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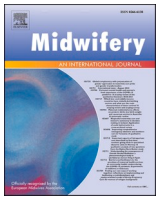

Review Article

Access of migrant women to sexual and reproductive health services: A systematic review

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ABSTRACT

Background: The number of people living in a different place from their place of birth is increasing year by year. Although women have always been involved in migratory movements, today they are increasingly doing so independently. Women are migrating from the Global South to higher-income countries. One of the challenges they face is access to sexual and reproductive health (SRH) services.
Aim: To identify the policy-level barriers that limit the access of migrant women to SRH services, their consequences, and strategies implemented to overcome these barriers.
Methods: A systematic review of the literature was undertaken in accordance with the PRISMA statement. A search was undertaken for articles published between 2018 and 2023 focusing on migrant women's experiences of SRH services. In total, 462 articles were retrieved from PubMed (n = 135), Scopus (n = 94) and Web of Science (n = 233); of these, 28 articles were included in this review.
Findings: The most common barrier to SRH services identified in the reviewed articles was lack of information (57 %), followed by language issues (43 %), cultural differences (39 %), economic status (25 %), administrative barriers (25 %) and discrimination (14 %). These barriers led to under-utilisation of maternity services and contraceptive methods. Strategies used by migrant women to overcome these barriers were primarily based on seeking help within their own community or family settings.
Conclusion: Strategies at institutional level to improve the access of migrant women to SRH services need to reduce existing barriers, promote health literacy, and train health workers to be culturally sensitive and responsive to the needs of migrant women.

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Statement of significance

Problem	What is already known	What this paper adds
Nowadays, there are more migrant women living independently worldwide. One of the challenges they face is access to sexual and reproductive health services.	• The vulnerability of migrant women is not only influenced by their migration status, but also by their gender. • Migrant women underuse health services. • Migrant women have a poorer perception of their health compared with the resident population. • Migrant women have higher rates of non-communicable diseases and mental disorders. • There is low utilisation of maternity services by migrant women.	• This study examined the barriers that migrant women face in accessing sexual and reproductive health services. • This study developed strategies and action plans to improve the health of migrant women.

Introduction

In 2020, 280 million people were migrants, compared with 57 million people in 2010 (McAuliffe and Triandafyllidou, 2021). Over the last decade, feminisation of migration has been taking place worldwide (Gabaccia, 2016; Pande, 2022). This increases the visibility of women, and their specific needs and issues in the context of migratory movements (Pande, 2022). Although migration can facilitate access of women to the resources offered by destination countries and may improve their socio-economic situation, it is not risk-free (Fleury, 2016). This is particularly relevant when considering the vulnerability often faced by migrants before, during and after the migration process. Their situation is influenced not only by their migration status but also by their gender, leading to double discrimination (Fleury, 2016).

Due to the intersectionality approach that has permeated migration research since the late 1990s, increasingly complex analyses have been developed that have successfully unravelled the experiences and issues affecting migrant women (Monzón, 2017).

Among the challenges faced by migrants, access to health systems and the utilisation of services have been investigated in depth. There is evidence of underutilisation of health services by migrants compared with the resident population, and this is particularly relevant in the case of specialised care (Carmona et al., 2014; Llop-Gironés et al., 2014; Saunders et al., 2021). Furthermore, migrants may have a poorer perception of their health compared with the resident population (Nielsen and Krasnik, 2010). A review by Lebano et al. (2020) showed that four European studies identified higher rates of non-communicable diseases and mental disorders in migrants compared with the local population. In the specific case of women, the available literature also suggests low utilisation of maternity services (Adewole et al., 2023). These services are essential to ensure the health of both the baby and the pregnant woman (Raatikainen et al., 2007).

In addition, migrant women face particular circumstances that highlight the need to ensure that sexual and reproductive rights are respected before, during and after transit. The migration literature has frequently explored how these rights are transgressed, including sexual violence during migration journeys (Infante et al., 2013), complications in obtaining health care during pregnancy (Wolff et al., 2008), and challenges in accessing contraception (Fanta Garrido, 2020). In their research on the experiences of people in transit to the USA and the violation of sexual rights, Infante et al. (2013) found that most migrants assumed the aforementioned risks as an intrinsic part of the process over which they have no control. Additionally, knowledge about the functioning of health services (Raymundo et al., 2021), diseases (Gilder et al., 2019) and screening methods (Eo and Kim, 2019) is generally low among migrant populations, which may have negative consequences for their health.

Therefore, it is important to examine the barriers that migrant women face in accessing sexual and reproductive health (SRH) services, and their consequences in order to develop strategies and action plans to improve the SRH of migrant women.

The main objective of this research was to understand these barriers and the overall situation of migrant women in terms of their access to SRH services.

Methods

Search strategy

A systematic review of the published literature was conducted, including randomised controlled trials, cohort studies, qualitative studies and mixed-methods studies. Scopus, PubMed and Web of Science were searched, following the PRISMA guidelines (Page et al., 2021). The search strategy is outlined in Fig. 1.

PubMed, Web of Science and Scopus are three of the main databases consulted by medical researchers, as they are comprehensive and facilitate the identification of relevant and authoritative research. The latest scientific reports on the topic were selected for this research, with studies published in the past 5 years (January 2018–March 2023) included in this review. The process followed for the selection of articles was the same for all three databases. The search strategy used MeSH (medical subject headings) and DeCS (descriptors in health sciences) terms. The first step in developing the search strategy was to group a series of descriptors that made the results fit the main topic of the study. The Boolean operators AND, OR, asterisk, parentheses and quotation marks were then used to elaborate the following strategy: health* AND (reproductive OR sexual) AND migrant AND *care AND system. The asterisk was also used to expand the search to include articles with the descriptors ‘healthcare’ and/or ‘health care’. These strategies resulted in the identification of 462 publications that met the requirements: 135 from PubMed, 94 from Scopus, and 233 from Web of Science. Of these, 137 were duplicates, leaving 325 publications.

Study selection

The aim of study selection was to identify those studies that investigated migrant women’s experiences of accessing health systems, particularly SRH services. Articles were screened by both title and abstract for relevance (Fig. 1). The inclusion criteria were: (i) original research articles studying migrant women’s experiences of access to SRH services; (ii) studies using quantitative, qualitative or mixed research methods; (iii) manuscripts published in English or Spanish; and (iv) articles published between January 2018 and March 2023. The following studies were excluded: (i) systematic reviews and studies that did not focus on migrant women and their experiences; (ii) studies that were based on health professional interviews and research focused on

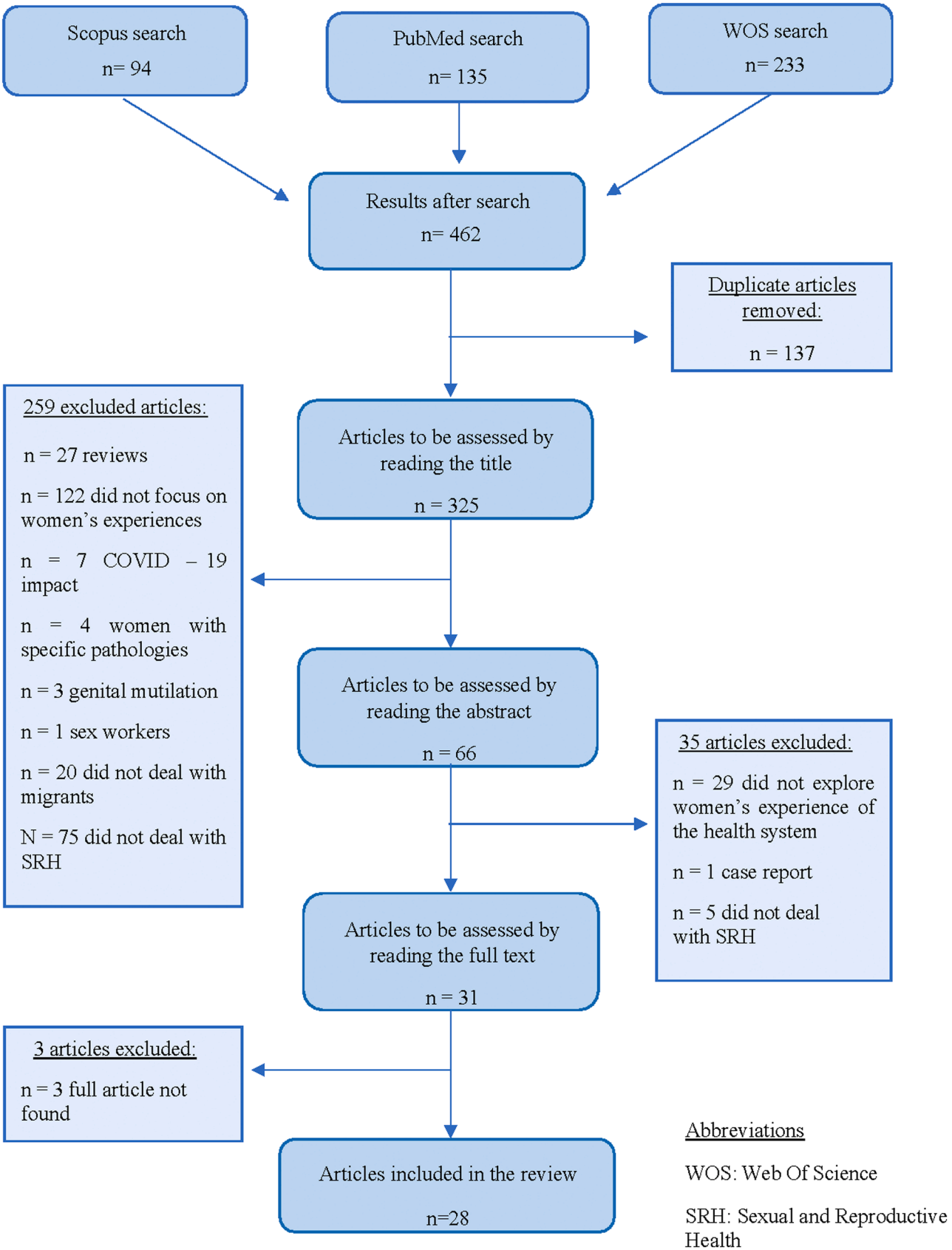

Fig. 1. PRISMA 2020 flow diagram for new systematic reviews.

Table 1
Characteristics of included literature ($n = 28$).

Author, year, country	Title	Journal	Research design[a]	Main results
Europe				
Schmidt et al., 2018, Switzerland	Barriers to reproductive health care for migrant women in Geneva: a qualitative study	Reproductive Health	C-SS: qualitative, FG	Migrant women's access to reproductive health services was affected by language barriers, lack of information, economic factors, feelings of shame, a sense of discrimination, and a sense of malfunctioning of services. At the community level, strategies and facilities to overcome these barriers were not in place
Bains et al., 2021, Norway	Challenges and barriers to optimal maternity care for recently migrated women – a mixed-method study in Norway	BMC Pregnancy and Childbirth	C-SS: mix, I-DI and MFMCQ	The main barriers mentioned by participants were: navigating the health system (46.1 %), language barriers (27.9 %), psychosocial and structural factors (12.5 %), and expectations of care
Schönborn et al., 2022, Belgium	Country of birth as a potential determinant of inadequate antenatal care use among women giving birth in Brussels. A cross-sectional study	PLoS One	C-SS: quantitative, MFMCQ	The majority of women surveyed had adequate antenatal follow-up in terms of first visit (93.9 % in the first trimester) and number of visits (82.2 % had the recommended number of visits). Women born in Sub-Saharan Africa were more likely to start consultations later. Other predictors were health insurance, housing and occupation
Sami et al., 2019, Switzerland	Giving birth in Switzerland: a qualitative study exploring migrant women's experiences during pregnancy and childbirth in Geneva and Zurich using focus groups	Reproductive Health	C-SS: qualitative, FG	Interviewees praised the availability of maternity services and the universality of the system. Some of the barriers they faced were lack of family support, lack of knowledge about medical procedures, feeling of discrimination, language barriers, administrative procedures, lack of access to health care, and constant change of doctors
Crowther and Lau, 2019, UK	Migrant Polish women overcoming communication challenges in Scottish maternity services: a qualitative descriptive study	Midwifery	C-SS: qualitative, S-SI	The woman interviewed described feelings of vulnerability and shame due to lack of language skills and lack of information in their mother tongue. They also stressed the importance of gaining confidence with the healthcare providers and the effort to get used to the differences in the Scottish system
Goodwin et al., 2018, UK	The midwife–woman relationship in a South Wales community: experiences of midwives and migrant Pakistani women in early pregnancy	Health Expectations	C-SS: qualitative, Et and S-SI	The patient–midwife relationship was important to the patient's experience of the pregnancy process. Cultural, familial, religious and communication barriers were identified as hindering understanding between patient and midwife, and affecting the relationship between the two, although these difficulties were not given equal importance
Bains et al., 2021, Norway	Satisfaction with maternity care among recent migrants: an interview questionnaire-based study	BMJ Open	C-SS: quantitative, MFMCQ	The women surveyed were satisfied with the treatment received. However, having a Norwegian partner and not being fluent in the language were associated with a higher likelihood of being dissatisfied with maternal care. Refugee women reported feeling discriminated against on the basis of race or religion more often than women who had migrated for other reasons
Lukin et al., 2023, Sweden	Syrian women's experiences of being pregnant and receiving care at antenatal clinics in Sweden for the first time after migration	Sexual & Reproductive Healthcare	C-SS: qualitative, Ph	Interviewees highlighted the importance of feeling understood by health staff and being able to communicate in order to feel safe. Some women reported not feeling respected by professionals, although most of the negative experiences were associated with being newcomers in the country

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Table 1 (*continued*)

Author, year, country	Title	Journal	Research design[a]	Main results
Grotti et al., 2018, Greece, Italy and Spain	Shifting vulnerabilities: gender and reproductive care on the migrant trail to Europe	Comparative Migration Studies	C-SS: qualitative, Et	In all three countries studied, pregnant refugee women are entitled to free medical care. In many cases, first pregnancy tests are carried out in the country of destination. Lack of language proficiency, precarious conditions and uncertainty strongly conditioned the refugee experience
Seidel et al., 2020, Germany	The influence of migration on women's use of different aspects of maternity care in the German health care system: secondary analysis of a comparative prospective study with the Migrant Friendly Maternity Care Questionnaire (MFMCQ)	Birth	C-SS: quantitative, MFMCQ	Migrant women started prenatal care later than non-migrant women. Economic status was the most important barrier. 20 % had no information on postnatal care
Cai et al., 2022, Switzerland	The pregnancy experiences and antenatal care services of Chinese migrants in Switzerland: a qualitative study	BMC Pregnancy and Childbirth	C-SS: qualitative, S-SI	The interviewees considered the Swiss healthcare system to be better than the Chinese, although they encountered barriers to access such as language, the appointment system and cultural differences
South America				
Soeiro et al., 2022, Brazil	A neglected population: sexual and reproductive issues among adolescent and young Venezuelan migrant women at the northwestern border of Brazil	International Journal of Gynecology and Obstetrics	C-SS: quantitative, Q based on MISP for SRH	The main concern of the respondents was contraceptive use, and 75 % were unable to obtain their preferred method. 10 % were pregnant. 30 % did not attend antenatal care. The main reasons were lack of knowledge about where to go and lack of documentation
Bahamondes et al., 2020, Brazil	Maternal health among Venezuelan women migrants at the border of Brazil	BMC Public Health	C-SS: mix, FG and Q based on MISP for SRH	The main concern of the respondents was access to contraceptives (33.1 %), followed by gynaecological problems (26.4 %) and symptoms associated with STIs (16.5 %). Only 37 % sought professional assistance. Many women reported encountering barriers to accessing health services. 24 % of pregnant or postpartum women did not receive any prenatal or postnatal care
Márquez-Lameda, 2022, Peru	Predisposing and enabling factors associated with Venezuelan migrant and refugee women's access to sexual and reproductive health care services and contraceptive usage in Peru	Journal of Migration and Health	C-SS: quantitative, national survey of the Venezuelan population residing in Peru	62 % of the women surveyed claimed to have no access to SHR services. Only 20.2 % of women reported having access to modern contraceptive methods. Factors such as lack of health insurance, length of residence, place of residence and low socio-economic status were associated with greater difficulties in accessing the health system
Giraldo et al., 2021, Colombia	Prenatal care of Venezuelans in Colombia: migrants navigating the healthcare system	Revista de Saúde Pública	C-SS: qualitative, S-SI	Respondents' resources were very limited, with poorly adapted housing and difficulties in accessing the health system due to bureaucratic barriers. In order to cope with the situation, many relied on migrant organisations to provide them with resources and information
Arcos et al., 2018, Chile	Motherhood inmigrant women in Chile: a qualitative study	Midwifery	C-SS: qualitative, OI	The mothers surveyed described difficulties with access to the health system due to structural barriers, high levels of stress during pregnancy due to their migrant status, and problems in raising their children
Makuch et al., 2021, Brazil	Reproductive health among Venezuelan migrant women at the north western border of Brazil: a qualitative study	Journal of Migration and Health	C-SS: qualitative, FG	The women interviewed identified barriers to both accessing the health system and obtaining long-acting contraceptive methods, although they reported that they were treated well. In addition, they were concerned about the transmission of STIs, although they reported a lack of control over STD prevention due to the promiscuity of their sexual partners

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Table 1 (*continued*)

Author, year, country	Title	Journal	Research design[a]	Main results
Dary Quintero et al., 2023, Colombia	Voluntary interruption of pregnancy and sexual and reproductive health in migrant women in Barranquilla	Revista Panamericana de Salud Pública	C-SS: qualitative, S-SI	Most of the respondents were not aware of their SRH rights and did not agree with abortion. In addition, they described difficulties in accessing health services, such as bureaucratic and financial barriers
North America				
Agbemenu et al., 2021, USA	Avoiding obstetrical interventions among US-based Somali migrant women: a qualitative study	Ethnicity & Health	C-SS: qualitative, CBPR approach, OI and FG	The strategies they used for not attending health services were: changing hospitals and doctors frequently, delaying arrival at the hospital at the time of delivery, and refusing any medical intervention during pregnancy. The main reasons given were: feeling of lack of privacy, fear of caesarean section, feeling of discrimination, and religious beliefs
Richter et al., 2020, Canada	Intersection of migration and access to health care: experiences and perceptions of female economic migrants in Canada	International Journal of Environmental Research and Public Health	C-SS: qualitative, Et and S-SI	The interviewees highlighted the importance of having a good care network to help them navigate the health system. The experience with the Canadian system was good, although they highlighted the absence of the cultural component of care and how their place of origin affected access to the system
Grassby et al., 2021, Canada	Qualitative evaluation of a mandatory health insurance 'wait period' in a publicly funded health system: understanding health inequities for newcomer immigrant women	BMJ Health	C-SS: qualitative, CBPR approach, S-SI and FG	Interviewees described feelings of uncertainty and powerlessness that had a negative impact on their health. Migrant networks were an important support in this situation
Asia				
Khin et al., 2021, Japan	Access to contraceptive services among Myanmar women living in Japan: a qualitative study	Contraception	C-SS: qualitative, S-SI	Most of the women interviewed did not use contraceptive methods. The main reasons for this were language barriers, lack of information, cultural factors, beliefs and financial factors. The consequences described were unwanted pregnancies and lack of control over their family planning
Asim et al., 2023, Hong Kong	Maternity care experience of Pakistani ethnic minority women in Hong Kong	Frontiers in Public Health	C-SS: quantitative, Q, adopted from SBWEM	Almost 60 % of respondents were very satisfied with antenatal, delivery and postnatal care. Predictors of satisfaction with care were place of birth and English proficiency. Women born in Hong Kong showed less satisfaction with care than Pakistani women
Vurgec et al., 2021, Turkey	Perinatal care experiences of immigrant Syrian women: a qualitative phenomenological study	Eastern Mediterranean Health Journal	C-SS: qualitative, pH, S-SI	The difficulties encountered by the women interviewed in pregnancy and the postpartum were related to language barriers, cultural incompatibility, lack of information and lack of social support
Sutan y Siregar, 2022, Malaysia	Reproductive health practices and use of health services among immigrant Indonesian women working in Malaysia	Revista de Saúde Pública	C-SS: quantitative, Q	95.7 % of the respondents had ever suffered from gynaecological health problems (dysmenorrhoea, irregular cycles). Although 75 % had health insurance, 78.3 % of women with reproductive problems did not attend medical services
Oceania				
Alam et al., 2022, Australia	Reasons behind low cervical screening uptake among South Asian immigrant women: a qualitative exploration	International Journal of Enviromental Research and Public Health	C-SS: qualitative, S-SI	The women interviewed showed a lack of knowledge about cervical cancer, language difficulties, access problems and personal beliefs. In addition, they demanded more information, a more proactive approach from health professionals, and new methods of self-sampling
Ilami and Winter, 2021, Australia	Iranian migrants' lived experiences of access to sexual and reproductive healthcare services in Western Australia: a conventional content analysis	Sexuality Research and Social Policy	C-SS: qualitative, S-SI	The main barriers described by participants were: feeling inadequate, lack of information, difficulty in feeling safe and trusting health professionals, previous unfavourable

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Table 1 (*continued*)

Author, year, country	Title	Journal	Research design[a]	Main results
				experiences, pre-established beliefs, and preference for Iranian sexologists
Africa				
Acharai et al., 2023, Morocco	Sexual and reproductive health and gender-based violence among female migrants in Morocco: a cross-sectional survey	BMC Women's Health	C-SS: quantitative, Q	Nearly 30 % of the respondents had undergone genital mutilation. 87.4 % had experienced gender-based violence. 62.1 % did not use contraception. Only 56 % of the pregnant women attended care prenatally. 87.9 % had been diagnosed with obstetric morbidity

[a] CBPR, community-based participatory research; C-SS, cross-sectional study; Et, ethnography; FG, focus groups; MFMCQ, Migrant Friendly Maternity Care Questionnaire; MISP, minimum initial service package; OI, open interviews; Ph, phenomenology; Q, questionnaire; SBWEM, Survey of Bangladeshi Women's Experience of Maternity Services; SRH, sexual and reproductive health; S-SI, semi-structured interviews; STI, sexually transmitted infection.

child health; (iii) studies that included migrant women with any other characteristic or circumstance that could influence their SRH healthcare experiences; (iv) studies that focused on people with specific pathologies and specific social groups within the collective of migrant women, such as sex workers and people who had undergone genital mutilation, as these were not the focus of this study and their experiences would diverge from the research; and (v) studies that investigated the influence of the coronavirus disease 2019 (COVID-19) pandemic in the field of SRH assistance, as COVID-19 was a disruptive phenomenon that could introduce more bias than useful information for this research. Based on these criteria, 259 publications were excluded after reading the title, and 35 more were excluded after reading the abstract. The search, initial screening and selection were carried out independently by two reviewers (MPS, FM), following the process specified in Fig. 1. To assess the risk of bias in the included studies, a third, independent researcher (AG) evaluated the inclusion of the selected papers in the review. Three articles for which the full text could not be found were also excluded. Ultimately, 28 articles were included in this review.

Data collection

Data were extracted using a structured template that included: study design; period; aim; sample; population; and outcomes (Table 1). For example, for the study by Schimdt et al. (2018), the following data were gathered:

- study design: cross-sectional, qualitative, with focus groups;
- period: between April 2014 and June 2015;
- aim: to explore barriers to reproductive health services in Geneva described by migrant women from a qualitative perspective;
- sample: 78 women aged 18–66 years;
- population: migrant women in Geneva, Switzerland; and
- outcomes: financial accessibility barriers, language barriers, real or perceived discrimination, lack of information, and embarrassment.

The quality of the included articles was appraised using the Critical Appraisal Skills Programme España, as reported previously (Ponze-Chazarri et al., 2023).

Results

Twenty-eight articles were included in this review. Their main characteristics are listed in Table 1, grouped by study origin: Europe (n = 11); South America (n = 7); North America (n = 3); Asia (n = 4); Oceania (n = 2); and Africa (n = 1). All were cross-sectional studies, and their research designs are shown in Table 1: 64 % (n = 18) were based on qualitative methods, 29 % (n = 8) were based on quantitative methods, and 7 % (n = 2) were based on mixed methods.

Barriers to accessing the health system

Barriers to accessing the health system are defined as obstacles that prevent or hinder migrant women from using health services. The cross-sectional studies of this research identified similar barriers (main results of Table 1), defined as: (i) lack of information; (ii) language; (iii) cultural differences; (iv) economic level; (v) administrative barriers; and (vi) discrimination. These categories are described in depth below. Fig. 2 shows the frequency of occurrence of these barriers, calculated as a percentage of the total number of studies in this review (n = 28).

Despite the wide diversity of countries in which these studies were

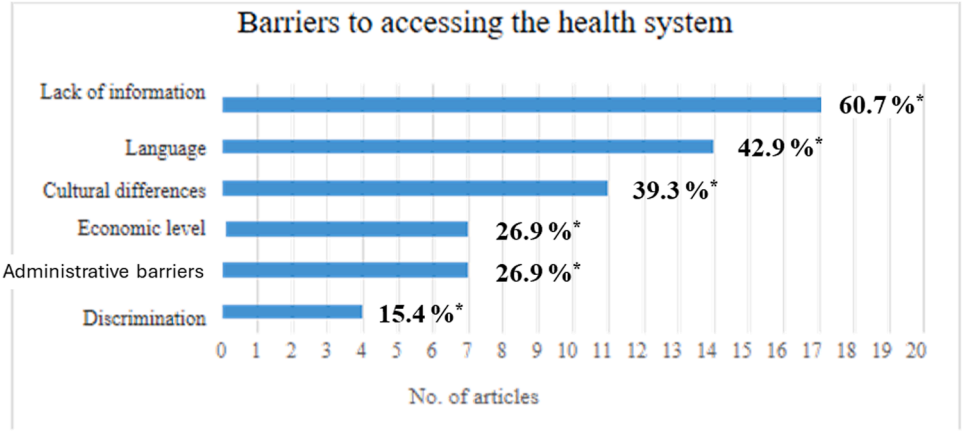

Fig. 2. Barriers to accessing the health system and number of articles in which they are identified.

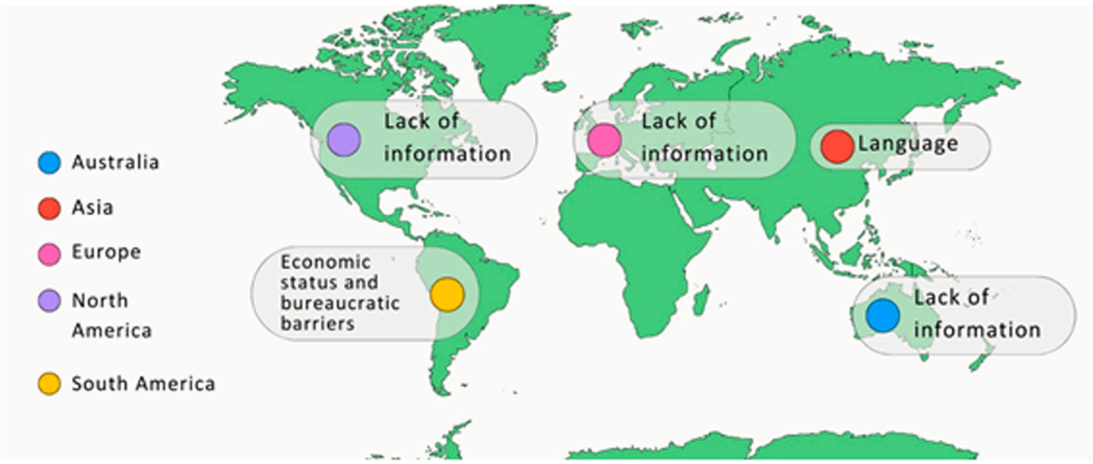

Fig. 3. Map with main barrier identified in each continent.

Table 2
Consequences of lack of information and articles in which they are mentioned.

Author, year	LAPS	IUMS	CM	LOA
Alam et al., 2022	✓			
Arcos et al., 2018	✓			
Schmidt et al., 2018	✓			
Vurgec et al., 2021	✓			
Ilami and Winter, 2021	✓			
Bains et al., 2021	✓	✓		
Sami et al., 2019	✓	✓		
Soeiro et al., 2022		✓		
Crowther and Lau, 2019		✓		
Khin et al., 2021			✓	
Makuch et al., 2021			✓	
Dary Quintero, 2023				✓
Schönborn et al., 2022				✓

LAPS, low adherence to prevention services; IUMS, inappropriate use of maternity services; CM, difficulty obtaining contraceptive methods; LOA, lack of awareness of sexual and reproductive health rights; ✓, article in which each consequence appears.

undertaken, and the nationalities of the women included, similar patterns and barriers were observed. However, it is worth noting that the same barriers do not predominate in all territories (Fig. 3). While the main barrier observed in the European, Australian and North American studies was lack of information, language was reported as the most important barrier for migrant women in Asian countries. In Latin American countries, economic difficulties and administrative procedures were found to have a greater impact on migrant women's experiences of the health system.

Lack of information

Lack of information was found to be a barrier to migrant women accessing the health system and enjoying its benefits in 60.7 % ($n = 17$) of articles. This was the most frequently mentioned barrier reported in this research (Arcos et al., 2018; Grotti et al., 2018; Schmidt et al., 2018; Crowther and Lau, 2019; Sami et al., 2019; Seidel et al., 2020; Bains et al., 2021; Giraldo et al., 2021; Grassby et al., 2021; Ilami and Winter, 2021; Khin et al., 2021; Makuch et al., 2021; Schönborn et al., 2022; Vurgec et al., 2021; Alam et al., 2022; Asim et al., 2023; Dary Quintero et al., 2023). In all of these studies, low familiarity with the healthcare system of the destination country was found to be a determinant of low access. The consequences of lack of information are summarised in Table 2. The main obstacle resulting from this barrier is low adherence to prevention services (43 %, $n = 7$), followed by inadequate use of maternity services (25 %, $n = 4$), difficulty in obtaining contraceptives (12.5 %, $n = 2$), and lack of awareness of SRH rights (12.5 %, $n = 2$).

Language

Language was identified as a barrier to accessing the healthcare system in 42.9 % ($n = 12$) of articles (Grotti et al., 2018; Schmidt et al., 2018; Crowther and Lau, 2019; Sami et al., 2019; Bains et al., 2021; Ilami and Winter, 2021; Khin et al., 2021; Vurgec et al., 2021; Alam et al., 2022; Cai et al., 2022; Asim et al., 2023).

The inability to communicate satisfactorily with health professionals, whether due to poor language skills or unfamiliarity with medical terminology, was found to make it difficult for women to receive appropriate medical care for their needs, and hindered their access to services such as cervical cancer screening (Alam et al., 2022), contraception (Khin et al., 2021) and maternity services (Cai et al., 2022; Vurgec et al., 2021). In many cases, language barriers and lack of information converge: women are unable to communicate with health professionals, making it impossible for them to obtain the necessary information from medical records, thus hindering diagnosis (Grotti et al., 2018). Similarly, migrant patients often cannot understand the staff's instructions (Sami et al., 2019). This communication impairment caused women to feel uneasy, embarrassed and distrustful (Grotti et al., 2018; Crowther and Lau, 2019; Sami et al., 2019; Bains et al., 2021).

To overcome language obstacles, interpreters were provided in many of the health centres attended by the women included in this research to facilitate communication with the women and their families (Schmidt et al., 2018; Crowther and Lau, 2019; Bains et al., 2021; Ilami and Winter, 2021). However, this service had certain shortcomings, as many women had not been informed of its existence and had not been able to take advantage of it (Schmidt et al., 2018; Bains et al., 2021). In cases where women were aware of the service, many stated that the

Table 3
Language-related challenges.

Author, year	AHS	VSR	DIS	NL
Alam et al., 2022	✓			
Cai et al., 2022	✓			
Khin et al., 2021	✓			✓
Vurgec et al., 2021	✓			✓
Asim et al., 2023				✓
Bains et al., 2021		✓		
Grotti et al., 2018		✓		
Sami et al., 2019		✓		
Crowther and Lau, 2019		✓	✓	
Bains et al., 2021			✓	
Ilami and Winter, 2021			✓	
Schmidt et al., 2018			✓	

AHS, difficulty in accessing health services; VSR, feelings of vulnerability, shame and rejection; DIS, difficulties with the interpreter service; NL, lack of information in the native language; ✓, article in which this barrier appears.

availability of the interpreter was inconsistent (Crowther and Lau, 2019). In addition, several articles highlighted the lack of information available in the migrants' native language, and how this hindered their access to the system and use of these services (Khin et al., 2021; Vurgec et al., 2021; Asim et al., 2023).

Cultural differences

In 39.3 % ($n = 11$) of articles, cultural differences were mentioned as an impediment to seeking or receiving care (Goodwin et al., 2018; Crowther and Lau, 2019; Sami et al., 2019; Richter et al., 2020; Agbemenu et al., 2021; Bains et al., 2021; Khin et al., 2021; Ilami and Winter, 2021; Vurgec et al., 2021; Alam et al., 2022; Cai et al., 2022). The main cultural shocks described by women were: the psychosocial approach to medicine, and modern methods and procedures (45.5 %, $n = 5$); the absence of religion in the treatment of pathologies (27.3 %, $n = 3$); not being able to be attended by female staff (18.2 %, $n = 2$); and the prohibition of performing cultural rituals after childbirth (18.2 %, $n = 2$) (Table 3).

Another important factor that made it difficult to seek medical care for SRH problems was pre-established beliefs. For cultural and religious reasons, for some women, SRH issues were surrounded by stigma, and discussing such issues caused shame and embarrassment. As a result, they rarely sought services such as gynaecological check-ups or contraception (Ilami and Winter, 2021; Khin et al., 2021; Alam et al., 2022). If they did seek these services, they requested female practitioners or professionals from their home countries, although these requests were often refused (Ilami and Winter, 2021; Cai et al., 2022).

Economic level

Economic hardship was identified as a barrier to accessing the health system in 26.9 % ($n = 7$) of articles (Schmidt et al., 2018; Grotti et al., 2019; Seidel et al., 2020; Giraldo et al., 2021; Khin et al., 2021; Márquez-Lameda, 2022; Dary Quintero et al., 2023). Resource constraints limited the utilisation of SRH services. Low utilisation of SRH services by migrant women can, in part, be the consequence of a situation of precariousness and low economic resources combined with the high costs of health services.

Administrative barriers

Administrative barriers were detected in 26.9 % ($n = 7$) of articles (Schmidt et al., 2018; Márquez-Lameda, 2019; Sami et al., 2019; Bains et al., 2021; Giraldo et al., 2021; Grassby et al., 2021; Dary Quintero et al., 2023). The main difficulties related to administrative barriers identified were: lack of documentation accrediting them as residents (57.1 %, $n = 4$); poorly functioning health services (42.9 %, $n = 3$); and changing migration legislation (28.6 %, $n = 2$).

Discrimination

In 15.4 % ($n = 4$) of articles, discrimination was identified as a factor affecting migrant women's experiences of the health system (Schmidt et al., 2018; Sami et al., 2019; Agbemenu et al., 2021; Lukin et al., 2023). The narratives of the women revealed widespread feelings of fear, shame and being judged by health workers. In some cases, women reported noticing staff impatience with the language barrier (Schmidt et al., 2018), and disapproval of their vulnerable status by birth attendants (Sami et al., 2018; Lukin et al., 2023), which led to feelings of guilt. Some of the interviewees claimed not to have received the same attention as resident women, and mentioned attending medical appointments where the health professional invited students to the consultation without their permission. These situations were perceived as a violation of their privacy and a consequence of their migrant status (Sami et al., 2019; Agbemenu et al., 2021).

Strategies facilitating access to health services

The provision of means to facilitate access to services by the migrant community was found to differ between the countries included in this review. For example, health issues were barely discussed with women who had migrated to Switzerland (Schmidt et al., 2018), whereas women who had migrated to Canada and Colombia received guidance from the community to access the health system and to fill in the necessary documentation (Giraldo et al., 2020; Grassby et al., 2021). In the latter two cases, the sense of unity and responsibility towards the rest of the community stands out. On the other hand, only two of the studies included in this review discussed the measures that the women interviewed felt needed to be implemented at community level. It is worth noting the importance that the interviewees attached to education, with many stating that having the possibility to attend classes or information meetings in the community would be a good way to improve their lives (Schmidt et al., 2018; Cai et al., 2022).

The main tool used by migrant women to access health system services was social capital. The only source of information for many migrant women was the people closest to them, who were already familiar with the system and could guide them regarding the steps to take by offering their own experience (Richter et al., 2020; Cai et al., 2022; Lukin et al., 2023). In some cases, women also tried to seek information in their own language (Cai et al., 2022), and even chose to seek out health professionals in their own country, believing that they would better understand their situation and SRH needs (Ilami and Winter, 2021). Other women avoided health services altogether, preferring to seek alternatives such as self-medication (Agbemenu et al., 2021).

Discussion

This review found that lack of information was the main barrier to accessing the health system faced by migrant women. Although studies from different sociopolitical contexts were included in this review, this research, in accordance with other reviews (Jain et al., 2022), found that the barriers faced by migrant women worldwide have not evolved, with no improvement in their situation over the last decades. For many migrant women, it was common not to attend preventive services as they were unaware of their existence (Arcos et al., 2018; Schmidt et al., 2018; Vurgec et al., 2021) or access routes (Sami et al., 2019; Bains et al., 2021; Ilami and Winter, 2021). There is also evidence for low adherence to preventive services, such as cancer screening (Ponce-Chazarri et al., 2023) and vaccination programmes (Deal et al., 2023), in migrant populations overall. This is particularly relevant for migrant women, due to health outcomes related to gender as a determinant. A telephone support intervention that has been successful in improving adherence to breast, cervical and colorectal cancer screening among low-income women was carried out in New York City (Dietrich et al., 2006). This intervention improved cancer screening rates among migrant women, and seemed to be well suited to health plans, large medical groups and other organisations that seek to increase cancer screening rates and address disparities in care.

Language barriers were the second most commonly mentioned barrier to accessing the health system for migrant women in this research. In the USA, a community education intervention, considering the racial/ethnic and language concordance of the presenter, was tested to increase the uptake of colorectal cancer screening among foreign-born Chinese American women (Kim et al., 2018). This study found that group education could be effective in promoting colorectal cancer screening. However, a racial/ethnic and language concordant presenter was not related to the uptake of colorectal cancer screening, confirming that language barriers do not appear to play a strong role in the uptake of colorectal cancer screening among migrants.

This review found that many women did not know where and how they could obtain long-acting contraceptive methods, limiting their access to contraception (Khin et al., 2021; Makuch et al., 2021). They were also unaware of their SRH rights, such as the right to pregnancy care (Schönborn et al., 2022; Dary Quintero et al., 2023) and the right to

voluntary termination of pregnancy (Dary Quintero et al., 2023). However, educational programmes carried out in schools in Cuba (Hernández-Millán et al., 2015), Mexico (Campero et al., 2021) and Brazil (Andrade et al., 2009) were successful in raising awareness about SRH rights and generating positive changes in the sexual behaviour of adolescents.

These findings are consistent with previous work, which identified lack of information and language as barriers to accessing health systems (Mishra et al., 2015; Ali and Watson, 2018). It is worth mentioning that difficulty in understanding the language of the destination country is a barrier present at various levels of migrants' experiences of the health system, from accessing the health system to interacting with health workers (Ali and Watson, 2018).

Similar to the findings of this review, cultural background has been identified previously as a factor conditioning people's experiences of health services in a number of ways, including reliance on advice from family members, and stigma in seeking care (O'Mahoney et al., 2013; Alzubaidi et al., 2015; Satinsky et al., 2019). The influence of religion is related to both the level of knowledge of SRH and access to services, as many migrant women have been found to be embarrassed and ashamed to seek medical attention on SRH issues due to religious beliefs (Arousell and Carlbom, 2016). Additionally, strategies to cope with menstruation by women and girls globally vary greatly between and within countries, dependent on local traditions and cultural beliefs, among other factors (Sumpter and Torondel, 2013). Due to these restrictions, women often manage menstruation with methods that could be unhygienic or inconvenient, which should be considered by health professionals. Moreover, the range of cultural food practices during pregnancy, including restricting or avoiding foods high in protein and iron, and foods rich in vitamins and minerals, are diverse among women globally. Olajide et al. (2024) found a need for culturally appropriate nutrition education resources to guide pregnant migrants through healthy and harmless cultural food practices and overall nutrition during this crucial period.

There are numerous barriers at institutional level that prevent migrants from accessing health services, especially upon arrival (Castañeda, 2009). In many countries, the lack of supporting documentation severely reduces the benefits available to migrants, resulting in a large proportion of the undocumented migrant population being forced to pay for health services (Hacker et al., 2015). Other studies have mentioned barriers related to lack of knowledge by health professionals due to their unfamiliarity with the legislation; cases have been described in which staff did not know that undocumented migrants had the right to access emergency services (De Vito et al., 2015).

Additional studies have suggested that it is not uncommon for migrant women to experience discrimination and hostility (Davidson et al., 2022; Obisie-Nmehielle et al., 2022). In the case of pregnant women, experiencing discrimination has been associated with premature births and low-birthweight babies (Mustillo et al., 2004).

Therefore, this review found similar barriers to accessing the health system for migrant women as other studies. These global barriers should be taken into consideration in order to avoid difficulties and delays in access to the health system by migrant women.

Implications for practice, policy and future research

It is important to highlight the significance of having interpreter services in health facilities to facilitate communication between staff and migrants (Bischoff et al., 2003; Hadziabdic et al., 2009). Effective communication, whether in the presence of an interpreter or not, has been associated with increased patient reporting of symptoms (Bischoff et al., 2003).

One of the main consequences of cultural differences and established beliefs is a decrease in the use of health services (Alzubaidi et al., 2015; Satinsky et al., 2019). The result of this underutilisation of health care is a delay in the diagnosis of diseases (Alzubaidi et al., 2015), and increased risk of complications in situations such as pregnancy (Essén et al., 2000). Therefore, there is an urgent need to design institutional strategies and policies that ensure culturally sensitive treatment adapted to the needs of migrant women (Mladovsky et al., 2012).

In the case of illness, migrants opt to seek other strategies before attending health facilities (Linardelli and Anzorena, 2021), with the inherent health risk that this entails. The consequences of institutional barriers observed for undocumented migrant women include increased risk of pregnancy-related pathologies, ectopic pregnancies and contracting human immunodeficiency virus (Linardelli and Anzorena, 2021). Thus, migrant women have more complications before, during and after childbirth, including perineal tears, haemorrhage (Almeida et al., 2014) and mental disorders, such as postpartum depression (Keygnaert et al., 2016; Heslehurst et al., 2018). Late initiation of maternal care has also been linked to increased risk of stillbirth (Mozooni et al., 2020). For these reasons, it is imperative to ensure free and accessible maternity services for migrant women.

In the articles included in this review, the strategies employed by women rely primarily on informal resources, with 'informal' being understood as those that are not offered by institutions. Having these strategies and being able to draw on their own resources has been found to bring migrant women closer to the health system, and to contribute to their empowerment and health literacy (Floyd and Sakellariou, 2017).

Research analysing the enablers of access to health services suggests that facilitating access for migrants requires action on three fronts: removing legal restrictions on migrants' access to preventive services; training health workers to provide culturally sensitive care, promoting the universality of the health system; and making local health services accessible (O'Donnell et al., 2016). However, barriers continue to outweigh enablers, hindering and delaying migrants' access to health services.

Limitations

All studies included in this review were cross-sectional studies, which means the results have a low level of evidence. However, given that the objective of this research was not to evaluate a health intervention but rather to identify the policy-level barriers that limit the access of migrant women to SRH services, their consequences, and the strategies that are put in place to overcome these barriers, it was expected that more descriptive studies would be found than other types of study. Another limitation was that articles were limited to those published in English or Spanish. This may have excluded relevant research in other languages. However, articles from all over the world were identified, including some from Africa and Asia, which was not expected. Future research in this field should include observational and experimental studies to provide better evidence on the issue.

Conclusions

This review identified a number of barriers that hinder the access of migrant women to SRH services globally. These barriers include: lack of information (57 %); language issues (43 %); cultural differences (39 %); economic status (25 %); administrative barriers (25 %); and discrimination (14 %).

The aforementioned barriers have been found to impact health outcomes and, in particular, the provision of maternity benefits, with the main consequences being delays in the start of maternity care, feelings of frustration and fear, and non-attendance at optional services, among others. These situations can increase the risk of complications before, during and after pregnancy. Similarly, these barriers affect the use of contraceptive methods, with many women unable to obtain the method of choice due to reasons related to lack of availability, scarcity of resources and pre-established stigmas. This leads to lack of control over family planning for many migrants, and an increase in the number of unwanted pregnancies.

Strategies found to overcome existing barriers were scarce, depending exclusively on the resources of migrant women. These strategies at both community and individual level are based on: obtaining information provided by migrant networks; seeking information in their native language; seeking professionals from the same country of origin; asking for help from family and friends; and even avoiding the health system.

There is an urgent need to establish strategies at institutional level that bring health services closer to migrant women, and to train health personnel to offer culturally sensitive services in accordance with the needs of migrant women, reducing existing barriers and contributing to the health literacy of this group, with the aim of improving their SRH.

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CRediT authorship contribution statement

María Pérez-Sánchez: Writing – original draft. **Palmira Immordino:** Writing – review & editing. **Gaetano Romano:** Formal analysis. **Antonio Giordano:** Resources, Formal analysis. **Carmen García-Gil:** Methodology, Conceptualization. **Fátima Morales:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Investigation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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