particularly disadvantaged. Even after two years in Scotland, one woman spoke English “not well” and did not read English. Language difficulties impacted on all areas of the media except the Internet, which women accessed through local libraries. Employers were reported as a helpful source of information. One rural North East employer took a proactive approach to occupational health, attempting to identify pre-existing health issues and providing generic health information and advice on registering for health care. Maximising the benefits of this exercise, however, was hampered by the lack of language appropriate material. Peers from their country of origin and family members were also frequently cited as aids to understanding. Strategies to offset language difficulties included: information sharing from those who had been in Grampian longer and translation of leaflets and posters. Those with good English accessed leaflets as per Scottish clients. Those with Scottish
boyfriends had a distinct advantage in that their partners knew where to access specialist services once pregnancy was suspected.

Both their migrant status and employment in unskilled occupations further limited access. None mentioned local authority or voluntary sector staff as references for information, highlighting a lack of awareness and “hidden” presence. Similarly, NHS staff were only referenced in the context of crisis management. It was not surprising that the majority presented to the abortion services within a year of arriving in Scotland, as for women up to 25 years of age, the cumulative unprotected conception rate is 60% at six months and 85% at a year.48 The minority who had accessed their GP for other health related issues commented on the lack of contraceptive leaflets in their surgery, with rarer conditions (eg bird flu) better represented. The majority were unaware that, in contrast to their country of origin, contraception was free, that EC was available in pharmacies, and that condoms were free in selected locations. This resulted in the use of cheap/free birth control methods- condoms, withdrawal, or crossed fingers. Similarly, time off work to attend healthcare appointments meant a loss of wages, so contact with healthcare providers was kept to a minimum. On a positive note, NHS Grampian has developed language appropriate contraception leaflets one year ago, and these have just become available to SRHC services. They are not yet, however, accessible for patients through the other languages section of NHS Grampian website or for primary care through the Clinical Guidance section of the NHS Grampian Intranet (Accessed October, 2007).

Regarding access to Tier two services, drop ins, community groups, and youth clubs exist both in Aberdeen City and Shire but were not mentioned by any of the women. Except in cases where the partner was Scottish, the women reported peer groups consisting of other a8/Eastern European migrants, probably reflecting working and living arrangements. Community pharmacies were almost universally cited as a source of condoms, suggesting that for this service, access was not a problem. There seemed a missed opportunity for Pharmacists to highlight the need for contraception and the importance of safe sex, to advertise the provision of EC and free condoms, and to sign post local sexual health service providers. In contrast, casualty departments/community hospitals were only used in crisis situations, when information provision was too late.

Overall, there appeared to be little interaction with primary care until crisis intervened. Women from a8/Eastern Europe reported difficulties accessing services providing basic sexual health and reproductive health needs, with the majority registering with a GP at the time of the pregnancy. With

those that registered earlier, there was a missed opportunity to assess health needs at that time, arrange a follow up appointment with one of the healthcare team, or opportunistically discuss contraception during a non-sexual health related consultation. This was further compounded by the lack of drop in clinics, particularly outside Aberdeen City, which was reported as attractive to a group with financial pressures and, at least perceived, vulnerable job security. Regarding communication, consulting primary care staff never used Language Line to aid understanding. This may have reflected lack of availability, uncertainty of how to use it, or concerns of its effect on consultation time or regarding cost. A recent review of telephone and physically present interpreting in two primary care trusts in north London showed that although interpreting services in a range of languages are available, many GPs are choosing not to use them. Lack of awareness of Language Line and a lack of confidence in negotiating the surgery’s reception or the consultation meant that contact was often differed until a peer or family interpreter was available. Out of desperation, some got peers/family to write notes that they could present at the surgery. It was therefore not surprising that a number of women specifically commented on the empowerment that Language Line provided. In all cases, no written information about contraceptive was given out, presumably because of perceived language difficulties. Cultural differences also played a role, as many women from a8/Easten European countries equated fertility control with a gynaecologist and failed to recognise the role of and expertise in general practice. This meant that, in many cases, supplies of contraception taken over from their country of origin were not replaced, but substituted by methods that could be accessed through pharmacies and supermarkets or nothing. Moreover, little was known about the LARC contraceptives, with most women suggesting the only pills and condoms.

Services providing specialist sexual health and reproductive health needs were virtually unknown to these women except in cases were the partner was Scottish or a peer/family member had prior knowledge. None living in Peterhead were aware of the bimonthly local outreach contraceptive clinics. In cases where the women had heard of LARC methods, they were unaware of how to access them. Finally, in contrast to usual practice, only one woman (who read and spoke English) attending Square 13 for a pregnancy test, was actively given written information about abortion.

Access to abortion counselling, for the most part appeared seamless, once the woman had contact with a healthcare provider. In one case there had been clearly a delay with different staff seeing the patient. Language difficulties and clarification of what the patient exactly wanted may have played a

part as the pregnancy was initially planned for and wanted until the couple ran into financial difficulties. Again, there were cultural driven expectations that the waiting time was too long and the suggestion that self referral to a gynaecologist would stream line this.

Overall, neither primary care nor specialist sexual health services had markedly changed practice or policy to target this large and challenging group of clients. The BMA’s The Right to Health: a Toolkit for Health Professionals provides guidance on instituting the four essential standards for health care services: availability, accessibility, acceptability and quality, for delivering health to an international community.

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51 See UN CESCR General Comment 14 The Right to the Highest Attainable Standard of Health
To determine a8/Eastern European migrant workers perception of needs and priorities for fertility control

The perception of needs and priorities equates to “what do patients want". It became clear during the interviews that fertility control ranked low in the women’s previous priorities. The majority had started a new life in Grampian and work and/or study were their main priority. Additionally, there was reference to supporting family members who had also emigrated or who were left behind, adding to the responsibility of maintaining gainful employment. All were in unskilled jobs and many expressed a financial vulnerability to taking time off. As such, relationships also played second fiddle to financial security. Though one woman had followed her new Scottish boyfriend home, for the rest, relationships lacked stability. Casual encounters, new relationships developing with men from similar backgrounds, and partners moving away for work, were more the norm. Provision of contraception was further influenced by cultural differences, with birth control previously issued at a cost by a gynaecologist rather than free from a GP or sexual health service. As a result, fertility control comprised of nothing (especially with casual encounters), withdrawal (free and easily accessible), or condoms (cheap and easily accessible).

Regarding fertility control, the lack of knowledge around choice and provision of contraception came out most strongly. Many had arrived in Grampian with an effective contraceptive method that then simply ran out. Most had no idea that contraception extended beyond condoms and pills. Likewise, few were aware that in Scotland, it was free and available from a number of different suppliers. All embraced the offer of contraception at the time of their pregnancy counselling appointment and there was no evidence that the group as a whole were using abortion as birth control. One individual was requesting her second Grampian abortion but cited a lack of contraceptive supplies and uncertainty of how to access more, as contributing factors. As such, a8/Eastern European women condemned the waiting times for and during appointments with GPs and pregnancy counselling staff and embraced the drop in approach available from Square 13 and Pharmacists and advocated more flexible use of nursing staff. There were suggestions to issue longer supplies of pills and requests for more information on the LARC methods. They were delighted with all attempts by staff to facilitate understanding using Language Line as most read English better than they spoke it. They were grateful for any form of information, verbal and written. Translated information sources were unavailable at the time the research took place but were acknowledged as an important need for truly informed consent. Finally, there was an appreciation by the interviewer of the isolation and vulnerability of these women and the need for a non-judgemental, friendly, language appropriate approach by health care providers.
To determine priorities for the most effective service planning and resource allocation for fertility control in female Eastern European migrant workers.

Extrapolating the background clinic data does suggest that a larger proportion of a8/Eastern European women are requesting abortion compared to their Scottish counterparts (9% of the requesting abortion population versus 8.4% of the TOTAL Grampian population). The findings from this report suggest that this reflects a lack of effective contraceptive use rather than a concerted approach to using abortion as a contraceptive method. NHS Grampian has to accept that this large ethnic group are young and sexually active and that contraceptive advice and provision are likely to be among their primary health needs. Furthermore, any service planning and resource allocation needs to include Aberdeenshire, in view of the numbers residing there.

Mapping the patient’s journey gives an indication of where the most effective targeted approaches should take place. The main reason for their coming to Grampian is work and/or study opportunities. In order to achieve this they require a National Insurance number and/or registration for higher learning. Few used recruitment agencies, with less formal arrangements the norm. Job centres, particularly, and University/College offices would be a good place to start sigh-posting preventative health strategies.

Within Job Centres, this could be as simple as language appropriate posters. A “credit card” given out at the time of registration could highlight the importance of registering with a GP and direct informal health queries to the NHS Grampian website or Health Point locations/ Healthline advice line. Currently, Aberdeen City Council has a Language Support section on its website with information in Bulgarian, Hungarian, Czech, Latvian, Lithuanian, Russian, Serbian, and Polish. The Russian and Polish sections have documents on why and how to register with a local GP, but it is not clear why this information is not available for all stated nationalities. Most nationalities also have a section on library internet use. Aberdeenshire Council website has no specific sections/links for Language support.

Those in formal study will have the advantage of better English proficiency skills and will have Scottish students and usually an International Officer/ International Student Adviser to approach. Aberdeen University, Robert Gordon’s University and Aberdeen College all have separate sections on their websites for international students, but information on SRHC services could be improved in line

54 http://www.aberdeencity.gov.uk/ACCl/nmsruntime/saveasdialog.asp?lID=10350&sID=270
with what is currently available in the Sexual Health section of NHS Grampian. Those in unskilled employment are likely to have greater language barriers and where many are employed, have less exposure to Scottish nationals. In this case, preventative health has to be sold to employers as a "business case". The Confederation of British Industry reports that "sickness" absence costs British Industry nearly £11 billion or £567/8.5 days per employee per year. No manager could argue with the choice between two hours off work accessing effective contraception versus three days off for an abortion. Many workplaces have signed up to achieve Health in the Workplace status and a proactive, preventative approach to fertility control and Sexual Health would be a key way of achieving this. The NHS Grampian Workplace Team provide advice and guidance at no cost and have access to Resources Direct which holds an extensive range of leaflets, booklets and posters. Currently, it includes an electronic guide to contraception in Polish that can be printed. Membership to Resources Direct is free to organisations with under 50 employees and pro rated for larger employers. Language appropriate posters in staff rooms could highlight the advantages of electively registering with a GP. Their high level of expertise and the rare need for specialist referral, should be emphasised. Other posters could inform that contraception is free and sign post the choices for provision, especially in rural areas. Emergency contraception needs separate emphasis, highlighting time limits, free provision sources, and where it can be purchased. Square 13 and its hubs in Peterhead and Fraserburgh need a higher profile as an alternative provider for those living in Aberdeen City and Aberdeenshire.

The majority of contraception provision in Scotland is primary care delivered. For those that register with a GP, there are a number of approaches that could be taken. Most waiting rooms have leaflet stands and in terms of self management, a specific “ethnic” stand with language appropriate NHS Grampian literature could be maintained and patients directed to it when they register. Alternatively, a language appropriate card/leaflet could be given, highlighting the availability of Language Line, listing the NHS Grampian website as a source of language appropriate health information, and encouraging a short appointment with the practice nurse/GP to discuss health issues/concerns. It could include a statement that a letter would be provided for employers, if required. This report, however, also identified a need for more flexible, drop in appointments. It is recognised that currently in Grampian most sexual health consultations are done by medical staff. Much of the counselling and advice

60 Health Intelligence Unit, NHS Grampian. Sexual Health Services in Primary Care- Results of Survey, September 2005.
could be given by nursing staff using protocols and proformas available from SRHC services. These could be posted on the Clinical Guidance section of the NHS Grampian Intranet for global use, similar to the system used in Glasgow.\textsuperscript{61} Those with additional skills, such as holders of the family planning diploma or in rural health advisor roles, could provide contraception through Patient Group Directions. A proposed re-design of SRHC services in Aberdeenshire North Community Health Partnership (CHP) plans to incorporate a weekly nurse-led clinic with a drop in option (personal communication, Dr Susan Brechin, Consultant, SRHC). It is proposed that the new service will target males and females under 25 years, but in view of the large numbers of A8/Eastern Europeans residing in Peterhead (3/10 in this study), it should be extended to include this vulnerable group. Finally, the participants highlighted the benefits of using Language Line in terms of developing rapport and gaining confidence and understanding. The use of interpreters has been promoted as a minimal standard for gaining consent by a number of sources- General Medical Council,\textsuperscript{62} RCOG,\textsuperscript{63} and Faculty of Sexual and Reproductive Health Care.\textsuperscript{64} In the sensitive area of sexual health it is often inappropriate to use family members and peers to interpret consultations. As Language Line has been rolled out to Aberdeen and Aberdeenshire, there may be a role for the Equality and Diversity team to target those practices in areas where migrants are known to reside, who are low users of the system. Surgeries should publicise the existence of Language Line in reception and waiting room areas.

Community pharmacies were highlighted by the women as a health point where access was not prohibitive. This is not surprising as they are located in places where people live, work and shop. Pharmacists have embraced the provision of EC and many have extended their role to include Sexual Health campaigns (Sexual Health Week, August 2007), contraceptive advice, provision of free condoms, and \textit{Chlamydia} screening. In line with the new contract for community pharmacists and with the number of pharmacy prescribers increasing, this is a group of health professionals are likely to play an important role in community sexual health. Again, this could range from displaying posters, distributing language appropriate leaflets/booklets, referring to a GP or sexual health clinic, and prescribing, aided by the proposed future roll out of Language Line. As many Pharmacists are used to purchase/obtain condoms, language appropriate information on EC, given out at the same time, would certainly increase awareness of access routes. The Royal Pharmaceutical Society of Great Britain has called for pharmacies to be the first point of call for sexual health advice and support.\textsuperscript{65}

\textsuperscript{63} http://www.rcog.org.uk/resources/Public/pdf/induced_abortionfull.pdf Accessed 3 October 2007
Regarding out of work activities, it was interesting that libraries were highlighted. There has been some interaction between the Racial Equality and Diversity team and specialist ethnic shops, but the impression was that these were not regularly frequented. Libraries, on the other hand, provide free Internet, email and computer access, and presumably are used to contact those at home. Information can be printed at a small cost of 20p per sheet. One has to be a library member to be eligible to use this facility and again this requires registration. Most libraries have a leaflet section highlighting social services, community learning and development, arts and entertainment, and some health issues. Possible information inputs could take the form of posters, leaflets, or a Language Support section that comes up when a client logs on and has Internet links to health information documents and sites. There is currently a working group looking at Migrant issues and a Migrant Communities Central Information Point is in development at the Central Library in Aberdeen (personal communication, Sheila Young, Community Contacts Team, Information Services Central Library). This display stand will contain information documents in different languages. At present, the only health leaflet pertains to registering with a GP. It is proposed that smaller information points will be installed in branch libraries. It is unclear whether a similar process is occurring in Aberdeenshire.

For those providing fertility control services, it is important not to disadvantage those with LEP and provide a less comprehensive service. This report gives numerous examples of strategies used by women to translate English health information and in this group, reading proficiency was better than speaking. Currently it would be better giving an English leaflet/booklet than nothing at all. In the future, however, minimal standards should include translated documents on contraceptive choices, abortion, and chlamydial infection. Aspirational standards should extend to specific contraceptive methods, STI testing, and STIs. At present, there is translated material from NHS Grampian (Appendix 4), NHS Highland (Appendix 4), and Aberdeen City Council that is not widely available. Corporate availability can only be achieved through registered resources and the Internet.

Regarding choice, Grampian’s Specialist SRHC services (Square 13 and City Clinic) need a higher public profile in this migrant group, as an alternative to services provided by primary care. The drop in option was particularly well received and it may be that this part of the service needs extended beyond under 25s so that other vulnerable groups are not excluded. This would be in line with many other Sexual Health services in the UK that run parallel walk in clinics.

The Racial Equality Annual Report highlights the lack of information gathering on any migrant group and notes that this makes appropriate service planning almost impossible. This contrasts with other
sectors that collect both ethnicity and nationality. Addition of information on ethnicity through the Scottish Morbidity Record (SMR) provides statistics on migrant activity in inpatients and day cases, outpatients, maternity patients, and community services. Through the Patient Focus and Public Involvement sector, NHS Grampian has pledged to increase the number of patients disclosing their ethnic origins and provide a SMR baseline to monitor progress and improvement for 2007/8. This important information also needs collected by Aberdeen’s TOP database. Nationally, an Ethnic monitoring Tool is available electronically and in leaflet form and locally, the Diversity Information Implementation Network will globally support NHS Grampian in collecting ethnicity data in hospital/GP settings and the sharing of good practice.

Finally, there is a real need for policy makers to recognise that language and cultural barriers adversely influence health. Those with poor English proficiency miss out on both active and passive information and the learning of proficient English should be promoted to maximise health. This is in line with recommendations from the “Amsterdam declaration”, a European initiative acknowledging the specific health problems of migrants in order to develop appropriate health strategies.

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66 http://www.margaretpyke.org/
69 Ethnic Monitoring for NHS Patients in Scotland leaflet as contained in the Communications Guidelines for the introduction of Ethnic Monitoring in Health Boards in Scotland www.isdscotland.org/isd/3393.html
70 Alderliesten ME, Vrijkotte TGM, van der Wol MF, Bonsel GJ. Late start of antenatal care among ethnic minorities in a large cohort of pregnant women. BJOG 2007; 114: 1232-1239.
Section eight: Recommendations

As Health Boards are now required to monitor and evaluate the use/non-use of health services by ethnic minorities, the factors that may undermine the fertility control health needs of A8/Eastern European women must be identified, understood, and addressed. There is good evidence that NHS Grampian has embraced the principles of equality and diversity and is involving migrant patients in the monitoring and redesign of healthcare services and responding to their needs. Local clinical teams, however, must be proactive in developing and improving clinical practice in relation to their own areas of expertise.

- **NSHAG**
  - Should task the Sexual Health and Wellbeing Learning Network to gather language relevant information sources related to fertility control and wider sexual health issues for global dissemination to Health Boards (See the COSLA website which has gathered national information material, including health-related items).
  - To task the translation of individual fpa contraceptive method leaflets into Polish, Russian, Latvian, and Lithuanian, for global Health Board dissemination through the Sexual Health and Wellbeing Learning Network.

- **NHS Grampian Racial and Equality Team**
  - Ensure that community plans and local health plans include migrant health needs.
  - Prioritise the collection of ethnicity data within NHS Grampian.
  - Support and commission local healthcare services to undertake research and development involving migrant populations.
  - A SRHC advisor should be co-opted onto the team, to advise on sexual health issues and progress these recommendations.
  - Update the public section of NHS Grampian’s website and NHS Grampian’s Intranet to include electronic versions of language appropriate contraceptive methods summaries and wider sexual health information.
  - Liase with Local Authorities, particularly Library and Information Services, to ensure that policies and initiatives that address social exclusion include actions to address fertility control.

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72 Convention of Scottish Local Authorities
Enlist higher/further education to ensure that policies and initiatives that address social exclusion include actions to address fertility control.

Engage with local Job Centres and Job Centre Plus through media campaigns and internet links.

Enlist the NHS Grampian Workplace Team to specifically target Grampian employers with large numbers of A8/Eastern European workers.

Advise Resources Direct to include a wider range of translated fertility control resources (Appendix 4).

Target GP practices in areas with moderate/high migrant populations, who are low users of Language Line.

Roll out Language Line to Community Pharmacies and promote their expanded role in fertility control and wider Sexual Health.

Emphasise the health gains from learning proficient English.

- **Grampian Racial Equality Council**
  
  Continue to represent and advocate the migrant “voice” in designing health programmes that use the host society’s services effectively.

  Train established migrants to act as mediators between clients and social and health workers aiming to facilitate better access to services and information.

  Emphasise the health gains from learning proficient English.

  Support local healthcare services in undertaking research and development involving migrant populations.

- **Health Promotion**
  
  Develop a communication strategy for highlighting the availability of interpreter/translation and fertility control services for A8/Eastern Europeans, including campaigns to heighten awareness of Language Line, and the full range of free contraceptive methods and sources of provision:

  - Inclusion of primary care, community pharmacists, casualty departments, community hospitals, workplaces, job centres, libraries, supermarkets, and nationality shops in the media campaign.

  NHS Grampian Workplace Team to prioritise fertility control and wider sexual health issues.
- **Grampian Sexual and Reproductive Health Care Services** (incorporating Square 13 and GUM)
  
  o Ensure that proposals to improve service access for all target populations are identified in the NHS Grampian’s interagency Sexual Health Strategy and Annual Service Plan.
  
  o Ensure that front line SRHC staff undergo Equality and Diversity training.
  
  o Promote training to enable the extension of nurse led SRHC services both in primary and secondary care.
  
  o Regarding the re-design of Aberdeen City and Aberdeenshire SRHC services:
    
    ▪ Include migrant health needs in service re-design.
    
    ▪ Core SRHC services to lead a Managed Care Network for GPs, practice nurses, and allied health professionals, identifying initial and on-going training needs, providing education and training, instituting protocols and care pathways, and supplying clinical governance framework.
    
    ▪ Look at providing/extending drop in SRHC services centrally and in Aberdeenshire hubs.
  
  o Addition to database variables- nationality and need for interpreter.
  
  o Request translation of contraceptive choices summary in Russian.
  
  o Highlight to staff the potential benefits of requesting a “same sex” interpreter when using Language Line for Sexual Health consultations.

- **Pregnancy Counseling Service:**
  
  o Request translation of the pregnancy counseling service’s abortion booklet into Polish, Russian, Latvian, and Lithuanian for availability in electronic and paper form
  
  o Addition to database variables- nationality and need for interpreter
  
  o Section in annual report- Migrants: numbers, gestation, abortion method, contraceptive method, further use of service
  
  o Telephone follow up at two weeks, using conference call facility, if necessary, to check contraceptive compliance and knowledge of future provision and advice sources
  
  o Targeted campaign to increase LARC use in this group, aiming for a 15% uptake in line with proposal 10.5: NHS Quality Improvement Scotland Draft Standards for Sexual Health Services, 2007.

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Section Nine: Resource implications and evaluation

This section examines the potential resource implications and evaluation strategy in response to the proposed recommendations.

Resource Implications

A solid foundation has been laid by the combined efforts of NHS Grampian’s Racial and Equality team and the Grampian Racial Equality Council, particularly with the roll out of Language Line. The recent appointment of two part-time consultants in SRHC through Sexual Health Strategy money mean that an advisor to the NHS Grampian’s Racial and Equality team can be provided from the expanded consultant team, bringing leadership to take forward these recommendations.

Tasking the gathering of language appropriate sexual health patient information to the Sexual Health and Well being Learning Network nationalises the process and prevents Health Boards duplicating translation costs, as has happened in Highland and Grampian. In the meantime, a Russian contraceptive methods summary and abortion information booklet have been identified as essential items requiring immediate translation by NHS Grampian.

NHS Grampian’s website and the Intranet already have an “other languages” and “Sexual Health” section, respectively. These just require updating followed by global dissemination to healthcare providers highlighting the amended format.

NHS Grampian’s Racial and Equality team, in conjunction with the local Sexual Health Strategy Committee, need to highlight to Aberdeen City and Aberdeenshire CHP and locality leads the fertility control needs of this vulnerable population and challenge action towards improving both registration and service provision.

Aberdeen City Council and particularly the Library and Information Services are currently addressing information difficulties with the A8/Eastern European community and this presents a timely opportunity for NHS Grampian’s Racial and Equality team and their SRHC member to provide fertility control information sources. Aberdeenshire Council will require specific targeting.

The University of Aberdeen, Robert Gordon’s University and Aberdeen College already have sections on their web sites pertaining to foreign students and/ or health. A link needs to be made through NHS
Grampian’s Racial and Equality team and SRHC services to ensure that fertility control information is included, relevant, and up to date.

The NHS Grampian Workplace Team is already in place but needs to respond to the challenge of targeting Grampian employers with large numbers of A8/Eastern European workers, prioritising fertility control and wider sexual health issues as key health needs in this population. Resources Direct only needs updating with key fertility control information documents that have already been translated.

The NHS Grampian’s Racial and Equality team need to further their relationship with Aberdeen City and Aberdeenshire Job Centres to include a health promotion campaign, highlighting interpreter services, fertility control options and sources, and progressing to wider sexual health issues.

The roll out of Language Line to Community Pharmacies and NHS Grampian’ collection of ethnicity data has already been factored into the NHS Grampian’s Racial and Equality Plan.

Within core SRHC services, as part the redesign of urban and rural SRHC provision, work is ongoing to develop a Managed Care Network, with centralised protocols and care pathways, and rolled out education and training. The lack of drop in facilities both within Aberdeen City and throughout Aberdeenshire is a key consideration in the redesign of Grampian’s SRHC services. Both pregnancy counseling and Square 13 databases have the capacity to include nationality and interpreter fields and once changed, audit of abortion rates and LARC use, for example, would be straightforward. As part of a Clinical Governance overhaul, an annual report will be produced in 2008 and should include a section on migrant issues. This section would also advise the local Sexual Health Strategy Committee’s annual report to the Scottish Executive. Equality and Diversity training is provided by GREC and has been timetabled for the SRHC services for 2008.

A telephone follow up by the pregnancy counseling nurses would involve an extra 2-3 calls per week but would be more cost effective than a DNA’d review appointment or repeat TOP. The process would be audited over six months in terms of effectiveness in reaching the women and providing advice.

The main cost implication will be through health promotion and a media campaign. Experts in this field should be approached to advise on a business case for targeting this population most cost effectively through both healthcare and non healthcare venues. The campaign would need to include promotion of interpretation/translation services, as well as fertility control information, choices, and provision.
What are the outcomes to evaluate change and the criteria to audit success?

Both NHS Grampian’s Racial and Equality Team and Sexual Health Strategy Committee produce annual reports which should, in future, include sections on Sexual Health and Migrant Populations, respectively. This would directly feedback on progress made regarding the above recommendations. The NHS Grampian’s Racial and Equality team have been tasked with providing Racial Equality and Diversity Impact Assessments and would lead on evaluating ethnically motivated changes within healthcare and allied services. Inclusion of nationality into the SRHC databases will ensure continuing audit and assessment of this vulnerable group within the context of Sexual Health. It is hoped that the results reported from this pilot will link into ongoing projects and inform the study design of larger, funded, collaborative qualitative research.
Section nine: Appendices 1-5
Appendix 1: Questionnaire

An assessment of the fertility control health needs of A8/Eastern European women requesting abortion

Thank you for agreeing to hear about our project assessing some of the health needs of Eastern European women requesting abortion. If you agree to be interviewed, I will ask you questions about your social circumstances, use of birth control, health professionals you may know about or have seen, and your views on how services around birth control could be adapted & improved to meet your needs.

All the information you give is strictly confidential and will not be passed onto members of your family, your employer, your doctor, or the police/immigration. Please ask for help if you don’t understand the questions and feel free to refuse to answer any questions you don’t feel comfortable answering. If you do not wish to participate, just say so. It will not affect your care in any way. It is hoped that the information gained will help us adapt our service to better serve women from Eastern Europe.

Date: __________________________ Study No. __________________________

1. Language line required No □ Yes □ go to 2

2. If yes, language ______________________________

Country/language of origin

3. What country did you come from? ______________________________

4. What language(s) do you speak? ______________________________

5. What language(s) do you read? ______________________________

6. How well do you speak English? Very well □

Well □

Not well □

Not at all □
Move to Scotland

7. Why did you move to Scotland?

8. Was a recruitment agency involved in your move?  No □ Yes □

9. How many months have you been in Scotland?

10. Did you get any health advice when you arrived here?  No □ Yes □ go to 11

11. If yes, what advice did you receive & from whom?

Occupation

12. Are you working?  No □ Yes □ go to a

   a. If yes: Has it been difficult to get time off work to attend these appointments?  No □ Yes □

   b. If yes, what difficulties have you had?

   c. Have these appointments meant loss of earnings for you?  No □ Yes □
Contraception

13. What birth control have you ever used? If none, go to a


a. If none, why not?


14. Do you use condoms? No □ Yes □

15. Where would you buy condoms?


16. Where can you get free condoms?


17. Were you using birth control when you fell pregnant? No □ go to a Yes □ go to b

a) If no, why not?


b) If yes, what method were you using?


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i. Where did you get your birth control?  

ii. Could you read the instructions?  No □  Yes □  N/A □

iii. Could you understand the instructions?  No □  Yes □  N/A □

18. Did you use emergency contraception (morning after pill) to prevent this pregnancy?  No □  go to a  Yes □

a) If no, had you heard of emergency contraception?  No □  Yes □  go to i

i. If yes, where would you get emergency contraception?

19. What method(s) of birth control do you plan to use after the abortion?

20. What method(s) of birth control would you not use?

   a. Why?

21. If we gave you written information on birth control method(s), what language would it need to be in?

22. Would you pay for birth control in (your country of origin)?  No □  Yes □
General practitioner

23. Are you registered with a general practitioner?  No □  go to a  Yes □  go to b
   a) If no, why not?  go to 24

   b) If yes, how many months ago did you register?

   c) If yes, have you visited your GP in the past 6 months?  No □  Yes □  go to i
      i. If yes, what did you consult about?

24. Have you visited any other health care staff at the surgery in the past 6 months?  No □  Yes □  go to a
   a. If yes, who did you consult?
   b. If yes, what did you consult about?

25. Regarding appointments at your GP’s surgery, did you have problems with any of the following:
   d) Making an appointment  No □  Yes □  go to i
      i. If yes, please explain the problems you had.
e) Attending the appointment  No □  Yes □ go to i
   i. If yes, please explain the problems you had.

f) Understanding the staff  No □  Yes □ go to i
   i. If yes, please explain the problems you had.

g) Understanding the advice given No □  Yes □ go to i
   i. If yes, please explain the problems you had.

26. Were you offered an interpreter?  No □ go to a  Yes □ go to b  N/A □ go to 27
   a) If no, why not?

   b) If yes, who provided the interpreter? go to l

   c) Did the arrangement work well?  No □ go to 2  Yes □

   d) If it didn't work well, what was the problem?
27. Overall how did you rate the (GP) service you received?

   Good  □
   Fairly good  □
   Not good  □
   Not applicable  □

Family planning clinics

28. Where is your nearest family planning clinic located?

29. Have you visited a family planning clinic in the past 6 months?
   No  □  go to a  Yes  □  go to b
   a) If no, why not?
   
   b) If yes, what did you consult about?

30. Regarding family planning clinic appointments, did you have problems with any of the following:
   a) Making an appointment  No  □  Yes  □  go to i
      i. If yes, please explain the problems you had.

   b) Attending the appointment  No  □  Yes  □  go to i
      i. If yes, please explain the problems you had.
c) Understanding the staff

No □ Yes □ go to i

i. If yes, please explain the problems you had.


d) Understanding the advice given

No □ Yes □ go to i

i. If yes, please explain the problems you had.

31. Were you offered an interpreter? No □ go to a Yes □ go to b N/A □ go to 32

a) If no, why not?


b) If yes, who provided the interpreter? go to i


i. Did the arrangement work well? No □ go to ii Yes □

ii. If it did not work well, what was the problem?
32. Overall how did you rate the (family planning) service you received?

- Good □
- Fairly good □
- Not good □
- Not applicable □

Referral to Aberdeen’s Abortion Service

33. How did you find out about this abortion service?

34. How many doctors/nurses did you see before getting this clinic appointment?

35. Were you given prior written information about this abortion service?  
   No □ go to 36  
   Yes □ go to a
   a) If yes, by whom?

36. Were you given prior written information about birth control?  
   No □ go to 37  
   Yes □ go to a
   a) If yes, by whom?
b) If yes, were you able to read it?  No  □  Yes  □

c) If yes, were you able to understand it?  No  □  Yes  □

37. Would you have requested an abortion in (your country of origin)?  No  □  go to a
      Yes  □  go to b

   a) If no, why not?  

   b) If yes, would you have had to pay for it?  No  □  Yes  □  go to i

      i. If yes, how much in UK £ _____

38. In the past, have you used abortion as birth control?  No  □  Yes  □  go to a

   a. If yes, why?  

Overall experience

39. What has been GOOD about your experience of fertility control services in Aberdeen/Aberdeenshire?

40. Regarding fertility control services in Aberdeen/Aberdeenshire, what needs IMPROVING?
41. Specifically, what are your views on how we can improve Eastern European women’s:

a) ACCESS to birth control

b) INFORMATION about birth control

Thank you very much for your participation.

42. Interpreter (if applicable): Were any questions/words difficult to translate?

43. Time of interview

min
Clinic notes/referral letter

46. Age

47. Parity  ____ + ____

48. Number of previous abortions  

49. Marital status

50. City/town

51. Referred by

52. Did the referrer alert the service of the patient's language needs?  
   No  □
   Yes  □
   N/A  □
Appendix 2: Patient Information Sheet

Patient Information Sheet

Protocol reference: 06/50801/99
Version number: 1

Part 1.

Title of Project: Fertility control health needs of women from a8/Eastern European countries

You are being invited to take part in a research study. In order to understand this information sheet, a telephone interpreter service is available, if you think this would be helpful. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read (listen to) the following information. Talk to others about the study if you wish. This study is to learn about your needs and views around your healthcare needs.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Aberdeen and Aberdeenshire have approximately 1200 workers and their families arriving each month from a8 & Eastern European countries. Within our pregnancy advisory service, we see 1-2 women from a8 & Eastern European countries each week requesting abortion. This study aims to look at your health needs for avoiding unplanned or unwanted pregnancy and your uptake and experience of local services that provide birth control.

Why have I been chosen?

You have been chosen because you are from an a8 or Eastern European country.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care you receive.

What will happen to me if I take part?

You will be asked to answer a questionnaire. A researcher, who is not involved in your medical care, will ask you the questions and she will write down your answers. The interview will take place at this clinic visit or, if appropriate, when you next visit the hospital to get a priming tablet as part of your treatment. We do not know how long the interview will take and as a result will be noting the time it takes so as to inform future participants.
Expenses and payments:
You will not need to make more hospital visits than that required for your usual treatment. There is no payment for taking part.

What do I have to do?
You will be asked to answer a questionnaire read out by a researcher. If you agree to be interviewed, she will ask you questions about your social circumstances, use of birth control, health professionals you know about or have seen, and your views on how services around birth control could be adapted & improved to meet your needs. Please ask for help if you don’t understand the questions and feel free to refuse to answer any questions you don’t feel comfortable answering.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get might help us adapt our service to provide better services and care for women from a8/Eastern European countries.

What happens when the research study stops?
The study that you are being asked to take part in is called a "pilot". A pilot study involves just a few people and advises on changes to the questionnaire and study design. The changes suggested by the pilot study are used to inform a larger study in the future.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details:

Study: Dr Susan Logan
Square 13, 13 Golden Square (Family Planning), Aberdeen AB10 1RH
Tel: 01224 642 7211 or 08454566000 Bleep 2183

Complaints: Dr Gillian Flett
Consultant in Family Planning and Reproductive Health Medicine
Square 13, 13 Golden Square (Family Planning), Aberdeen AB10 1RH
Tel: 01224 555116

This completes Part 1 of the Information Sheet.
If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.
Part 2

What will happen if I don’t want to carry on with the study?
You are free to refuse to answer any questions you don’t feel comfortable answering or say at any
time during the interview that you do not wish to participate. It will not affect your care in any way. Any
data collected up to that point will be destroyed immediately as confidential waste.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak with the researcher who
will do her best to answer your questions (Dr Susan Logan, Square 13, 13 Golden Square (Family
Planning), Aberdeen AB10 1RH, Tel: 01224 642 7211 or 08454566000 Bleep 2183).

If you remain unhappy and wish to complain formally, you can do this through the Head of Service (Dr
Gillian Flett, Consultant in Family Planning and Reproductive Health Medicine, Square 13, 13 Golden
Square (Family Planning), Aberdeen AB10 1RH, Tel: 01224 555116) or through the NHS Complaints
Procedure. Details can be obtained from the hospital.

These contacts relate only to the study and not to your medical care.

We do not anticipate any harm resulting from participation in this study as it will follow guidance from
the Scottish Executive Health Department Research Governance Framework for Health and
Community Care (Feb 2006) and the Declaration of Helsinki. However, in the event that something
does go wrong and you are harmed during the research study, there are no special compensation
arrangements. If you are harmed and this is due to someone’s negligence then you may have
grounds for a legal action for compensation against NHS Grampian Indemnity. You may, however,
have to pay your legal costs. NHS Indemnity does not offer no-fault compensation i.e. for non-
negligent harm, and NHS bodies are unable to agree in advance to pay compensation for non-
negligent harm. They are able to consider an ex-gratia payment in the case of a claim. The normal
National Health Service complaints mechanisms will still be available to you, if appropriate.

Will my taking part in this study be kept confidential?
All information that is collected about you during the course of the research will be kept strictly
confidential. Data collected during the interview will be anonymised, which means you will not be
identified in any way. All answers you give are strictly confidential and will not be passed onto
members of your family, your employer, your doctor, or the police/immigration. We would like your
permission to access your medical records to obtain information that is normally collected during your
medical consultation: age, previous pregnancies, marital status, town/city, and origin of referral. We
may wish to use your exact wording, as stated during the interview, for use as quotations in the writing
up of this study. Quotations will be identified to a study number, not you.

All questionnaires will be kept in a locked file and inputted into computers whose access can only be
gained by a password. Only authorised persons (researchers and regulatory authorities will have
access to view your data). The Research & Development department of NHS Grampian may also wish
access for monitoring the quality of the research. Our procedures for dealing with your data are
compliant with the Data Protection Act 1998. The questionnaires will be retained for 10 years in a
locked research data room and then will be disposed of securely. You have the right to check the
accuracy of data held and correct any errors.

Involvement of the General Practitioner/Family doctor (GP)
We do not plan to inform your GP of your involvement in this study as it is assesses the services
currently offered to you.
What will happen to the results of the research study?
The results of this pilot study will be used in a report to NHS Grampian, including the Sexual Health Strategy Implementation Group. It will also be available to other health boards and the Scottish Executive National Sexual Health Advisory Committee. This pilot study will inform the study design of a larger study assessing the sexual health needs of women from Eastern European countries. A report will also be submitted for publication in the Journal of the Faculty of Family Planning and Reproductive Healthcare. You will not be identified in any report/publication. We do not propose reporting back to you on the results of this pilot, but would be happy to send you a copy of the report, if requested.

Who is organising and funding the research?
This pilot study is organised jointly by the pregnancy advisory service of the Department of Obstetrics & Gynaecology and the Department of Public Health. It is unfunded but sponsored by NHS Grampian.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS by the Grampian Research Ethic’s Committee.

Thank you for considering taking part and taking the time to read this sheet.

If you agree to participate you will be given a copy of the information sheet and a signed consent form to keep.
Appendix 3: Consent form

Study Number: 

CONSENT FORM

Title of Project: An assessment of the fertility control needs of Eastern European women requesting abortion

Protocol reference: 06/50801/99

Name of Researcher: Dr Susan Logan

Please initial box

1. I confirm that I have read and understand the information sheet dated .../..../... (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at anytime, without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of any of my medical notes and data collected during the study, may be looked at by responsible individuals from the NHS Grampian, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I consent to the possible use of my exact wording, as stated during the interview, for use as quotations in the writing up of this study.

5. I agree to take part in the above study.

_________________________________________ ________________ ____________________
Name of Patient Date Signature

_________________________________________ ________________ ____________________
Name of Person taking consent Date Signature
(if different from researcher)

_________________________________________ ____________________
Researcher Date
Signature

Contact: Dr Susan Logan
Square 13, 13 Golden Square (Family Planning), Aberdeen AB10 1RH
Tel: 01224 642 7211 or 08454566000 Bleep 2183
Appendix 4— NHS translated information on primary care registration and contraception

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<th>Information</th>
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<th>Source</th>
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<td>Polish</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Contraception Leaflet in Polish November 2006 (159k bytes)</td>
<td>Polish</td>
<td>NHS Grampian</td>
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### Appendix 5– Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a8</td>
<td>Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, &amp; Slovenia</td>
</tr>
<tr>
<td>ARI</td>
<td>Aberdeen Royal Infirmary</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>COC</td>
<td>combined oral contraceptive pill</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Health Partnerships</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depo medroxyprogesterone acetate</td>
</tr>
<tr>
<td>DNA</td>
<td>did not attend</td>
</tr>
<tr>
<td>EC</td>
<td>emergency contraception</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>fpa</td>
<td>family planning association</td>
</tr>
<tr>
<td>GREC</td>
<td>Grampian Racial Equality Council</td>
</tr>
<tr>
<td>GUM</td>
<td>genitourinary medicine</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>IUS</td>
<td>Intrauterine system</td>
</tr>
<tr>
<td>LARC</td>
<td>long acting reversible contraception</td>
</tr>
<tr>
<td>LEP</td>
<td>limited English proficiency</td>
</tr>
<tr>
<td>MOT</td>
<td>Ministry of Transport</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NSHAG</td>
<td>National Sexual Health Advisory Committee</td>
</tr>
<tr>
<td>Pills</td>
<td>combined oral contraceptive pill/progesterone only pill</td>
</tr>
<tr>
<td>PIS</td>
<td>patient information sheet</td>
</tr>
<tr>
<td>POI</td>
<td>progesterone only implant</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians &amp; Gynaecologists</td>
</tr>
<tr>
<td>SMR</td>
<td>Scottish Morbidity Record</td>
</tr>
<tr>
<td>SRHC</td>
<td>Sexual &amp; Reproductive Health Care</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection(s)</td>
</tr>
<tr>
<td>TOP</td>
<td>termination of pregnancy</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
</tbody>
</table>