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Review

Barriers migrant women face in accessing sexual and reproductive health: An integrative review

Barreiras de acesso à saúde sexual e saúde reprodutiva de mulheres migrantes: revisão integrativa

Barreras para el acceso a la salud sexual y reproductiva de las mujeres migrantes: una revisión integradora

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Abstract

Objective: To synthesize diverse evidence related to the barriers migrant women face in accessing sexual and reproductive health care. **Method:** This is an integrative review study conducted in the Medline, Embase, Web of Science and Scopus databases. It included full-text articles published between 2014 and 2023, regardless of study type and written in Portuguese, English and Spanish. **Results:** A total of 230 studies were identified, including 35 of them (all published between 2017 and 2023). The barriers to accessing sexual and reproductive health care were classified into four categories: Sociocultural barriers (social stigma); Barriers related to the migrant women's circumstances (financial factors); Barriers related to the health professionals (male gender); and Barriers related to the health systems and services (limited accessibility). **Conclusion:** Although the barriers were categorized in a didactic way, they were found to be complexly intertwined and inter-related, regardless of whether they were sociocultural or related to the migrant women's circumstances, to the health professionals or to the health systems and services. Consequently, overcoming these barriers will certainly require organized actions along with other society segments beyond the health sector itself.

Descriptors:
Women. Migrants. Access Barriers. Sexual Health; Reproductive Health.

What is already known

Migrant women in complex life situations and marginalized suffer from a communication breakdown between health systems and the challenges inherent to the migratory process, which hinders their access to sexual and reproductive health.

What this study adds

A total of 60 types of sexual and reproductive health access barriers were identified. The COVID-19 pandemic intensified pre-existing barriers and imposed new ones on migrant women.

Resumo

Objetivo: Sintetizar evidências relacionadas às barreiras enfrentadas por mulheres migrantes para o acesso à atenção em saúde sexual e saúde reprodutiva. **Método:** Trata-se de um estudo de revisão integrativa, realizado nas bases de dados Medline, Embase, Web of Science e Scopus, que incluiu artigos publicados entre 2014 e 2023, disponíveis em texto completo, independentemente do tipo de estudo, nos idiomas português, inglês e espanhol. **Resultados:** Foram identificados 230 estudos, sendo incluídos 35, publicados entre 2017 e 2023. As barreiras no acesso à atenção em saúde sexual e saúde reprodutiva foram classificadas em quatro categorias: barreiras socioculturais (estigma social); barreiras relacionadas às condições das mulheres migrantes (fatores financeiros); barreiras relacionadas aos profissionais de saúde (sexo masculino); barreiras relacionadas ao sistema e aos serviços de saúde (falta de acessibilidade). **Conclusão:** As barreiras foram categorizadas didaticamente, mas verificou-se que elas estão implicadas umas às outras, de forma complexa e inter-relacionada, independentemente de serem barreiras socioculturais, relacionadas à situação das mulheres migrantes, aos profissionais de saúde ou ao sistema e aos serviços de saúde. Com isso, constata-se que a superação dessas barreiras exigirá ações organizadas em conjunto com outros setores da sociedade que extrapolam o setor saúde.

Descritores:

Mulheres. Migrantes. Barreiras ao Acesso. Saúde Sexual; Saúde Reprodutiva.

Resumen

Objetivo: Sintetizar la evidencia relacionada con las barreras que enfrentan las mujeres migrantes para acceder a la atención de salud sexual y reproductiva. **Método:** Estudio de revisión integradora, realizado en las bases de datos Medline, Embase, Web of Science y Scopus. Se incluyeron artículos publicados entre 2014 y 2023, disponibles en texto completo, independientemente del tipo de estudio, en portugués, inglés y español. **Resultados:** Se identificaron 230 estudios, de los cuales se incluyeron 35, publicados entre 2017 y 2023. Las barreras para acceder a la atención de salud sexual y reproductiva se clasificaron en cuatro categorías: barreras socioculturales (estigma social); barreras relacionadas con las condiciones de las mujeres migrantes (factores financieros); barreras relacionadas con los profesionales de la salud (sexo masculino); barreras relacionadas con el sistema y los servicios de salud (falta de accesibilidad). **Conclusión:** Si bien las barreras se categorizaron didácticamente, se constató que están interconectadas de manera compleja, ya sea que se trate de barreras socioculturales, relacionadas con la situación de las mujeres migrantes, con los profesionales de la salud o con el sistema y los servicios sanitarios. Por lo tanto, la superación de estas barreras requiere acciones organizadas en conjunto con otros sectores de la sociedad que trascienden el ámbito de la salud.

Descriptores:

Mujeres. Migrantes. Barreras de Acceso. Salud Sexual; Salud Reproductiva.

INTRODUCTION

Migration is a global phenomenon that has been part of humanity since the beginning of its history, manifesting itself with higher or lesser intensity, and enriching and developing societies with new cultural, social and human dimensions and aspects. In addition to that, it is a fundamental human right and the broadest manifestation of the free circulation right.[1]

Since the enactment of the Universal Declaration of Human Rights at the United Nations General Assembly in December 1948, mutual cooperation across countries has been established to ensure rights considered basic for life, including effective access to information and services related to sexual and reproductive issues to all people, including migrants, refugees and other foreigners.[2]

In this sense, the term "migrant" is used to refer to all those who, for economic or individual reasons, choose to live in a country other than their own. As for refugees, they migrate from one country to save their life or ensure freedom of their rights for fear of persecution. In turn, internally displaced people live in a situation that is similar to the refugees', but they migrate within their own country.[1]

Irregular or forced migration exposes them to hostile situations such as work-related accidents, rapes, unplanned pregnancies, tuberculosis and Sexually Transmitted Infection (STIs) such as the Human Immunodeficiency Virus (HIV).[3]

Brazil has been pointed out as an appealing destination for the migratory flow, a result of the economic crisis faced by traditional welcoming nations in the past decade, of the positive performance shown by the Brazilian economy and of its migration policy. More recently, it consolidated itself as a structural destination for migratory life projects, ceasing to be a mere emergency destination, sheltering more than 2 million migrants in 2025, from approximately 200 nations and with the Venezuelan, Haitian, Angolan and Cuban populations standing out. This new scenario is accompanied by changes in the national migration policy after the enactment of the National Migration, Shelter and Statelessness Policy, which substituted the 2017 Migration Law.[4]

It is estimated that there were nearly 135 million international migrant women in 2020, which represents 3.5% of the female world population. Added to social inequalities sustained by gender, age group, social class, ethnic-cultural and linguistic issues, living in a cultural context other than one's own represents deeper social vulnerability and gender-based violence and, consequently, more difficulty accessing comprehensive health care for migrant women, including Sexual and Reproductive Health (SRH).[5]

Many migrant women do not know how to access SRH services or fail to seek them due to the absence of guaranteed access or to their irregular migration status, for assuming that they might be reported and/or lose their jobs.[6] These risks can be worsened due to limited access to health care services and social benefits, wheher in the original, transit, destination or return territories.[3]

Starting from the principle that these migrant women should have their sexual and reproductive rights guaranteed, in addition to the fact that countries face countless challenges to ensure them, the purpose of this study is to define the barriers migrant women face in guaranteeing these rights in terms of access to SRH care.

This problem is related to Goal five of the 2023 Agenda for Sustainable Development, entitled "Gender Equality", as well as cross-sectionally associated with Goal three: "Health and Well-Being". Thus, its relevance lies in contributing to promoting, protecting and ensuring SRH, as well as sexual and reproductive rights, in consonance with the Action Program implemented by the International Conference on Population and Development, with the Beijing Action Platform and with the documents resulting from its review conferences.[7] Therefore, the objective was to synthesise diverse evidence related to the barriers migrant women face in accessing SRH care.

METHODS

Type of study

This is an integrative literature review, a type of study that allows searching and critically analyzing relevant scientific productions, supporting decision-making and improving the clinical practice from a synthesis of the knowledge obtained from multiple studies published on a given subject matter.[8]

The stages described by Mendes, Silveira and Galvão (2008) as necessary to develop a relevant integrative review were followed to conduct this study, as described below.[8]

Identifying the topic and selecting the research question

The guiding question for this research was developed by means of the PICo strategy, an acronym where: "P"=Participants (migrant women); "I"=Phenomenon of Interest (access barriers); and "Co"=Study Context (sexual and reproductive health)[9]. Consequently, the research question was defined as follows:"Which are the SRH care access barriers faced by migrant women".

The following Emtree terms were selected for the searches made in the databases: "female", "migrant", "health care access", "health service" and "sexuality and reproduction"; as well as these MeSH terms: "women", "transients and migrants", "health services accessibility", "reproductive health", "sexual health"and "sex education", which altogether comprised the search strategy when combined by means of "AND" and "OR" Boolean operators.

Establishing the inclusion and exclusion criteria, the sampling method and the search in the literature

The inclusion criteria were as follows: articles published between 2014 and 2023, available in full, regardless of study type, in Portuguese, English and Spanish and answering the research question. In turn, the exclusion criteria corresponded to duplicate articles, those including men in the study population (except for those focused on health professionals' points of view), editorials, preprints, articles with no abstract and materials classified as theses, dissertations or monographies.

The data were collected in November 2023 from the following databases: Medical Literature Analysis and Retrieval System Online (MEDLINE, via PubMed); Excerpta Medica Database (EMBASE); Web of Science and Scopus, due to the greater range of the scientific collection in these platforms. Thus, the main strategy was tested in each database and all due operational adjustments were implemented, resulting in the final strategy presented in Chart 1.

Chart 1. Search strategies used in the databases, Porto Velho, RO, Brazil, 2024.

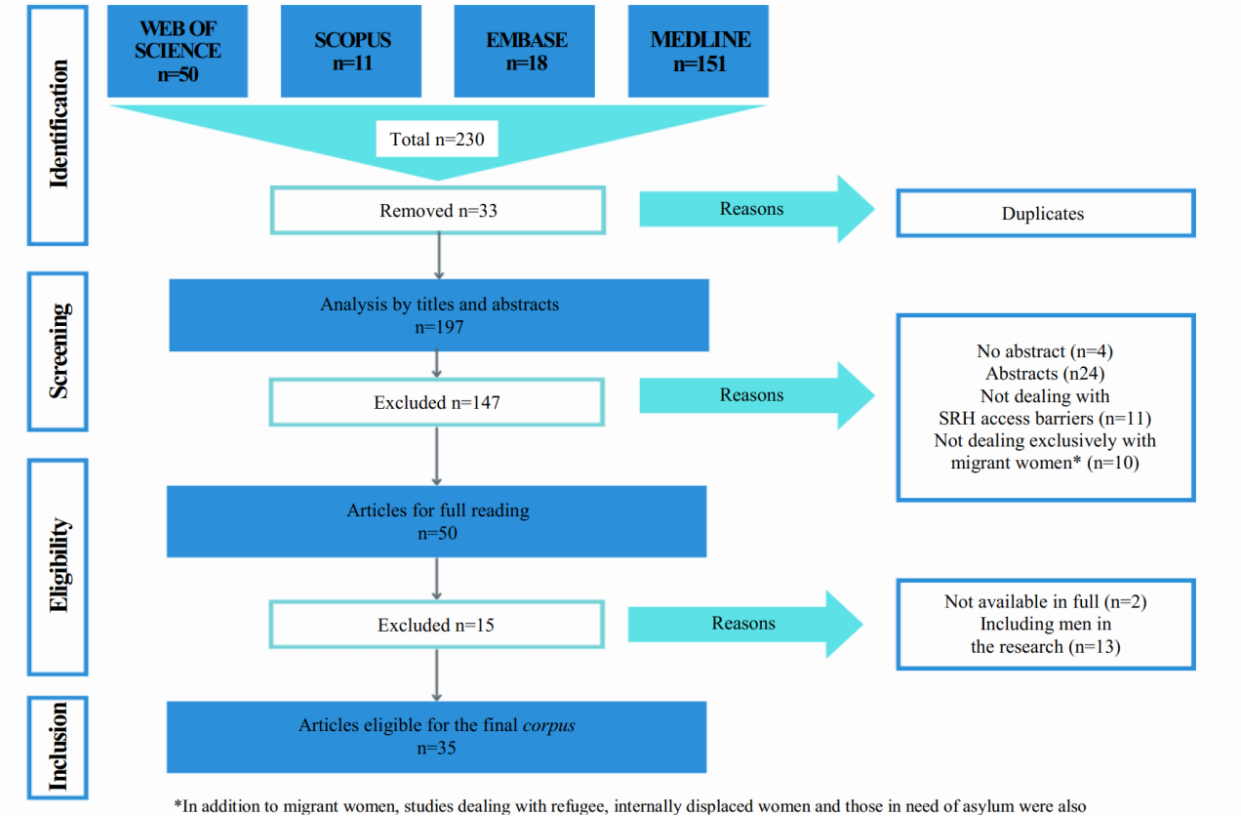
Database	Search syntax
SCOPUS	INDEXTERMS (women OR girl* OR woman OR "Women's Group*" OR "Women Groups") AND INDEXTERMS ("Transients and Migrants" OR "Migrant* and Transient*" OR transient* OR squatter* OR "Migrant Worker*" OR "Worker*, Migrant*" OR migrant* OR nomad*) AND INDEXTERMS ("Health Services Accessibility" OR "Access to Care*" OR "Access To Care, Health" OR "Access to Contraception*" OR "Access to Health Care" OR "Access to Health Services" OR "Access to Medication*" OR "Access to Medicine*" OR "Access to Therap*" OR "Access to Treatment*" OR "Access, Contracept*" OR "Access, Medication" OR "Accessibilit*, Health Services" OR "Accessibility of Health Services" OR "Accessibility, Program" OR "Availability of Health Services" OR "Availability, Contraceptive" OR "Care*, Access to" OR "Contraception, Access to" OR "Contracepti* Acces*" OR "Contraceptive Availability" OR "Health Services Availability" OR "Health Services Geographic Accessibility" OR "Medication Acce*" OR "Medication, Access to" OR "Medicine*, Access to" OR "Program Accessibility" OR "Therapy, Access to" OR "Treatment, Access to") AND INDEXTERMS ("Reproductive Health" OR "Health, Reproductive") OR INDEXTERMS ("Sexual Health" OR "Health, Sexual") OR INDEXTERMS ("Sex Education" OR "Sexuality Education" OR "Education, Sexuality" OR "Education, Sex" OR "Family Planning Instructor*" OR "Instructor*, Family Planning" OR "Family Planning Education" OR "Education, Family Planning" OR "Family Planning Training" OR "Training, Family Planning")
EMBASE	'female'/exp AND 'migrant'/exp AND 'health care access'/exp AND 'health service'/exp AND 'sexuality'/exp AND 'reproduction'/exp
MEDLINE	(((((((Women[MeSH Terms]) OR (Women[Title/Abstract])) OR (Girl[Title/Abstract])) OR (Woman[Title/Abstract])) OR (Women's Group[Title/Abstract])) OR (Women Groups[Title/Abstract])) AND (((((((Transients and Migrants[MeSH Terms]) OR ("Transients and Migrants"[Title/Abstract])) OR (Transient[Title/Abstract])) OR (Squatter[Title/Abstract])) OR (Migrant Worker[Title/Abstract])) OR (Worker*[Title/Abstract])) OR (Migrant*[Title/Abstract])) OR (Nomad*[Title/Abstract]))) AND ((((((((((((((((((((((((((((Health Services Accessibility[MeSH Terms]) OR (Health Services Accessibility[Title/Abstract])) OR (Access to Care*[Title/Abstract])) OR (Access To Care, Health[Title/Abstract])) OR (Access to Contraception*[Title/Abstract])) OR (Access to Health

	Care[Title/Abstract])) OR (Access to Health Services[Title/Abstract])) OR (Access to Medication*[Title/Abstract])) OR (Access to Medicine*[Title/Abstract])) OR (Access to Therap*[Title/Abstract])) OR (Access to Treatment*[Title/Abstract])) OR (Access, Contracept*[Title/Abstract])) OR (Access, Medication[Title/Abstract])) OR (Accessibilit*, Health Services[Title/Abstract])) OR (Accessibility of Health Services[Title/Abstract])) OR (Accessibility, Program[Title/Abstract])) OR (Availability of Health Services[Title/Abstract])) OR (Availability, Contraceptive[Title/Abstract])) OR (Care*, Access to[Title/Abstract])) OR (Contraception, Access to[Title/Abstract])) OR (Contracepti* Acces*[Title/Abstract])) OR (Contraceptive Availability[Title/Abstract])) OR (Health Services Availability[Title/Abstract])) OR (Health Services Geographic Accessibility[Title/Abstract])) OR (Medication Acce*[Title/Abstract])) OR (Medication, Access to[Title/Abstract])) OR (Medicine*, Access to[Title/Abstract])) OR (Program Accessibility[Title/Abstract])) OR (Therapy, Access to[Title/Abstract])) OR (Treatment, Access to[Title/Abstract]))) AND ((((((((((((((((Reproductive Health[MeSH Terms]) OR (Reproductive Health[Title/Abstract])) OR (Health, Reproductive[Title/Abstract])) OR (Sexual Health[MeSH Terms])) OR (Sexual Health[Title/Abstract])) OR (Health, Sexual[Title/Abstract])) OR (Sex Education[MeSH Terms])) OR (Sex Education[Title/Abstract])) OR (Sexuality Education[Title/Abstract])) OR (Education, Sexuality[Title/Abstract])) OR (Education, Sex[Title/Abstract])) OR (Family Planning Instructor*[Title/Abstract])) OR (Instructor*, Family Planning[Title/Abstract])) OR (Family Planning Education[Title/Abstract])) OR (Education, Family Planning[Title/Abstract])) OR (Family Planning Training[Title/Abstract])) OR (Training, Family Planning[Title/Abstract]))
WEB OF SCIENCE	TS=(Women OR Girl* OR Woman OR "Women's Group*" OR "Women Groups") AND TS=("Transients and Migrants" OR "Migrant* and Transient*" OR Transient* OR Squatter* OR "Migrant Worker*" OR "Worker*, Migrant*" OR Nomad*) AND TS= ("Health Services Accessibility" OR "Access to Care*" OR "Access To Care, Health" OR "Access to Contraception*" OR "Access to Health Care" OR "Access to Health Services" OR "Access to Medication*" OR "Access to Medicine*" OR "Access to Therap*" OR "Access to Treatment*" OR "Access, Contracept*" OR "Access, Medication" OR "Accessibilit*, Health Services" OR "Accessibility of Health Services" OR "Accessibility, Program" OR "Availability of Health Services" OR "Availability, Contraceptive" OR "Care*, Access to" OR "Contraception, Access to" OR "Contracepti* Acces*" OR "Contraceptive Availability" OR "Health Services Availability" OR "Health Services Geographic Accessibility" OR "Medication Acce*" OR "Medication, Access to" OR "Medicine*, Access to" OR "Program Accessibility" OR "Therapy, Access to" OR "Treatment, Access to") AND TS=("Reproductive Health" OR "Health, Reproductive" OR "Sexual Health" OR "Health, Sexual" OR "Sex Education" OR "Sexuality Education" OR "Education, Sexuality" OR "Education, Sex" OR "Family Planning Instructor*" OR "Instructor*, Family Planning" OR "Family Planning Education" OR "Education, Family Planning" OR "Family Planning Training" OR "Training, Family Planning")

Source: The authors (2024).

The articles were searched and selected based on the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guide, preparing a flowchart with four stages: Identification, Selection, Eligibility and Inclusion of studies, which showed how the final *corpus* was obtained (Figure 1).[10]

Figure 1. Flowchart showing the process followed to select articles. Porto Velho, RO, Brazil, 2024.



Source: The authors (2024), adapted from the PRISMA recommendation.

In all, 50 articles were selected in Web of Science, 11 in SCOPUS, 18 in EMBASE and 151 in MEDLINE, totaling 230 articles written in Portuguese, English and Spanish. They were all exported to Rayyan® for the initial selection of references in the context of a review, by titles and abstracts. Subsequently, 33 duplicate articles were excluded. The other 197 articles were subjected to analysis by reading their titles and abstracts, resulting in 147 excluded materials, for the following reasons: 4 articles had no abstract, 11 did not dealt with access barriers for SRH services and 130 did not exclusively discuss the topic of migrant women. Consequently, 50 articles were selected for full-reading, excluding 15. In all, 35 articles were chosen to comprise the final *corpus*. The entire selection process, from identification in the databases to defining the final *corpus*, was in charge of two researchers who worked simultaneously and as a team.

It is noted that this entire review was targeted at migrant women and that other classifications of women who migrate forcefully or voluntarily were detected in the sample, such as refugee and internally displaced women and those in need of asylum, also considering them in the greater category of "migrant women".

Defining the information to be extracted from the studies selected and categorizing the materials

The data were extracted from the *corpus* based on an adapted validated instrument[11] that enabled analyzing each article separately, both at the methodological level and regarding the research results. This adaptation was divided into two parts: the identification data pertaining to the articles and authors, the study context, the type of scientific journal and the methodological characteristics were addressed in the first one. In turn, the second part dealt with identifying SRH access barriers pointed out by the authors, with verifying if the studies presented a specific or general approach to SRH and with determining care practices/attitudes to face and overcome the SRH access barriers identified.

Evaluating the studies included in the integrative review

One of the available possibilities in the literature to assess the levels of evidence established is based on the proposal by Melnyk and Fineout-Overholt (2011), namely: Level I - Evidence from systematic reviews or meta-analyses of multiple controlled and randomzied clinical studies; Level II - Evidence from

at least one well-designed, controlled and randomized clinical trial; Level III - Evidence from well-designed non-randomized clinical trials; Level IV - Evidence from well-designed cohort/case-control studies; Level V - Evidence from systematic reviews of descriptive and qualitative studies; Level VI - Evidence from a single descriptive or qualitative study; and Level VII - Evidence from authorities' or experts' opinions.[12]

Interpreting the results

The analysis was performed by organizing a data bank in Microsoft Office Excel to identify and categorize the barriers migrant women face in accessing SRH, duly detected by authors. In order to analyze the care practices and attitudes to face and overcome the SRH access barriers pointed out in the articles, a text *corpus* was organized with the answers to the question; this *corpus* was processed in the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ) software program to create a word cloud. This statistical technique graphically groups and organizes terms based on their frequency, so that larger font sizes signal more relevance, as they are used more times in each *corpus*.[13]

Presenting the knowledge synthesis

The results were organized based on the bibliometric data pertaining to the articles included, followed by the identification of the types of barriers and their characteristic factors surveyed in the *corpus*.

Ethical issues

For being an integrative review, this study waives registration and appraisal by any Research Ethics Committee, according to the national ethics guidelines for research studies with human beings.

RESULTS

The studies selected were published between 2017 and 2023, with 2022 concentrating the most publications, which corresponded to 28.57% (10) of the articles. Of all the publications analyzed, 88.5% (31) were in English and mostly indexed in the MEDLINE database: 54.29% (19). A total of 20 different contexts were identified across the studies analyzed in the survey, classifying one of the groups as “multiple contexts”, considering plurality and the impossibility of defining an individual classification, representing 25.71% (9) of the studies. The other 74.29% (26) were developed in different countries, with Brazil standing out: 14.29% (5).

Chart 4. Characterization of the studies included, Porto Velho, RO, Brazil, 2024.

Author(s)/ Year	Objective	Database/ Language/LoE	Context	Participants	Period	SRH approach
Sawadogo et al. (2023)[14]	To identify the barriers and facilitating factors for migrant women to access SRH services.	EMBASE English V	Multiple contexts	Migrant and displaced women, as well as those in need of asylum or refugees	Not mentioned	General
Azad et al. (2022)[15]	To explore the knowledge, attitude and practice regarding family planning and the associated factors among Rohingya women living in refugee camps in Bangladesh.	EMBASE English VI	Chittagong Division, Bangladesh	Refugee women	October-December 2019	Family planning
Egli-Gany et al. (2021)[16]	To identify the social and structural determinants of migrants' and refugees' SRH rights.	EMBASE English V	Multiple contexts	Migrants, refugees and/or people in need of asylum	Not mentioned	STIs, sexual violence and unplanned pregnancies
Khin et al. (2021)[17]	To explore access barriers, with a specific focus on contraceptive services and their consequences among migrants from Myanmar in Japan.	EMBASE English VI	Chiba and Saitama, Tokyo, Japan	Migrant women and health professionals who are also interpreters	January-April 2020	Contraception
Bahamondes et al. (2020)[18]	To provide an overview of the SRH issues that affect Venezuelan migrant women in the state of Roraima, Brazil.	MEDLINE English V	Boa Vista and Pacaraima, Roraima, Brazil	Migrant women	November 2019	General
Chalmiers et al. (2022)[19]	To analyze studies on refugee women's contraceptive preferences and their experience regarding the contraceptive care provided in high-efficacy resettlement countries.	MEDLINE English V	Multiple contexts	Refugee women	Not mentioned	Contraception
Larrea-Schiavon et al. (2022)[20]	To identify the intervention characteristics and the impacts exerted on reproductive health among migrant and refugee women.	MEDLINE English V	Multiple contexts	Migrant and refugee women	Not mentioned	Reproductive health
Nabulsi et al. (2021)[21]	To explore the scope of the SRH services implemented in the context of the crisis of Syrian refugees in Lebanon.	MEDLINE English V	Multiple contexts	Refugee women	Not mentioned	General
Davidson et al. (2022)[22]	To synthesize the evidence on access barriers and facilitators in terms of SRH preventive care from the perspective of women and their health care providers.	MEDLINE English V	Multiple contexts	Refugee women, as well as those in need of asylum and internally displaced, in addition to health professionals	Not mentioned	General
Rocha et al. (2022)[23]	To describe the sociodemogaphic characteristics and access to SRH care, in addition to assesing menstrual poverty among Venezuelan migrant women.	MEDLINE English VI	Boa Vista, Roraima, Brazil	Migrant women	January 2021	General

Author(s)/ Year	Objective	Database/ Language/LoE	Context	Participants	Period	SRH approach
Bahamondes et al. (2022)[24]	To assess the availability of and access to SRH services among Venezuelan migrant women in the Brazil-Venezuela border during COVID-19.	MEDLINE English VI	Boa Vista and Pacaraima, Roraima, Brazil	Health professionals, managers and directors and public policy makers	June 2020-July 2021	SRH and the SARS-CoV-2 pandemic
Makuch et al. (2021)[25]	To study the opinions of Venezuelan migrant women sheltered in the state of Roraima (Brazil) regarding the SRH health care they were provided.	MEDLINE English VI	Boa Vista and Pacaraima, Roraima, Brazil	Migrant women	November 2019-February 2020	General
Ha et al. (2023)[26]	To assess how SRH services were used and the barriers to accessing them, in addition to factors associated with use of such services among migrant working women.	MEDLINE English VI	Thang Long, Hanoi, India	Migrant women	January-November 2020	General
Asuamah and Agyenim-Boateng (2023)[27]	To explore the challenges inherent to accessing reproductive health care among African women in Beijing.	MEDLINE English VI	Beijing, China	Migrant women	May-July 2019	General
Acharai et al. (2023)[28]	To describe SRH, as well as sexual and gender violence experiences, among the migrant female population in Morocco.	MEDLINE English VI	Rabit, Morocco	Migrant women	July-December 2021	General and Gender-based violence
Smith et al. (2018)[29]	To analyze the opinions of Chuukese patients with limited proficiency in English about dual-function interpreters in Guam and Chuuk.	MEDLINE English VI	Guam, USA, Chuuk, Federated States of Micronesia	Migrant women and health professionals	September 2012-August 2013	General
Rajbangshi et al. (2021)[30]	To explore reproductive and maternal health needs or experiences among displaced mothers in terms of accessing these services.	MEDLINE English VI	Bru, Tripura, India	Displaced women	June and July 2018	General
Ivanova; Rai and Kemigisha (2018)[31]	To explore and synthesize the available evidence on knowledge, experiences and access to SRH services among refugee, migrant and displaced girls and young women in Africa.	MEDLINE English V	Multiple contexts	Migrant, refugee and displaced women	Not mentioned	General
Guijarro et al. (2018)[32]	To explore health professionals' opinions about barriers and opportunities in terms of accessing SRH services, changes during COVID-19 and different perceptions among professionals, by health level and definition of care measures.	MEDLINE English VI	Quito, Ecuador, USA	Health professionals	Not mentioned	SRH and the SARS-CoV-2 pandemic

Author(s)/ Year	Objective	Database/ Language/LoE	Context	Participants	Period	SRH approach
Bianco (2017) et al. [33]	To explore participation in breast and cervical cancer screening and to obtain diverse information about access to health services during the pregnancy-puerperal cycle among immigrant women in southern Italy.	MEDLINE English VI	Southern Italy	Migrant women	May 2012-April 2013	Cervical cancer, breast cancer and maternal health services
Reinero et al. (2023)[34]	To determine the characteristics of migrant pregnant women who gave birth during 2019 in Catalonian public health centers, when compared to native women.	MEDLINE in Spanish VI	Catalonia, Spain	Migrant women	Not mentioned	Pregnancy
Loganathan et al. (2020)[35]	To explore the opinions of the main informants about how SRH services for migrant women are provided in Malaysia.	WEB OF SCIENCE English VI	Malaysia	Migrant women	July 2018-July 019	Education on SRH, contraception, abortion, pre-natal care, delivery and gender violence
Rocha-Jiménez et al. (2018)[36]	To explore migrant sex workers' experiences and reports related to their unment needs and to accessing SRH services in the Mexico-Guatemala border.	WEB OF SCIENCE in Spanish VI	Tecún Umán and Quetzaltenango, Guatemala/Tapachula, Mexico	Migrant women	May 2012-June 2015	General
Gray et al. (2021)[37]	To explore the sexual health experiences and outcomes among "Asian" women living in "Western" high-income countries, using Bronfenbrenner's socio-ecological model.	WEB OF SCIENCE in English V	Multiple contexts	Migrant women	Not mentioned	General
Marques et al. (2021)[38]	To explore health professionals' and community agents' opinions about migrant women's participation in cervical cancer screening in Portugal.	WEB OF SCIENCE in English VI	Lisbon and Vale do Tejo, Portugal	Health professionals	June-November 2020	Cervical cancer
Schmidt et al. (2018)[39]	To identify barriers to access reproductive health services faced by migrant women in Geneva and to understand if the community played any role in solving those barriers.	WEB OF SCIENCE in English VI	Geneva, Switzerland	Migrant women	April 2014-June 2015	General
Mocelin et al. (2023)[40]	To investigate the perceptions of Venezuelan migrant women living in Brazil about the barriers and facilitators to access health services and HIV/AIDS and syphilis diagnosis and treatment.	WEB OF SCIENCE in Portuguese VI	Manaus, Amazonas and Boa Vista, Roraima, Brazil	Migrant women	February-May 2021	HIV/AIDS and Syphilis
Sutan et al. (2022)[41]	To analyze how Indonesian working women use health services and the reproductive health problems they face in Malaysia.	WEB OF SCIENCE in English VI	Kuala Lumpur, Johor Bahru and Penang, Malaysia	Migrant women	Not mentioned	General
Ivanova et al. (2019)[42]	To assess the experiences, knowledge and access to SRH services among refugee adolescents in the Nakivale settlement, Uganda.	WEB OF SCIENCE in English VI	Nakivile, Isingiro, Uganda	Refugee women	March-May 2018	General

Author(s)/ Year	Objective	Database/ Language/LoE	Context	Participants	Period	SRH approach
Mengesha et al. (2017)[43]	To examine Australian health professionals' opinions and practices about how SRH care is provided to refugee and migrant women.	WEB OF SCIENCE in English VI	South New Wales, Australia	Health professionals	August 2015-January 2016	General
Pérez-Urdiales and Goicolea (2018)[44]	To explore health professionals' perception about the access barriers and facilitators found by immigrant women to access public health and SRH services in the Basque Country.	SCOPUS in Spanish VI	Basque Country, Spain	Health professionals	September-December 2015	General
Machado et al. (2022)[45]	To describe inequalities and determinants of engagement with SRH services among immigrant women in Canada and to understand their experiences regarding barriers and facilitators.	WEB OF SCIENCE in English V	Multiple contexts	Migrant women	Not mentioned	General
Corvino and D'Andrea (2022)[46]	To present the conflict between community behavior and the right to reproductive health and to discuss aspects inherent to intimate partner violence such as degrading or violent human dealings for exercising reproductive rights.	MEDLINE in English VI	Florence, Italy	Health professionals	August-September 2021	General
Sampson et al. (2023)[47]	To assess the impact exerted by an intervention on the improvement of SRH services among women in the Wass Camp for Internally Displaced.	EMBASE in English VI	Abuja, Nigeria	Internally displaced women	September 2020 -June 2021	Reproductive health
Castaner et al. (2022)[48]	To explore the tactics adopted by health care providers to meet migrant women's SRH care needs.	MEDLINE in English VI	Copenhagen, Denmark	Health professionals	January-April 2020	General

LoE: Level of Evidence; USA: United States of America

Source: The authors (2024)

As for levels of evidence, 74.29% (26) of the materials was identified as Level of Evidence VI: results from surveys consisting in a single descriptive or qualitative study. Among the samples of participants in the studies, 71.43% (25) corresponded to migrant women's views, 20% (7) to health professionals' perspectives and 8.57% (3) to the opinions of both groups.

Regarding the data collection periods to develop the studies, 34.29 (12) failed to specify them; the rest, 65.71% (23), ended them between 2013 and 2021, with 2021 as the most prevalent year: 17.14% (6).

The SRH care access barriers faced by the migrant women were surveyed and grouped into four main categories: Sociocultural barriers; Barriers related to the migrant women's circumstance; Barriers related to the health professionals; and Barriers related to health systems and services. Each category was comprised by various subtypes of barriers, identifying 60 different classes (Chart 3).

Chart 3. Identification of the barriers surveyed in the *corpus* analyzed, Porto Velho, RO, Brazil, 2024.

Types of barriers and characteristic factors	%
Sociocultural barriers	
Social stigma[14-17,19,26-28,30-33,36,41-47]	61.11%
Cultural[14-17,19-21,24,27,30,32-34,37-39,43-48]	60.00%
Linguistic[16-17,19-20,22,25,27,30-31,34,38-41,44-46,48]	51.43%
Nationality-related discrimination[14,16-17,19-20,21-22,25,28,30-32,34-35,39,41,44-46]	51.43%
Partner's influence/coercion in decision-making[17,19,21-22,26,28,35,37,43,44-45,47]	34.29%
Gender issues[15,21,23,28-29,37,42,45,47]	25.71%
Inadequate communication[14,19-20,22,25,27,38,46]	22.86%
Religious values[15,17,19,22,46]	14.29%
Values and beliefs about SRH[17,22,27,38]	11.43%
Ethnicity[16,37,46]	8.57%
Stigma related to sex work[20,36]	5.71%
Discriminatory migration policy[27]	2.86%
Barriers related to the migrant women's circumstances	
Financial factors[14-17,19-23,25-28,30-32,35-36,39-41,43,45,47-48]	71.43%
Fear related to migration status – Undocumented individuals[15,17-18,20-23,28,32,35,37,41-42,44-45,48]	48.57%
Difficulty navigating an unknown health system[16-17,19,21,23,25,43,45]	22.86%
Not seeking health services[17-18,20,28,33,36,38,48]	22.86%
Previous negative experiences with health providers[21-22,25,27-28,38,43,45]	22.86%
Lack of knowledge about SRH[14,16,22,30-31,38,41-42]	22.86%
Dissatisfaction with the services and methods offered[17-19,23-24,27,42,45]	22.86%
Scarce sources of adequate SRH information[17,21,28,31,35-36,39,45]	22.86%
Discomfort/Embarrassment/Shyness	20.00%
Unemployment and problems with employers[16,18,27,35,41]	14.29%
Need for interpreters[22,29,45]	8.57%
Low schooling level[22,34]	5.71%
Time living in the country[33,45]	5.71%
Adverse reactions to treatments[41]	2.86%
Social isolation[45]	2.86%
Disinterest in discussing SRH[17]	2.86%
Barriers related to the health professionals	
Male health professionals[22,38,44-45]	11.43%
Inadequate comments and assumptions about SRH preferences[19,3642,45]	11.43%
Hostile discourse related to migration[16,21-22]	8.57%
No professional-patient bond[38,46]	5.71%
Barriers related to health systems and services	
Non-accessible health services[14,16-17,19,21-27,30-32,34-35,38,40-42,45-46,48]	68.57%
Discrepancies between the users' preferences and the services offered[17,21-23,27,32,35,39,44-46]	31.43%

Types of barriers and characteristic factors	%
Lack of investment in public policies, devices, inputs and professional training targeted at SRH[18,21-25,31-32,42-43]	28.57%
Inadequate disclosing of SRH information and services[14-15,21-22,25,27,42,45]	22.86%
Uncertainty about confidentiality of the services offered[20,28-29,42,45]	14.29%
Inadequate service time[19,21-22,44,48]	14.29%
Unavailability in terms of inputs and services[14,24,43,48]	11.43%
Lack of privacy in health services[20,36,42]	8.57%
High cost of services, treatments and contraceptive methods[26,30,35]	8.57%
Insufficient number of professionals[18,23,44]	5.71%
Long waiting times to be served[31,43]	5.71%
SARS-CoV-2 pandemic[32,40]	5.71%
Low-quality services[14,18]	5.71%
Overcrowded health services[32]	2.86%
Inconvenient working hours for clinical care[26]	2.86%

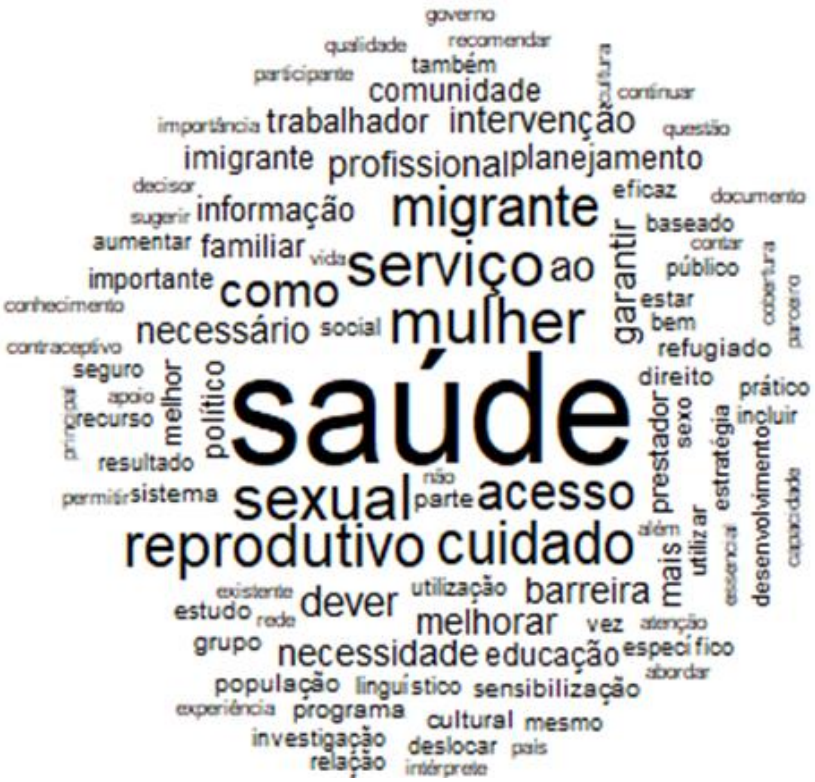
Source: The authors (2024)

The following stood out in the Sociocultural barriers category: social stigma in 61.11% (22) of the articles; cultural issues in 60% (21); and linguistic issues and nationality-related discrimination, with 51.43% (18) each. Among the barriers directly related to the migrant women, it was detected that the financial factors were significant, as they were mentioned in 71.43% (25) of the articles, followed by fear related to migration status (undocumented individuals) with 48.57% (17). In addition to that, difficulty navigating an unknown health system, not seeking health services, previous negative experiences with health care providers, lack of knowledge about SRH, dissatisfaction with the services and methods offered and scarce sources of adequate information about SRH reached 22.86% (8) each (Chart 1).

The barriers related to the health professionals were present in lower numbers, as male professionals and inadequate comments and assumptions about SRH preferences were mentioned in 11.43% (4) of the articles each, whereas hostile discourse related to migration was only pointed out in 8.57% (3) and lack of professional-patient bonds in only 5.71% (2). In turn, the barriers related to health systems and services were mainly linked to inaccessibility of the services, indicated in 68.57% (24) of the articles and followed by discrepancy between the users' preferences and the health services offered with 31.43% (11) and by lack of investment in public policies, devices, inputs and professional training targeted at SRH, with 28.57% (10).

Another aspect identified in the studies was proposing actions and/or attitudes to face the barriers experienced by migrant women, recording the most frequent words that comprised the word cloud, with the following standing out in the center: Health (*Saúde*) (115 instances); Service (*Serviço*), Sexual and Woman (*Mulher*) with the same frequency each (41 instances); Reproductive (*Reprodutivo*) (39 instances), Care (*Cuidado*) (36 instances); Migrant (*Migrante*) (35 instances); and Access (*Acesso*) (28 instances) (Figure 2).

Figure 2. Word cloud showing the *corpus* corresponding to the actions/attitudes to deal with the SRH care barriers faced by migrant women. Porto Velho, RO, Brazil, 2024.



Source: Iramuteq report, research data.

DISCUSSION

The diverse evidence synthesized reveals that the SRH access barriers faced by migrant women do not operate in isolation; they are retrofed in a chain that encompasses from sociocultural stigma to the structure of health systems. The increase in the number of publications on the topic researched is in consonance with the higher female migration flow at the global level; in addition and although it reflects a regional migratory specific aspect, the concentration of studies in Brazil also exposes a gap: high- and low-income contexts are rarely compared in the literature, which limits inferences regarding which barriers are universal and which ones depend on each local health system.

In relation to the levels of evidence of the studies identified, the fact that most of them are classified as Level VI and the heterogeneity detected in terms of designs represent the low soundness of the available scientific evidence on the barriers faced by migrant women, hindering the trust deposited in the information, as well as its strength to define recommendations that will ensure overcoming those barriers.[12] This weakness is not uniform across the categories: subtypes mentioned in dozens of convergent studies (financial factors: 71.43%; inaccessibility of the services: 68.57%; social stigma: 61.11%) are grounded in reasonable inductive triangulation, even if at a low level of evidence. In turn, subtypes solely mentioned in 1-2 articles (social isolation, inconvenient service hours, adverse reactions to treatments) should be interpreted as hypotheses to be confirmed and not as established patterns. This internal hierarchization of the very evidence synthesized is what confers selective credibility to the recommendations that shall be proposed. Therefore, studies with methodological designs that provide more scientific evidence strength need to be conducted on this problem, as most of the evidence synthesized came from studies with samples comprised by migrant women themselves, who experience difficulties accessing SRH care, which is also relevant for decision-making.

Corroborating the breadth of the SRH notion, the barriers surveyed in the study at hand transcend the biological dimension of care and reveal themselves as manifestations of structural vulnerability[49]: migratory status places these women in a hierarchally disadvantaged position in health systems, in the labor market and in the legal framework of the destination countries, so that apparently different barriers (stigma, undocumented individuals, professional unpreparedness and inadequate structure of services) derive from the same structural condition of subordination and not from isolated or accidental factors. It is

precisely that shared structural condition and not each category in isolation that explains why migrant women are still sub-assisted even in formally universal health systems, as is the case in the Brazilian Unified Health System, and why overcoming an isolated barrier tends to exert a limited effect as long as the structural stance that produces it remains unchanged. Therefore, the categories were didactically named with the purpose of better categorizing them, as follows: Sociocultural barriers; Barriers related to the migrant women's circumstances; Barriers related to the health professionals; and Barriers related to health systems and services.

The sociocultural barriers work less as isolated obstacles and more as a filter that is prior to the contact with a health service itself: stigma and fear of being judged are activated even before migrant women seek care, which explains why the underutilization of screening and pre-natal assistance services[49-51] is not the mere result of offer barriers but of a prior decision one: women exclude themselves from health systems before any institutional negative response. In and by its own, this anticipated judgment is an effect of the structurally vulnerable position they hold: migrant women (oftentimes undocumented) are already stigmatized based on gender rules in force both in their country of origin and in the destination one, which turns avoidance into a rational response to a structural condition of helplessness and not an isolated individual behavior.

Furthermore, it is worth highlighting that migrant women may be welcomed in countries where people hold strong preconceptions and taboos about sexuality and sex outside marriage, overtly impacting access to care mainly among women who resort to sex work for their livelihood due to financial difficulties.[52-53] Moralization of migrants' sexuality and the association with sex work are only documented in the sample from the Mexico-Guatemala border context,[36] where documentation precariousness, sex work criminalization and non-existence of social protection networks intensify their dependence on this activity to earn their living. Not having detected similar findings in other South-South border contexts included in the sample, such as Brazil-Venezuela,[24-25] does not allow concluding whether the phenomenon is geographically restricted or reflects absence of available studies in these other contexts for not specifically researching that dimension. In turn, in high-income countries, this review points less to livelihood through sex work and more to barriers of other natures (such as linguistic, bureaucratic and lack of knowledge about the system), suggesting that the prevailing type of barrier can vary according to the socio-economic context and to the potentialities of the social protection network in the destination country.

Regarding the linguistic limitations, two aspects proved to be relevant in the SRH care provided to migrant women: in consultations, they trigger discomfort and shyness when facing professionals, especially when they are male;[14,22,26,38,44-45] they also impair understanding of the guidelines received and SRH knowledge enhancement later on,[6,38,54] precluding women from fully exercising their sexual and reproductive rights. As it affects both communication and information retention, that barrier is rarely solved by merely having an interpreter during the appointment, requiring ongoing communication strategies that are culturally sensitive throughout the entire therapeutic path followed by migrant women.

The hostile discourse related to migration is oftentimes justified by professionals as a way to safeguard their countries' health systems from the overload represented by the migrant population. Consequently, disrespectful and hostile human dealings tend to hinder women's access.[16,21]

It draws the attention that the barriers least frequently reported (11.43% of the studies) were those directly attributed to health professionals. This can reflect both lower actual incidence and certain limitation in the study designs, predominantly based on reports by the migrant women themselves, who may not explicitly identify professional behaviors as a barrier but experience them diffusely, embeded into the already mentioned stigma and inadequate communication. A number of studies where the professionals were listened to first-hand[32,38,48] tend to more sharply evidence this type of barrier.

Furthermore, migrant women's search for health services may suffer from interference from their partners, even for decision-making, frequently resulting in gender inequality and violence, marginalization of migrant women and social isolation.[27,37] This interference from partners in decision-making exemplifies how all four barrier categories are intertwined: economic dependence on partners (a barrier related to migrant women's circumstances) is combined with a sociocultural barrier (gender norms that legitimize that coercion and result in social isolation), which in turn limits women's contact with health professionals and community-based organizations that might identify and mitigate that violence, closing a cycle in which the relational barrier also becomes a system one due to the absence of early detection options in health services.[17,19,21-22,26,28,35,45,47]

As a second example, in contexts where religious values and family taboos discourage open discussions about sexuality (sociocultural barrier), young migrant women tend to resort to health services, when they actually manage to do so, seeking specific care without fully revealing their actual sexual needs or background, in order to avoid being judged.[46] At the same and based on each woman's nationality, professionals assume that they do not want or cannot discuss contraception (inadequate comments and assumptions about SRH preferences, a barrier related to professionals).[38] Such being the case, women are not provided with any guidance on the most suitable method for their case and leave the appointments without the assistance they were actually looking for. Uncertainty regarding confidentiality of the appointments (a barrier related to health systems and services) is added to the above, as well as fearing that the information might reach their communities, family members or employers, resulting in not using suitable contraception methods.[15,19,22,31] In the communities of origin, unplanned pregnancies resulting from this circuit reinforces the narrative that this topic should not be shared with strangers, further hindering that the next woman from the same social group seeks formal guidance, closing a cycle that propagates itself not only at the individual level but also at the community and inter-generational ones.

Given these mechanisms inherent to the barriers faced by migrant women, the findings point to coping actions (Figure 2), where the term "Health" signals SRH as broadly framed as part of a major right to health, not only as an isolated niche. The fact that the words "Service", "Sexual" and "Woman" share the same position suggests that, in these studies, the barriers related to the offer of services, the sexual health dimension and female subjects appear together and with equal weight; in other words, the actions pointed out treat SRH as something articulated with migrant women and not merely as something aside to be applied to them. Despite the limitations associated with evidence strength, this result can be interpreted as a hint that the literature tends to propose solutions centered on each woman and on her subjectivity, not merely as a target of disconnected interventions.

Another relevant aspect is that "Care" is more frequently mentioned than "Migrant" in the coping actions, which may signal a discourse that tends to universalize responses in the general care logic, rather than specializing by this specific group comprised by migrant women. On the one hand, this may point to a positive aspect that reflects certain precaution so as not to further label this population segment, avoiding framing it as a special situation. However, it warns about still insufficient solutions that fail to adapt to the specific and already discussed vulnerabilities inherent to migratory status.

As for the central issue addressed in this review, Access, it was the least frequent term, suggesting that the literature deals more with providing better care to the women who are already in the system than with removing actual access barriers. Another issue is the relationship between care and access, signaling the convergence in the literature towards solutions centered on bonding and on care continuity.

As an example of these coping strategies, some studies point to actions to overcome the barriers experienced by migrant women, such as the research by Castaner *et al.* (2022),[48] where the authors mention tactics developed by health professionals to bypass bureaucratic obstacles and ensure care for undocumented migrants, such as employing translation apps, community-dwelling interpreters or visual resources to bridge idiomatic barriers. In addition to that, the professionals used their position as volunteers to gain these women's trust and work with colleagues from the migrants' communities, resorting to their cultural knowledge to meet the SRH demands presented by this group.

In the same sense, Sampson *et al.* (2023)[47] describe how mobile technologies can be used to expand access to family planning among internally displaced women. Larrea-Schiavon *et al.*, (2022)[20] state that enabling migrant women free or low-cost access to SRH services promoted their resorting to these services for greater use of contraceptive methods; in turn, the educational interventions exerted positive effects on knowledge about SRH, mainly when involving partners and seeking to meet the specific needs of a population segment in a mobility situation. The importance of these actions and recommendations is noted since, in addition to promoting improvements in the care provided to migrant women, they point to strategies to ease their access to health systems and overcome the barriers related to documentation, to fear and to lack of knowledge.

Despite the breadth of contexts, the sample practically does not include specific population segments within a large group of migrant women, as there are no studies on migrant transgender women, aged women or women with disabilities, which are subgroups presenting different SRH needs and probably subjected to additional barriers related to their life circumstances. Likewise, 74.29% of the studies correspond to Level of Evidence VI and no experimental or quasi-experimental study tested a specific intervention for overcoming barriers using a comparative design. In addition to that, the studies that

directly address interventions have a descriptive design.[47-48] Finally, although 65.71% of the studies reported their data collection period, none of them follows-up the same cohort of women over time, which precludes knowing if the barriers are attenuated as women live more time in the destination country or if they remain unchanged.

Knowing the barriers herein synthesized allows targeting actions in at least three levels: Clinical-assistance, training professionals to provide culturally-sensitive care and offering interpreters; Institutional, ensuring confidentiality, flexible service times and active disclosing of services via accessible channels for migrants; and Public Policy, disconnecting access to health from migration status and providing specific SRH funding for migrant populations. This differentiation is relevant because not all the barriers identified may respond to the same type of intervention or responsible actor.

The following limitations should be considered in this review: not having included scientific articles published in lower-impact journals (not indexed in the major databases consulted); and the fact that the selection process has not been implemented by two reviewers observing a blinded procedure. Furthermore, the heterogeneity detected in the designs of the studies included (predominantly qualitative and descriptive, Level of Evidence VI) impairs dircet comparisons across the 60 subtypes of barriers identified. It was verified that the subtypes cited in dozens of studies (financial factors in 71.43%, for example) had sounder inductive support than those mentioned in a single article (social isolation and inconvenient service hours, for example), which may reflect singularities inherent to each context and not a pattern that can be generalized. The predominance of studies in English (88.5%) and the absence of materials with a quantitative-qualitative mixed approach may have excluded barriers solely reported in regional publications or in service utilization metrics. However, the findings synthesized meet the objective set forth for this study, presenting a broad overview of the barriers faced by migrant women in terms of SRH access, thus contributing to advancing knowledge on the topic and identifying new gaps.

CONCLUSION

The study provides a synthesis of diverse evidence about the SRH care access barriers faced by migrant women. To such end, these barriers are categorized and described, in addition to indicating their daily interference in this access. Social stigma, financial factors, male professionals and limited accessibility of health services were the main SRH care access barriers faced by migrant women. Although the findings have been categorized in a didactic way, it is inferred from them that these barriers are intertwined in a complex and inter-related way, whether they are sociocultural or related to the migrant women's circumstances, to health professionals or to health systems and services. Consequently, it is verified that overcoming these barriers will require organized actions along with other society sectors beyond the health scope.

SRH care should be for all; however, migrant women represent a social segment still marginalized in terms of sexual and reproductive rights, as evidenced by the findings of the current study. Therefore, it becomes necessary to develop attitudes and actions to face and overcome the SRH care access barriers faced by these migrant women. Public policy managers and makers should devise strategies and actions that integrate the different sectors of society, with the objective of safeguarding migrant women's sexual and reproductive rights. Thus, as for the health sector, the findings of this study provide public managers with insights so that they can adapt laws and regulations, which will favor full and fair access to SRH care, information and education for this population segment.

CONTRIBUTIONS

Study conception or design: Conceição NLM, Parmejiani EP. Data collection: Conceição NLM, Silva KM, Parmejiani EP. Data analysis and interpretation: Conceição NLM, Parmejiani EP. Writing or critical review of the article: Conceição NLM, Pinheiro AS, Cunha MPL, Melo NC, Queiroz ABA, Parmejiani EP. Final approval of the version to be published: Conceição NLM, Pinheiro AS, Cunha MPL, Melo NC, Silva KM, Queiroz ABA, Parmejiani EP.

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