Barriers to accessing appropriate sexual and reproductive health services

The problem

Access to sexual and reproductive care depends on the regulations of the single country. Migrants face different legislative and bureaucratic barriers to accessing sexual and reproductive health services. In some countries they are entitled only to emergency care. There might be limitations regarding sex and age or pregnancy status, etc., while in other contexts undocumented migrants cannot access health care at all. In addition there is a general lack of knowledge among health-care workers, who ignore the legal framework and the respective entitlements.

A group of experts gathered in the workshop conducted in the LHU of Reggio Emilia agreed that there are many issues surrounding sensitive topics: abortion for instance is free in certain countries, in others it requires parents' permission, and based on the political context it may become an illegal service, for which physicians may even incur in some kind of punishment. Decentralization of regulations within countries was mentioned as another barrier, as well as the loss of continuity of care during the different phases of the asylum seeking process, and the lack of free fertility care. There is a huge debate as to whether the latter should be considered as an essential service or not. On linguistic and cultural barriers, the group of experts mentioned the lack of cultural mediators in hospitals and no specific academic curricula for mediators.

Evidence on the barrier

Limited access to sexual health services and reproductive services, such as cervical and breast cancer screening, antenatal, delivery and postnatal care, abortion, limited knowledge about contraception, sexual health or sexually transmitted infections, acceptance of fertility services, as well as lack of recognition of post-natal depression are among the major issues experienced by migrant women identified in the systematic literature review.

A recent review (Keygnaert I et al., 2016) identified affordability as the major barrier to access maternal health-care. The exclusion of migrants from legal frameworks often means that these populations can only access health care services if they have the financial means to do so. The situation regarding financial costs for maternal health care varies among European countries; in certain countries child delivery in a hospital can be very expensive.

Legislative barrier is a second important barrier hindering access to sex and reproductive care for refugee women. Research shows that lack of legal documentation creates barriers to access family planning programmes, leading to delayed prenatal care (Keygnaert I et al., 2016). From the health-care workers side, the lack of information on legal issues reflects on difficulties in determining what level of service they can provide to each migrant.

Linguistic and socio-cultural barriers have been reported as having a negative impact on the quality of women's health care. Suboptimal care is often associated to miscommunication, lack of professional interpreters (Yelland et al., 2016), and limited knowledge and information on sex and reproductive care (Keygnaert I et al., 2016). In sexual and reproductive care the interweaving of language and socio-cultural factors are more evident, different understandings of the body parts, as well as the gender role, could become issues in childbirth and parenting. For instance, most migrant women are resistant to common gynaecological and obstetrical care practices and prefer to give birth at home with the assistance of family and they can have misconceptions on the western/conventional clinical approach in managing pregnancy and delivery. One study indicated (Brown, Carroll, Fogarty, & Holt, 2010) that Somali women may have aversion to caesarean section, because of fear of death and resistance on other obstetrical interventions. Last but not least, pregnancies in migrant women have frequent complications, among these diabetes

mellitus, hypertension, infectious diseases (HIV, Hepatitis B) as well as the lack of immunization coverage for relevant infection in pregnancy (Correa-Velez & Ryan, 2012).

In general, lack of information and familiarity with the health system (Tobin, Murphy-Lawless, & Beck, 2014) hamper access to sexual and reproductive care (Riggs et al., 2012). Migrant women do not know how to navigate the health system and are often unaware of their rights and of the available services, in addition they have limited access to transportation, lack of confidence in speaking in the language of the arrival country and making phone bookings for clinical appointments (Riggs et al., 2012). Not only refugee and asylum seeking women lack knowledge of sexual and reproductive services, they may also not have had health education regarding the importance of such services (Sudbury & Robinson, 2016).

A study conducted by United Nations High Commissioner for Refugees (UNHCR) and the Women's Refugee Commission shows that awareness of family planning methods and the use of contraceptives is very low among refugee women. Furthermore, the literature identifies a significant lack of knowledge regarding cervical cancer and screening practices. For example only few participants included in one study (Haworth, Margalit, Ross, Nepal, & Soliman, 2014) reported ever hearing of a Pap test and ever having one. Similar findings have been retrieved for breast cancer screening in migrants (Percac-Lima, Ashburner, Bond, Oo, & Atlas, 2013; Percac-Lima, Milosavljevic, Oo, Marable, & Bond, 2012).

Regarding organizational barriers, expert participants at the Reggio Emilia workshop reported that problems arise when there is an imbalance between the gender of the health care provider and the patient, and when there is a lack of coordination between services, between health services and NGOs and community services. For instance, experts agreed that lack of collaboration between services may hinder access to health care when there is a lack of dialogue between mental health services and sexual reproductive health departments, as well as the lack of collaboration between public and private health care providers and the lack of communication with social and education sectors.

Measures to address the barrier

Scientific evidence is abundant on migrant sexual and reproductive health-related issues, but it is scant in providing solutions. In the literature few studies specifically focus on possible interventions and although efforts in high-income countries to increase access to appropriate sexual and reproductive health care services are reported, not enough changes have been observed over time. (Yelland, Riggs, Small, & Brown, 2015)

A synthesis report (Bradby, Humphris, Newall, & Phillimore, 2015) indicates that provision of full health coverage for all pregnant women and for children regardless of immigration status is the first important step to ensure equal access to health care. Secondly, It is indispensable to ensure accurate information on available maternal health services and rights to access them.

Strategies such as promoting and investing in family planning can be effective ways to improve migrant women's health and prevent unintended pregnancies (Keygnaert I et al., 2016). The recommendations developed by United Nations High Commissioner for Refugees and the Women's Refugee Commission, stress the importance on the one hand, of promoting global advocacy to ensure a full range of family planning methods, including emergency contraception are available in settings of displacement, and, on the other hand, of enhancing information and acceptance of family planning methods among refugee women (UNHCR, 2011). It is also important that all relevant information and education around sexual and reproductive care should take into account the socio-cultural dimension of migrants and their relevant health literacy needs (Keygnaert, Vettenburg, Roelens, & Temmerman, 2014).

Tailored community based services delivered in primary care setting involving MDs, cultural mediators, health educators, midwifes and other health care workers at the community level would enhance the possibility of building a relationship with caregivers and would offer women greater continuity of care (Tobin et al., 2014). Direct access to midwife care within the community for women who are asylum seekers and refugees is indicated as a key strategy which help to identify women earlier, reduce non-attendance rates and build partnerships in care (Briscoe & Lavender, 2009). Midwife counselling in providing information, education and care plays a vital role both for women and new-borns (Briscoe & Lavender, 2009; Sudbury & Robinson, 2016). Furthermore, the implementation of community midwifery teams in UK proved to be successful in responding to refugee women's complex health and social needs by multidisciplinary working, establishing links with emergency care, sexual health, NGOs, and housing associations (Sudbury & Robinson, 2016).

Most research strongly supports the need to provide "culturally competent" care. This requires specific training, service adaptation and guidelines for health care providers (Haith-Cooper & Bradshaw, 2013). It also implies involving migrants and their communities in service planning and development, and facilitating interactions between service users and health professionals.

The use of intercultural mediators, or similar mediators, such as community health educators and link workers, has proved to be very useful in helping migrant women to navigate the system, understand health information and effectively utilise the available services (Yelland et al., 2016). Some countries implemented university courses for mediators focusing on sexual and reproductive health (e.g. Female Genital Mutilation). In the context of maternity care a potential solution included community and language-specific groups of pregnancy care combining antenatal services with support provided by multi-professional health care workers and qualified interpreters (Yelland et al., 2015).

Educational aids as well as the provision of language support should be delivered with a culturally sensitive approach in order to improve migrant maternal and sexual health and to respect their social, psychological and cultural backgrounds respectively (Keygnaert I et al., 2016). The need to provide for effective health education/promotion and preventive programmes to migrant communities has also been stressed by experts participating in the workshop in Reggio Emilia. To this purpose the role of community health educators was emphasised in providing information and education activities at the community level, and connecting migrants with health services.

The health network approach, and the organisation of mothers' groups for social contact and information exchange proved to be successful to overcoming access barriers (Goosen, van Oostrum, & Essink-Bot, 2010). The provision of information material in several languages on maternal issues - induction of labour, epidural analgesia, caesarean section and breastfeeding - as well as the availability of trained interpreters are considered essential (Tobin et al., 2014).

Finally, further research to support migrant women's needs and experiences are necessary to fill the knowledge gaps on reproductive health as well as problems related to pre- and postnatal care in addition to migration issues (Balaam et al., 2013).

Successful example

ZANZU: MY BODY IN WORDS AND IMMAGES

Country of development:
Belgium and Germany

Service/department in charge of the measure:
Zanzu is created by Sensoa, the Flemish Expertise Centre for Sexual Health, and BZgA (Bundeszentrale für gesundheitliche Aufklärung), the German Federal Centre for Health Education.

Description of the measure:
Zanzu is a website that helps both professionals and patients to communicate in their own/different language(s) through translation about sexuality, their body, health, relationships, legal information... The website is a support tool and provides tips for talking about sexuality in a multicultural context.
It has been developed in 12 different languages

Expected outcomes:
To overcame linguistic barriers and to help patients in their relationship with health professionals.
To increase the level of information and knowledge of patients.

Resources needed for implementation:
IT support and technical skills

Available at:
http://www.zanzu.be/en

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