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Abstract

Background: The sexual and reproductive health and rights (SRHR) of migrants and refugees present important public health challenges. Social and structural determinants affect both the general health and SRHR of migrants, but the drivers of SRHR among migrant and refugee populations remain understudied.

Aims: To identify upstream social and structural determinants of SRHR health of migrants and refugees reported in systematic reviews.

Methods: We conducted a systematic review of reviews. We studied 3 aspects of SRHR: sexually transmitted infections, sexual violence and unintended pregnancy in migrants and refugees. We used an inductive approach to synthesize emerging themes, summarized them in a narrative format and made an adapted version of Dahlgren and Whitehead’s social
determinants of health (SDH) model.

Results: We included 12 systematic reviews, of which 10 were related to sexually transmitted infections, 4 to sexual violence and 2 to unintended pregnancy. We identified 6 themes that operate at 4 different levels in an adapted version of the Dahlgren and Whitehead SDH model: economic crisis and hostile discourse on migration; limited legal entitlements, rights and administrative barriers; inadequate resources and financial constraints; poor living and working conditions; cultural and linguistic barriers; and stigma and discrimination based on migration status, gender, sex and ethnicity.

Conclusion: This review provides evidence of how upstream social and structural determinants undermine the SRHR of refugees and migrants. Unless these are addressed in policy-making and planning, the health of migrants and refugees is at risk.

Keywords: migrants, refugees, sexual and reproductive health, social and structural determinants of health

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Introduction

The sexual and reproductive health and rights (SRHR) of migrants and refugees are important public health issues (1,2). While migration brings opportunities for better lives and prosperity, it also increases risks to health for diverse and heterogeneous groups of people (1). Most
migrants are of working age (3), including the peak age groups for sexual activity and have a range of related health problems (4). Today, most of the world’s 258 million international migrants live in low- and middle-income countries (LMICs) (1,3), which also experience a high burden of poor SRHR outcomes (5). Due to political upheaval and conflict, the Eastern Mediterranean Region hosts 66% of the world’s refugees and 33% of asylum seekers (6). In 2018, a large proportion of asylum seekers arriving in European Union (EU) Member States originated from the Eastern Mediterranean Region (7).

The SRHR of migrants is closely linked to political, environmental and cultural conditions. Migration is recognized as a social determinant of health (SDH) (9) by the International Organization for Migration (IOM) (8,10) and the World Health Organization (11) because the conditions surrounding migration lead to health inequalities, increased health risks and negative health outcomes (8). The SDH provide a model for understanding the social and structural factors that influence health at different levels according to their causal proximity to a health problem; upstream and distal (such as general socioeconomic and environmental conditions) or downstream and proximal (individual factors) (Figure 1) (12,13). Understanding the underlying causes of poor health is crucial as they are likely to have greater impact on population health than individually targeted approaches (14,15). Population level health can be improved through shifts in public policies and targeting upstream determinants of population health (14). Structural and social factors are responsible for a major proportion of health inequalities (16). For disadvantaged populations, these factors relate to higher risks, reduced access to services leading to poorer disease outcomes, and worse economic and social outcomes related to poor health and the costs of treatment (17). In addition, global aspirations for the health-related targets of the Sustainable Development Goals, including universal health coverage, cannot be fulfilled without ensuring that all migrants are able to realize their rights, including in relation to sexual and reproductive health and rights (18). We conducted a systematic review to identify the structural and social determinants which put migrants and refugees at risk of poor SRHR outcomes, and to locate key policy areas where action can address inequalities in health.

The aim of this review was to identify upstream social and structural determinants of SRHR of migrants and refugees reported in systematic reviews. We addressed 3 aspects of SRHR outcomes: sexually transmitted infections (STIs), including hepatitis B and C and HIV/AIDS; sexual violence; and unintended pregnancies, along with access to health care for the prevention and treatment of these outcomes. Results related to health in general were included where they also applied to SRHR.

Methods
Design

We conducted a review of systematic reviews following guidance from the Joanna Briggs Institute methodology group (19). We included systematic reviews which provided methods
sufficiently detailed to be reproduced by another researcher. The protocol is registered on the electronic PROSPERO (international prospective register of systematic reviews) database (20) (PROSPERO CRD42018086039).

**Search strategy**

We searched the PubMed/MEDLINE and Web of Science (Science and Social Science Citation Index) electronic databases from 1 January 1980 to 9 February 2018. The search strategy included terms for the SRHR outcomes and populations of interest. For PubMed/MEDLINE, the terms were combined with a filter for reviews (21); this search strategy is published (20). We restricted our search to reviews published in English or German.

**Population of interest**

Our population of interest was international migrants, refugees and/or asylum seekers. We included systematic reviews that reported results for the population of interest separately. We excluded articles that did not give a definition for the target population that coincided with a definition from the IOM (22) or the United Nations High Commissioner for Refugees (UNHCR) (23). In brief, migrants include “all cases where the decision to migrate was taken freely by the individual concerned for reasons of ‘personal convenience’” (22); refugees include any “person who meets the eligibility criteria under the applicable refugee definition” (23) and asylum seekers include any “individual who is seeking international protection … whose claim has not yet been finally decided on” (22). We included systematic reviews that reported findings for any of these defined populations. We excluded articles that did not give clear definitions of the study populations. We also excluded articles that only included data for (internal) domestic migrants, rural-to-urban migrants and internally displaced individuals.

**Social and structural determinants of interest**

Our review focussed on the upstream social and structural determinants of health from Dahlgren and Whitehead’s SDH model and did not examine individual-level factors (Figure 1) (12).

**Review screening, selection, analysis and synthesis**

One researcher screened the titles and/or abstracts of retrieved articles, assessed the full text of potentially eligible articles and extracted data about review characteristics and determinants of the SRHR outcomes. A second reviewer checked all full-text inclusion and exclusion decisions and the extracted data. Discrepancies were resolved through discussion. Following an inductive approach, all authors discussed the included reviews and agreed upon emerging themes. We synthesized emerging themes and displayed them in an adapted version of Dahlgren and Whitehead’s SDH model. We reported the findings narratively, using terms for
SRHR outcomes that the authors of the included systematic reviews used.

**Results**

**Selection**

We screened 440 articles and included 11 systematic reviews that fulfilled our selection criteria (24–34) ([Figure 2](#)). Twenty-eight articles were excluded because there was no IOM or UNHCR population definition. On re-examination, we included one of these 28 reviews because it identified a new theme (economic crisis) (35). The 12 reviews included a median of 38 articles (interquartile range 29–45). [Table 1](#) reports the characteristics of the included reviews. Ten of the 12 reviews examined health outcomes related to STIs (24–29,31,33–35), 4 to sexual violence (29–32) and 2 to unintended pregnancies (25,27). Most reviews included studies with both qualitative (10/12) and quantitative (9/12) data. The reviews included migrants and/or refugees originating from sub-Saharan Africa (8/12), Asia (7/12), Latin America (7/12), the Middle East and North Africa (MENA) (6/12), Europe (6/12), Oceania (2/12) and North America (1/12). All reviews included Europe as a receiving region, whereas Asia, Latin America, MENA, and sub-Saharan Africa were receiving regions in less than half of the included reviews.

**Data synthesis**

We identified 6 themes ([Table 2](#)) that operate at 4 different levels in our adaptation of the Dahlgren and Whitehead SDH model ([Figure 3](#)): prevailing norms and narratives, structural determinants, living and working conditions and social and community factors. The themes are:

**Economic crises and hostile discourse on migration**

Our findings show that the general tenor of societal discourse on migration and migrants influences the perceptions of host communities and migrants themselves about the acceptability of using resources for SRHR needs of migrants (27,34). Anti-immigrant rhetoric, especially against undocumented migrants, draws attention to economic crises (34); when migration is framed as a threat to the economy and a burden on health systems, it negatively influences public opinion and constrains migrants’ SRHR choices as they fear being perceived as “using too many resources” (27). Influenced by anti-immigrant rhetoric and policies, providers may deny needed SRHR services to undocumented migrants, who may feel too threatened to seek care (34). During economic crises in Europe, there is evidence of a disproportionately higher risk of STIs among migrants related to unemployment and poverty, which directly create the conditions for STI transmission and austerity measures and cuts to prevention and treatment programmes (35).

**Limited legal entitlements, rights and administrative barriers**
A comprehensive literature review from the EU found that the right to health, including access to health care, for migrants is influenced by competing policy narratives and frameworks, e.g. rights versus immigration; the latter mostly emphasizing immigration control. In practice, this contradiction can deter migrants from seeking care, especially undocumented ones (27). The review found a general lack of policies, regulations and guidelines on migrant SRHR (27).

In the EU, legal entitlements to care varies with the type of migrant and is particularly restrictive for undocumented migrants (27). Most recent policies in the EU focus only on asylum seekers and refugees. In many EU countries, undocumented migrants only have access to emergency services. The definition of “emergency services” varies across countries and is subject to change, creating uncertainty about entitlement to sexual and reproductive health (SRH) care. In the United Kingdom, HIV treatment used to be an emergency service but this was rescinded in 2009, thus ending free HIV treatment for all (27). Many European countries restrict undocumented migrants from accessing treatment for hepatitis C and HIV infections (25). As a result, documented migrants from LMICs in high-income countries (HICs) have comparatively better access to HIV testing than undocumented migrants, whose legal status and fear of deportation act as deterrents to HIV testing (26). The absence of regional guidelines on HIV testing among migrants also poses a barrier to HIV testing in HICs (26).

In the EU, few policy documents address both SRHR and migrants (27). The legal provisions on migrant SRHR focus on a narrow understanding of reproductive health, concentrating mainly on pregnant women and neglecting important dimensions (27), e.g. sexual violence in highly vulnerable migrant sub-groups (30). Most policy documents dealing with sexual violence do not consider sexual violence against men, undocumented migrants and sex workers. The effect of structural factors, such as legal status and living conditions, on predilection to sexual violence is also ignored. While sexual violence in the countries of origin (e.g. in war, during trafficking or female genital mutilation) is considered, the potential for sexual violence against vulnerable migrants after arriving in the EU is ignored; the exception is sexual violence in migrant accommodation centres (30). As a result, migrants vulnerable to sexual violence face significant legal obstacles in realizing their rights to SRH services in the EU (30).

Fulfilling the administrative requirements needed to access care can be prohibitive for migrants as well as providers. For instance, when requirements such as proof of residence (27), insurance (24,27) or resources (27) are unclear, they create uncertainty about entitlement for both migrants and providers (27). Moreover, differing entitlements for various groups of migrants make it difficult for medical and administrative staff to determine which services can be offered (27). The situation is more complicated for undocumented migrants. Even when legally entitled, de facto access to care can be limited by administrative and financial burdens (33).

Inadequate resources and financial constraints
The limited finances and resources available for the SRHR of migrants and refugees delay needed diagnosis and treatment. Lack of financial allocation for migrant health, including preventive services, results in suboptimal levels of HIV testing of migrants from LMICs (26). While accessing care after an AIDS diagnosis, Latino migrants in United States were prevented from accessing care because of bureaucratic requirements and generally poor access to health care (34). Requirements for out-of-pocket payments create direct financial barriers, especially for undocumented migrants, while housing and transport costs are indirect financial constraints (27). Inadequate financial and human resources (e.g. health providers, interpreters) have been identified as barriers to adequate migrant health care by health providers (33), while nongovernmental agencies have raised concerns about limited funding, which negatively affects care for migrants affected by sexual violence (30).

**Poor living and working conditions**

Migrants move regularly and live in underserved areas, creating barriers to health care access and contributing to poor SRHR (27). Alternatively, offering services in easily accessible places facilitates HIV testing in HICs (26). Legal stipulations about sex work and their own legal status may deter migrant sex workers from seeking care (27). Adverse working conditions, such as confiscation of passports and withholding of food, are associated with abuse at the workplace among female domestic workers (31), which may lead to sexual violence. Living in detention and reception centres is associated with being subjected to violence. In one systematic review, the prevalence of sexual violence in these centres in HICs ranged from 13.6% to 77.8% (32). Poverty has also been associated with human trafficking and subsequent sexual violence (29). Evidence about migrant SRHR in LMICs is more limited. One review found that migrant female sex workers in lower income countries were at higher risk of HIV than non-migrant sex workers (28).

**Cultural and linguistic barriers**

Communication, language and cultural problems related to the migration process influence access to health services across the EU for arriving migrants and refugees (25). Communication and language problems limit the effectiveness of health promotion activities targeted at migrants (26), make it difficult for migrants to navigate health systems (27), and prevent health workers from providing adequate services to migrants (33). For instance, the inability of migrants to effectively communicate signs and symptoms of illness could decrease the probability of syndromic diagnosis of infections (24), potentially leading to inadequate management of HIV and STIs.

Cultural attitudes and beliefs among both migrants and providers can act as barriers to adequate SRH of migrants. For example, suboptimal knowledge, attitudes and practices about
SRH puts female domestic workers at higher risk of STIs (31). Health providers consider cultural differences between health providers and migrant patients, professional norms, and poor cultural fit of service provision guidelines as barriers to delivery of quality care (33). The lack of cultural sensitivity of health care providers limits uptake of HIV testing among migrants (26). Sociocultural factors (e.g. early child marriage, lack of access to social services, etc.) leave women and children vulnerable to human trafficking and subsequent sexual violence (29).

**Stigma and discrimination**

Discrimination based on migration status, gender, sex and ethnicity impact migrant SRH. Migration status intersects with other factors such as race, ethnicity and gender to exclude migrants, particularly women, from accessing care (27). Gender discriminatory practices were found to be a risk factor for human trafficking in, within and outside of Ethiopia, which results in migrants experiencing poor health outcomes and sexual violence (29). Female asylum seekers have a higher risk of sexual torture compared with males (32).

Stigma was reported as a barrier to accessing health care (26,27,29). Perceived and experienced stigma have been reported as significant barriers to HIV testing across migrant groups in HICs (26). Pregnancy outside marriage and the associated stigma were also identified as a factor leaving women vulnerable to trafficking and subsequently poor SRHR outcomes (29). Migrant male sex workers are particularly vulnerable to sexual violence due to stigma associated with migrant status, sex work and homosexuality, yet this vulnerability is not acknowledged in sexual violence policies in Europe (30).

**Discussion**

**Summary of main findings**

This review provides evidence about social and structural determinants that preclude migrants and refugees from maintaining good SRH and realizing their right to enjoyment of the highest attainable standard of health (36). We identified 6 determinants (Table 2), operating at 4 levels (Figure 3). Our findings align with research on underlying causes of poor migrant health (1,9,10,37). Our review adds new knowledge about how multiple determinants are harmful to SRHR. Economic crises; hostile environments; and limited legal entitlements, rights and policies exclude migrants from realizing their right to health and health care. Inadequate financial and human resources limit the health care services offered and care-seeking. Poor living and working conditions are associated with poor SRHR. Different languages and cultural norms between health care providers, migrants and the community are barriers to adequate diagnosis and treatment. Stigma and discrimination related to migration status, sex, gender and sexual orientation negatively impact the SRHR of migrants. Furthermore, our adapted model of determinants is relevant beyond the specific findings of this review and links upstream determinants (narratives and values) to health inequalities (Figure 3).
Strengths and limitations

The strengths of this review include the systematic search, the identification of the most consistent upstream determinants of migrant and refugee SRHR, and our adaptation of a widely used SDH framework (12). Our focus on STIs, sexual violence and unintended pregnancies is likely to have narrowed the number of identified determinants. The review of systematic reviews, rather than primary studies, might be seen as a limitation. In a research field as broad as the health of diverse groups of migrants and refugees, however, we were able to take advantage of existing systematic searches to compile the most relevant literature pertinent to various migrant sub-populations.

Implications for research and policy

Our review identified upstream social and structural determinants that impact migrants’ SRHR, but many reviews focused on downstream determinants. Given the politicized debates and growing xenophobic rhetoric and actions targeting migration (38), research about upstream determinants is an important priority. Our review identified findings mainly coming from HICs; research is lacking from the Eastern Mediterranean Region and other regions with larger fluxes of migrants and refugees (39) as are studies on unintended pregnancies and sexual violence in these populations. Research is also needed to connect knowledge of identified determinants and effective policies to mitigate the effect of these structural inequities, including rights-based approaches to improve the SRHR of migrants. Moreover, research into differing norms, power and political prioritization is needed to understand why SRHR among migrants remains a de-prioritized area.

Our review examined determinants of 3 selected SRHR outcomes. The nature of these determinants depends on context and relates to different populations of migrants and refugees – leading to caution in overt generalizations. Nevertheless, some potential policy implications arising from our review should be highlighted. First, to address key structural barriers to SRHR, sectors beyond health must be engaged. Second, the scope of migrant SRHR policies should be expanded to include areas such as sexual violence. Responses to sexual violence in host countries should be based on the consideration that migrants and refugees are at risk of sexual violence in countries of origin, in transit and in destination countries and need appropriate legal and health system protections. Third, in an era of austerity, preventive and curative SRH services for migrants, including undocumented migrants, and refugees must be adequately resourced in order to respect, protect and fulfil the right to health. Finally, evidence-informed SRHR services should be delivered in culturally sensitive ways to ensure uptake, provide appropriate linguistic support and assure privacy, confidentiality and dignity.

Conclusion
This review provides evidence for how upstream social and structural determinants undermine the SRHR of refugees and migrants. Unless these are addressed in policy-making and planning, the health and rights of migrants and refugees is at risk.

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