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Review

Language and Cultural Barriers and Facilitators of Sexual and Reproductive Health Care for Migrant Women in High-Income European Countries: An Integrative Review

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Introduction: Dealing with intercultural communicative barriers in European countries' national health services is an increasing and necessary challenge to guarantee migrant women's right to health care. This integrative review describes the communication barriers and facilitators that migrant women encounter to access and use sexual and reproductive health (SRH) services in Europe.

Methods: A literature search was performed to identify original studies in PubMed, CINAHL, PsycINFO, Web of Science, and Scopus, using keywords associated with migrant women and SRH services. This was supplemented by scanning the reference lists from relevant studies and similar reviews. Studies exploring the perspective of migrant women about communication barriers and facilitators to the access and use of SRH services were included, whereas those that solely explored health professional's experiences were excluded. Findings were organized into 4 themes: (1) verbal-linguistic barriers, (2) nonverbal language barriers, (3) cultural barriers, and (4) communication facilitators.

Results: Nineteen studies met the inclusion criteria. Results showed that when women had problems understanding or being understood by health professionals, they experienced feelings of anxiety, fear, insecurity, and discrimination that discouraged them from using SRH services. The most requested facilitators by women were health education, access to professional interpreters and translation of written information, and increasing the practitioners' cultural competence.

Discussion: Communication barriers undermine migrant women's right to benefit from preventive SRH programs and to make informed decisions concerning their health. It is necessary to establish tailored plans in each health care center to improve intercultural communication that integrate facilitators proposed by women. Future research should provide solid evidence on the effectiveness of each facilitator implemented.

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Keywords: sexual and reproductive health services, migrant women, communication, language, cultural, barriers, facilitators

INTRODUCTION

At the international level, no universally accepted definition for *migrant* exists. A broad and general concept of migrant women would include women who have left their nation of to dwell in another country, voluntarily or forcibly. These would be the first generation of migrant women. Their daughters and granddaughters born in the receiving country would be the second and third generation, respectively.[1]

It is estimated that in 2020 there were approximately 281 million international migrants in the world (3.6% of the world population). By region, Europe is the main destination (30.9% of the migrant population), followed by Asia (30.5%) and North America (20.9%). By country, the United States ranks first, with more than 51 million migrants, followed by Germany, with 16 million. The migration corridor between Mexico and the United States is the busiest in the world.[1] The Organization for Economic Cooperation and Development estimates that 2 out of every 3 migrants go to countries classified as *high-income economies*, which, according to the World Bank, is a nation with a gross national income per capita of US $13,205 or more in 2021.[2]

Women account for 48% of the world's migrant population; however, in both Europe and North America, more women than men immigrate, 51.6% and 51.8% respectively.[1] Migrant women are a vulnerable population, with specific problems related to sexual and reproductive health (SRH). The complexity of migrants' diverse religions and cultures, educational levels, migration histories, current living conditions, and legal status can influence their sexual health, including their vulnerability to sexual violence and increased risk of

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Quick Points

- ✦ Migrant women can experience several communication barriers mainly because of the lack of knowledge of the host country's language, which prevents them from obtaining information on how to navigate the health care system, understanding invitations to screening programs, and communicating with health care professionals.
- ✦ Most of the host countries included in this review had a professional interpreter service, yet women were unaware of its existence and thus did not use it.
- ✦ For immigrant women, being treated in a professional and respectful manner was paramount to communicate effectively with practitioners and represented a facilitator in woman-practitioner relationship.
- ✦ The imposition of host country's cultural values on sexual and reproductive health care is an important barrier for using health services.
- ✦ To practice woman-centered and culturally competent sexual and reproductive health care, it is necessary to ask every woman about her needs and preferences because of the variability in attitudes and beliefs among women from shared ethnic and religious groups.

sexually transmitted infections (STIs).[3] The use of SRH services is essential to ensure women's health as it has been associated with improved nutrition, mental health, and clinical benefits such as reduced rates of STIs and unintended pregnancies.[4]

Nonetheless, studies conducted in high-income countries show that compared with nonmigrant women, migrant women experience barriers when accessing cancer screening programs,[5] family planning services,[6] and gynecologic wellness visits.[7] Moreover, they undertake poorer diagnosis and treatment of STIs,[8] and perinatal care provided to this population shows important deficiencies that increase maternal and fetal morbidity and mortality.[9] The correct understanding of all the barriers and facilitators related to SRH can be essential to enhancing equitable conditions among all women.

Previous systematic reviews have examined barriers to accessing and using health services for migrant populations. The identified barriers included sociodemographic determinants,[9–11] health care cost and location,[9,12] psychological distress,[10,11] legal status (fear of deportation),[9] migration background,[10] social and family support,[9,13] and type of health coverage in the host country.[9,10,13] The studies included in these reviews highlighted the relevance that language and cultural barriers have on the access to and use of health services. However, included studies were focused only on the barriers to accessing health care services in specific countries (especially English-speaking), with less attention given to European countries. Moreover, most articles focused on pregnant women only. Although understanding and reducing communication barriers is necessary and important for pregnant migrant women, few studies have focused on the use of SRH by migrant women. Migrant women from different cultures may be less open to talk about their concerns regarding SRH,[9] exposing them to major health problems, which may extend to their partners or children.

Considering the increasing number of migrants arriving in Europe each year, knowing the existing barriers to accessing services for migrant women could bring new insights needed to adequately organize SRH services and guide policy decisions on transcultural health strategies. Therefore, this study aimed to explore and describe the communication barriers and facilitators on migrant women's access and use of SRH services in high-income European countries.

METHODS

We have reported this integrative review according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.[14] The review protocol was registered on PROSPERO (CRD42022345544).

Design

We conducted an integrative review attending the following steps: (1) problem formulation, (2) literature search, (3) data evaluation, and (4) data analysis.[15]

Eligibility Criteria

The inclusion criteria for articles encompassed quantitative, qualitative, and mixed methods studies exploring the perspective of migrant women (aged 18 or older) on communication barriers and facilitators to access and use SRH services, in a high-income European country (gross national income per capita ≥US $13,205), published in English, Spanish, French, and Italian, within international scientific peer-reviewed journals, and with no date restriction. If studies included the experiences of other groups (men, professionals, etc), only the views of migrant women were included in the analysis.

Articles were excluded if the study focused on internal migrants (ie, moved from rural to urban areas within the same country or region) or defined communication barriers as other linguistic barriers (eg, cognitive deficit, speech-language pathology, physical handicap). The publication was also excluded if it was not assessable by the Mixed Methods Appraisal Tool (MMAT) or if it was classified as a review, meta-analysis, editorial or opinion piece, concept analysis, theoretical framework, dissertation, conference proceeding, unpublished manuscript, or grey literature.

Information Sources and Search Strategies

To identify potentially relevant documents, we searched the following bibliographic databases: PubMed, CINAHL,

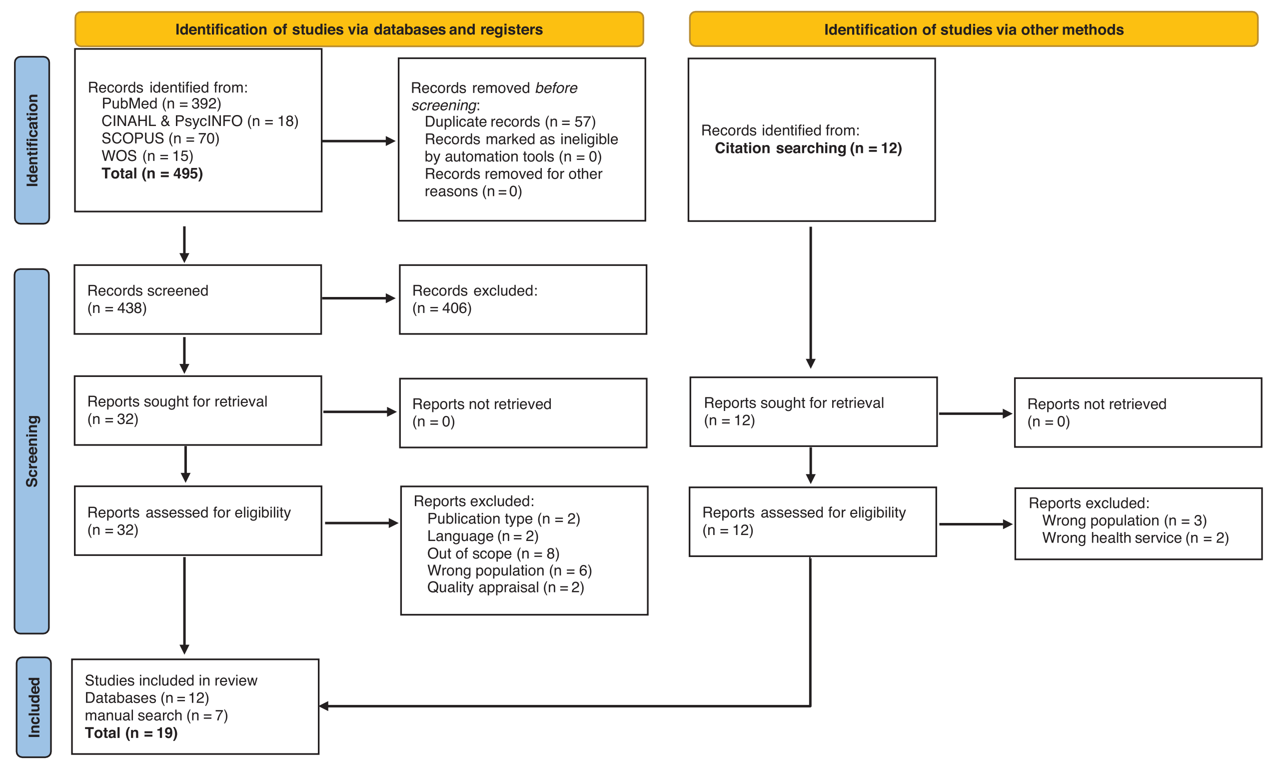

Figure 1. PRISMA Flow Diagram

Abbreviation: WOS, Web of Science.

PsycINFO, Web of Science, and Scopus. An experienced researcher (M.D.N.) drafted the search strategy, which was further refined through team discussion. The search terms and search strategy for each database can be found in Supporting Information: Appendix S1. We exported the final search results into Rayyan reference manager[16] and removed duplicates. We supplemented the electronic database search by scanning the reference lists from relevant studies and other reviews on the same topic. We analyzed the included references in each paper that passed through the eligibility phase.

Before the screening phase, 2 reviewers (A.D., S.C.) independently screened 20 studies, randomly selected from the retrieved collection, to increase consistency among reviewers. Afterwards, the selection process was discussed with the study group. We amended the data extraction criteria before beginning screening for this review. Every study retrieved from the search was then screened by title and abstract by 2 reviewers independently (R.R.V.-H., C.B.-R.). Then, the full text of all the studies included in the screening phase was retrieved and independently analyzed for inclusion and data extraction by the same 2 researchers who carried out the screening phase. Disagreements on study selection and data extraction were resolved by consensus and discussion with other reviewers.

Search Outcomes

The initial search of all databases returned 495 results. Fifty-seven were duplicates and thus removed. After reviewing titles and abstracts, 406 studies were excluded for not meeting the eligibility criteria. After reading the full text of the remaining 32 studies, 12 articles were retained. From the manual search, 7 articles, which had not appeared in the initial search, were selected. As a result, 19 articles were included in this review (Figure 1).

Quality Appraisal

We critically appraised the included original qualitative, quantitative, and mixed methods studies using the MMAT.[17] The MMAT consists of a total of 7 items: 2 screening questions (common to all types of study) and 5 methodological quality questions (specific for each type of study). The methodological quality of each included study was rated with the appropriate 5 criteria for each study design. Three reviewers (R.R.V.-H., A.D., C.B.-R.) independently assessed and rated all the studies. Scores were compared and discussed, discrepancies were resolved, and a consensus was reached.

We did not measure the methodological quality of the studies to discard those of lower quality but to give greater weight in the narrative synthesis to those of higher quality. The score was included as a variable in the data analysis stage.

Data Analysis and Synthesis

Two independent reviewers analyzed, extracted, and synthesized data from each primary source using a Microsoft Excel spreadsheet, which was subsequently converted into 2 summary tables for better data management. Table 1 includes information on the author, year of publication, country, aim of the study, design and research method, sample, health service, findings (related to barriers and facilitators to the access and use of SRH services), and quality score.

Table 1. Summary of Included Studies

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Abdullahi, (2009)[23] England	To explore the barriers to the uptake of cervical screening and to identify strategies for overcoming these barriers	Qualitative (focus groups and in-depth interviews)	19 Somali women	Cervical cancer screening	Lack of knowledge about the need for cervical screening Fatalistic attitudes, associated with the idea of "God's will" Embarrassment associated with FGM Language difficulties Fear of the test and negative past experiences	Provision of education and information about cervical screening in their native language Translated materials Providing education and information orally Improving access to a more culturally appropriate service Health care staff should be trained about Somali culture, particularly regarding FGM Improving translators' medical training	5/5
Åkerman, (2017)[18] Sweden	To explore Thai women's health care-seeking behavior in relation to sexual and reproductive health (knowledge, access, and use of contraceptive counseling and HIV prevention)	Qualitative (in-depth interviews)	19 Thai women	Sexual health (family planning and STI detection)	Poor access to health care in Sweden due to lack of knowledge about the health care system and language difficulties, preferring to seek care in Thailand Partners playing a key role in women's access to health care Lack of an adequate interpreter	No perceived risk of HIV, but a positive attitude toward prevention Women believed that the information should come from health care providers and that information should be communicated by regular mail and/or Facebook	5/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Bains, (2021)[36] Norway	To identify challenges and barriers that recently arrived migrant women face in accessing and using the maternity health care service in Norway	Mixed methods, quantitative (structured questionnaire) and qualitative (in-depth interviews)	Quantitative (401 migrant women) and qualitative (20 migrant women and 7 midwives)	Perinatal care	Low familiarity with the health care system and unmet needs for interpreter use LLP Disruptions in the interpersonal relationship with health care professionals or mistrust of the system Unmet expectations of care caused by cultural dissonance and confrontation Impact of religious beliefs Differences in views of the body, sexuality, and gender relations	A few women emphasized the importance of having female health care personnel, mostly for clinical work and wellness visits Professional interpreter preferred if female	3/5
Binder, (2012)[19] England	To gain a deeper understanding of the multiethnic care setting and the roles that ethnicity and language play during the sensitive care encounter between immigrant women and their Western perinatal care providers	Qualitative (qualitative techniques inspired by naturalistic inquiry) In-depth semistructured individual and focus group interviews	39 migrant Somalis, 11 migrant Ghanaians, 10 White British women, and 62 perinatal care providers (doctors and midwives)	Perinatal care	Professional-patient communication was hindered due to LLP Disuse or inaccessibility of adequate interpreter services Mistrust due to difficult migration experience Impact of religious beliefs Differences in views of the body, sexuality, and gender relations	Choice of health professional Availability of interpreters	5/5
Degni, (2013)[34] Finland	To explore immigrant Somali women's experiences of reproductive and maternity health care services and their perceptions about the service providers	Qualitative (focus group)	70 Somali women	Perinatal health care	LLP Religious beliefs had an important impact on SRH care ministration Health professionals' attitudes toward migrant women: disrespectful and unkind treatment Perceived discrimination	Provision of cultural competence training for professionals Interpretation services Opportunity to learn the native language of the host country	4/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Gele, (2017)[20] Norway	To acquire better insight into perceived barriers and challenges to cervical cancer screening, with the aim of identifying common features that in turn could be used to develop a culturally adapted intervention for immigrant women	Qualitative (focus group discussions based on the Ecological Model)	35 migrant women (18 Pakistani, 17 Somali)	Cervical cancer screening	Individual barriers: not understanding the benefits of the screening due to lack of health literacy and LLP Sociocultural barriers: stigma and fatalistic attitudes toward disease; cultural dissonance; confrontations (eg, FGM); and disagreement about the body, sexuality, and gender relationships Lack of trust toward the health care system and disruption of the interpersonal relationship with health professionals	In-person communication and information material at health centers Verbal communication with women through seminars and workshops to educate them about their risk of cancer and the importance of screening The initiation of better recall through SMS and letters written in native languages	5/5
Gele, (2020)[21] Norway	To explore the barriers and facilitators to contraceptive use among Somali immigrant women in the Oslo area	Qualitative (unstructured in-depth interviews)	21 Somali women of reproductive age, >18 y	Contraceptive use	Language problems and low health literacy Lack of adequate information and need for a professional interpreter Religious beliefs and fatalistic view of disease Gender roles Social pressure	Information in native language Increasing multicultural communication skills of health providers Religious leaders as partners in contraception use	4/5
John, (2021)[22] Scotland	To explore the experiences of pregnancy, childbirth, antenatal and postnatal care in women belonging to ethnic minority groups and to identify any specific challenges that these women faced during the COVID-19 pandemic	Qualitative (semistructured interviews)	16 pregnant or postpartum women from Black, Asian, and minority ethnic groups	Perinatal health care	Lack of communication: disrespect, accent bias, language barrier and cultural dissonance Lack of harmony with other health care systems Racism (institutional, interpersonal, or internalized)	Interactions with health care professionals: continuity of care and empathy Informed and adequate decision-making Accessible use of an interpreter Adapting the means of communication	4/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Johnsen, (2020)[24] Denmark	To explore the main organizational barriers, which impacted the intended mechanisms of an intervention consisting in the training of midwives in intercultural communication in Danish antenatal care	Qualitative (in-depth interviews)	21 non-Western immigrant women	Perinatal health care	LLP Lack of knowledge of medical terminology Lack of interpreting quality and accessibility	Translated information material Paper leaflet and smartphone application (app) for women Midwives' Cultural competence	5/5
Konje, (2021)[25] United Kingdom	To explore and describe the views and experiences of Somali migrant women on accessing care before and during pregnancy in the United Kingdom and the factors that influence these, and on childbirth	Qualitative (focus groups discussion and individual semistructured interviews based on grounded theory	16 Somali women	Perinatal care	Language difficulties and ineffective communication Absence of professional interpreters Lack of cultural awareness Preconceived ideas by some hospital caregivers makes them unsupportive and insensitive Impact of personal, community, and religious factors	Positive attitudes of community midwives and availability lead to positive and meaningful experiences Need for continuity of care and the provision of resources are needed to build important trusting relationships with care providers Documents such as pregnancy booklets, patient information leaflets, and other educational materials should be translated into the language of minority groups Community discussion groups led by or supported by peer educators	5/5
March, (2018)[27] Spain	To characterize the knowledge and perceptions of breast cancer and breast cancer screening of immigrant women from low-income countries who are living in Spain; to identify differences in the discourses about cancer prevention among immigrants from different geographical origins and native Spanish women with similar socioeconomic status; and to identify the barriers that prevent immigrant women from participating in breast cancer screening programs	Qualitive (in-depth interviews)	22 migrant women and 4 native Spanish women	Breast cancer screening	Language barrier Lack of knowledge about the health system Fatalistic cancer perceptions and beliefs Gender relationships		4/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
McCourt, (2000)[28] England	To explore the perinatal care views and experiences of minority ethnic women who did not respond to a postal survey of mothers' responses to care and to assess whether the concept of continuity mattered to them	Qualitative (semistructured narrative interview)	20 minority ethnic women at about 6 months postpartum (half receiving caseload midwifery and half conventional care)	Perinatal care	Inadequate and inappropriate information (although most of this group spoke English reasonably fluently, or as a first language) Disrespectful treatment Perceived discrimination	Need for professional interpretation Continuity of care	2/5
Naish, (1994)[29] United Kingdom	To determine the factors that deter ethnic minority women living in east London from attending their GP for cervical cytology screening	Qualitative (focus group discussions)	Between 66 and 110 non-English-speaking women	Cervical cancer screening	Inadequate and inappropriate information (even if they were fluent or native English speakers) Inadequate surgery premises and concerns about sterility (low health literacy) Attitudinal barriers to cervical cytology screening such as fear of cancer Gender relationships between the practitioner and the migrant women	• Continuing relationship with practitioner enabled good communication	1/5
Sami, (2019)[30] Switzerland	To explore positive and negative experiences with maternal health services in the University Hospitals of Geneva and Zurich and to identify specific barriers to health care accessibility	Qualitative (focus group discussions based on a questionnaire)	33 women	Perinatal care	Lack of health literacy Language barriers Lack of information Fatalism about disease Perceived discrimination		4/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Schmidt, (2018)[26] Switzerland	To identify access barriers to reproductive health services by migrant women in Geneva and to understand if the community played a role in addressing those barriers	Qualitative (focus groups conducted using semistructured interviews)	78 women migrants	Reproductive and sexual health (family planning, preventive programs, and wellness visits)	Language barriers Lack of awareness concerning the professional interpreter service Real or perceived discrimination Lack of information Embarrassment and modesty related to bodies and gender relationships Cultural competence shortfall	Community-based health programs The provision of information material that is easy to understand and available in multiple languages Mandatory provision of sensitive cultural training for health professionals to inform about the availability of interpreter services and social services to offer appropriate care The evaluation and adaptation of nurses' skills or social assistance to guide migrants through the Swiss health system The inclusion of monitoring and evaluation programs for the prevention of personal and systemic discrimination	4/5
Shangase and Egbe, (2015)[31] United Kingdom	To identify the barriers to accessing HIV services in the Black African communities in Cambridge and Huntingdon	Qualitative (focus group discussions)	30 migrant Africans (18 women and 12 men)	HIV service	Language barriers and lack of awareness of interpreter services Lack of understanding of cultural diversity, perceived discrimination Gender-related cultural preferences of health practitioners Lack of awareness of how and where to access health services Difficulties getting information	• Provision of cultural competence training for professionals	5/5

(*Continued*)

Table 1. (Continued)

Author (Year) Country	Aim	Design and Method	Sample (Population)	Health Care Service	Results (Barriers)	Results (Facilitators)	Quality Score
Thomas et al, (2005)[33] United Kingdom	To describe some of the factors that act as barriers to effective uptake of breast and cervical cancer screening services among BME groups living in Brent and Harrow in the United Kingdom	Qualitative (focus group)	85 participants (85 women and 80 men) Black and minority ethnic individuals	Breast and cervical cancer screening	Poor knowledge, underlying health, and cultural beliefs Fatalistic vision of disease and impact of religious beliefs Unhelpful attitudes of health professionals: disrespectful treatment and mistrust Language barrier Inadequate translation of screening information leaflets	Community-based cancer awareness education sensitive to religious and cultural needs Involvement of religious leaders Cultural competence training for health care professionals	5/5
Verran et al, (2015)[32] United Kingdom	To explore Chinese asylum seekers knowledge and understanding of family planning once living in the United Kingdom	Qualitative (semistructured interviews)	10 female Chinese asylum seekers with limited English proficiency	Contraceptives use (family planning service)	Women arrived from China with little knowledge of contraception (health literacy) Differences in sexual and reproductive health care Gender relationships Limitation of the information provided		4/5

Abbreviations: BME, Black minority ethnic; FGM, female genital mutilation; GP, general practitioner; LLP, limited language proficiency; SMS, short message service; STI, sexually transmitted infection.

We extracted codes from qualitative studies and quantitative data from mixed studies using narrative summaries. For data synthesis, we coded all relevant findings considering the purpose of this integrative review and its research questions. Then, based on the coded text and using an inductive approach, we determined final themes and subthemes. At the end of the synthesis phase, a third researcher (A.D.) verified the developed themes with the findings from primary studies to enhance the trustworthiness of the extracted data.

RESULTS

Study Characteristics

Table 1 summarizes the 18 included articles. Seventeen articles were qualitative,[18-34] and one was mixed method.[35] They were conducted in the United Kingdom,[19,22,23,25,28,29,31-33] Norway,[20,21,35] Switzerland,[26,30] Sweden,[18] Finland,[34] Denmark,[24] and Spain,[27] and the analyzed health contexts were perinatal care,[19,22,24,25,28,30,34,35] screening of cervical cancer[20,23,26,29,33] and breast cancer,[26,27,33] family planning,[18,21,26,32,34] and HIV prevention services.[18,26] The sample comprised migrant women, but some studies also included health professionals,[19,35] women from the host country,[19,27] and men.[31,32] All studies aimed to describe and understand barriers and facilitators from the perspective of migrant women. The common methods for data collection were semistructured, in-depth interviews, and focus groups. In the mixed method study, quantitative data were collected through a questionnaire and qualitative data through an in-depth survey.

Quality Appraisal

All qualitative and mixed method studies had a clear objective, and data collection aimed to answer the research question. In the qualitative studies, 10 specified the research approach,[19,20,22-25,28,31-33] but, of these, only 6 justified it.[19,20,24,25,31,33] In most, the method was adequately described (ie, the information reported were in accordance with the MMAT items) except in 2 studies: one did not provide sufficient data on the recruitment of the sample[28] and another one lacked information on ethical issues and data handling.[30] Regarding whether the influence of the researcher on the research, and vice versa, was addressed, only 1 study carried out bracketing,[32] and 3 identified the lack of bracketing as a limitation.[22,26,30] The results were based on textual quotes from the participants and did not include the authors' opinions, except for one study.[29] Results were interpreted based on the data, and only 2 studies examined the trustworthiness of the results.[21,31] Finally, except for 2 articles,[28,29] the limitations of their research were pointed out. The mixed method study's authors[35] justified the method chosen and adequately integrated and interpreted the qualitative and quantitative components. However, they did not address possible inconsistencies between quantitative and qualitative results, and the methodology of quantitative data collection and analysis was not clearly explained.

Participants

Approximately 663 women constituted the qualitative sample, and 401 constituted the quantitative sample. The most represented group was Somali women, who participated in at least 5 of the 18 studies,[19-21,23,25] followed by Pakistani, Thai, Ghanaian, and Chinese women.[21-23,25,32,34,35] The vast majority were first-generation migrants.[18,21-23,25,32,34,35] The migration related characteristics of the sample can be found in Supporting Information: Appendix S2.

We identified 3 themes that described the barriers to access and use of SRH services, including verbal language barriers, nonverbal language barriers, and cultural barriers. The fourth theme described facilitators to support access of SRH services by migrant women through linguistic or cultural adaptations. Themes and examples are provided in Table 2.

Verbal Language Barriers

Limited Language Proficiency

Women had difficulties in understanding and being understood. Lack of knowledge of the language prevented them from obtaining information on how to navigate the health care system,[18,25,26,30,35] understanding invitations to screening programs,[20,23,29] and communicating with health care professionals.[19,21,23,26,28,34] This barrier caused them anxiety,[23,26] fear,[26] insecurity,[27] and embarrassment.[28] These feelings discouraged them from attending cancer screening,[23] family planning centers,[21,26] or prenatal care.[28] Women travelled to their home country to consult with practitioners who could answer their questions about contraceptive methods[18] or preferred to seek information from other women in their community.[21]

Even when women began to master the language of their host country, these barriers did not disappear. They found difficulties in understanding dialects, variations of the language, or the coexistence of several languages in the country.[35] Language proficiency required time spent in the country. Some women had the language skills to understand but were not able to speak and explain themselves well.[24]

Overall, there were additional difficulties with understanding written language compared with oral language.[27] For example, Somali women's culture has developed and is mainly transmitted orally.[23] Thus, when information about the screening test came in a written form they ignored it, even if it was in their language. Also, the translated material used terminology too difficult to understand.[20,23,25,29,33]

The language barrier became particularly significant during the last pandemic when face-to-face visits were replaced by telephone consultations. Women expressed uncertainty about the information conveyed over the phone. The reliance on books or websites to receive advice left those who could not read English unable to resolve their concerns. They felt that the decisions that were made about their motherhood were not consensual.[22]

For migrant women, language difficulties led to misunderstandings with health care providers.[19,34] Their

Table 2. Verbal-Linguistic Barriers (Spoken and Written Language) Themes and Subthemes[a]

Themes and Subthemes	Cancer Screening	Gynecologic Care	Perinatal Care
Verbal Language Barriers			
Limited language proficiency	Abdullahi (2009)[23]; Gele (2017)[20]; March (2018)[27]; Naish (1994)[30]; Thomas(2005)[33]	Åkerman(2017)[18]; Gele (2020)[21]; Schmidt (2018)[26]; Shangase (2015)[31]; Verran (2015)[33]	Bains (2021)[35]; Binder (2012)[19]; Degni (2014)[34]; John (2021)[22]; Johnsen (2020)[24]; Konje (2021)[25]; Sami (2019)[31]
Lack of health literacy and knowledge about the health system	Abdullahi (2009)[23]; Gele (2017)[20]; March (2018)[27]; Naish (1994)[29]; Thomas (2005)[33]	Åkerman (2017)[18]; Gele (2020)[21]; Shangase (2015)[31]; Verran (2015)[32]	Bains (2021)[35]; Johnsen (2020)[24]; Konje (2021)[25]; Sami (2019)[30]
Lack of adequate interpreter services and knowledge about their existence	Thomas (2005)[33]	Åkerman (2017)[18]; Gele (2020)[21]; Schmidt (2018)[26]; Shangase (2015)[31]	Bains (2021)[35]; Binder (2012)[19]; Johnsen (2020)[24]; Konje (2021)[25]
Nonverbal Language Barriers (Attitudes, Perceptions, and Emotions)			
Limitation of information provided	Abdullahi (2009)[23]; Gele (2017)[20]; Thomas (2005)[33]	Gele (2020)[21]; Schmidt (2018)[26]; Shangase (2015)[31]; Verran (2015)[32]	Konje (2021)[21]; McCourt (2000)[28]; Sami (2019)[30]
Interpersonal relationship impairments			
Disrespectful and unfriendly treatment	Gele (2017)[20]; Thomas (2005)[33]		Degni (2014)[34]; John (2021)[22]; Konje (2021)[25]; McCourt (2000)[28]
Lack of empathy			Konje (2021)[25]
Mistrust	Gele (2017)[20]; Thomas (2005)[33]		Degni (2014)[34]; Bains (2021)[35]; Binder (2012)[19];
Perceived discrimination		Schmidt (2018)[26]; Shangase (2015)[31]	Degni (2014)[34]; John (2021)[22]; Konje (2021)[25]; McCourt (2000)[28]; Sami (2019)[30]
Cultural Barriers			
Cultural idea of the disease			
Stigma	Gele (2017)[20]		
Fatalistic ideas toward disease (associated with God's will or other cultural beliefs)	Abdullahi (2009)[23]; Gele (2017)[20]; March (2018)[27]; Naish (1994)[29]; Thomas (2005)[33]	Gele (2020)[21]	Konje (2021)[25]; Sami (2019)[30]
Dissonance and cultural confrontation (racism)			
Misunderstandings, criticism, and disagreements			Bains (2021)[35]; Binder (2012)[19]; Degni (2014)[34]; John (2021)[22]; Konje (2021)[25]; McCourt (2000)[28]; Sami (2019)[30]
Highly contested practices (eg, female genital mutilation)	Abdullahi (2009)[23]; Gele (2017)[20]		Degni (2014)[34]; Konje (2021)[25]
Disallowing or preventing cultural rites and practices			Bains (2021)[35]
Impact of religious beliefs	Thomas (2005)[33]	Gele (2020)[21];	Binder (2012)[19]; Degni (2014)[34]; John (2021)[22]; Konje (2021)[25]

(*Continued*)

Table 2. (Continued)

Themes and Subthemes	Cancer Screening	Gynecologic Care	Perinatal Care
Body, sexuality, and gender relationships			
Modesty and shame	Abdullahi (2009)[23]; Gele (2017)[20]; Thomas (2005)[33]	Schmidt (2018)[26]	
Gender relationships (between patients, relatives, and practitioners)	Abdullahi (2009)[23]; Gele (2017)[20]; March (2018)[27]; Naish (1994)[29]; Thomas (2005)[33]	Åkerman (2017)[18]; Gele (2020)[21]; Schmidt (2018)[26]; Shangase (2015)[31]	Bains (2021)[35]; Binder (2012)[19]
Differences in sexual and reproductive health care		Schmidt (2018)[26]; Verran (2015)[32]	Bains (2021)[35]; Degni (2014)[34]; Konje (2021)[25]; Sami (2019)[30]
Cultural competence deficits		Schmidt (2018)[26]	John (2021)[22]
Communication Facilitators			
Group health education	Abdullahi (2009)[23]; Gele (2017)[20]; Thomas (2005)[33]	Gele (2020)[21]; Schmidt (2018)[26]	Bains (2021)[35]; Konje (2021)[25]
Engaging religious leaders	Gele (2017)[20]; Thomas (2005)[33]	Gele (2020)[21]	
Translating the information (patient leaflets and other educational materials)	Abdullahi (2009)[23]; Gele (2017)[20]	Gele (2020)[21]; Schmidt (2018)[26]	Konje (2021)[25]; Johnsen (2020)[24]
Cultural adaptation of communication means (eg, oral and written forms, face-to-face)	Abdullahi (2009)[23]; Gele (2017)[20]	Åkerman (2017)[18]; Schmidt (2018)[26]	John (2021)[22]; Konje (2021)[25]
Availability of a professional interpreter	Abdullahi (2009)[23]; Gele (2017)[20]		Bains (2021)[35]; Binder (2012)[19]; John (2021)[22]; Konje (2021)[25]; McCourt (2000)[28]
Continuity of care			John (2021)[22]; Konje (2021)[25]; McCourt (2000)[28]; Sami (2019)[30]
Choice of practitioner	Gele (2017)[20]		Binder (2012)[19]
Provision of cultural competence training for professionals	Abdullahi (2009)[23]; Thomas (2005)[33]	Gele (2020)[21]; Shangase (2015)[31]	Degni (2014)[34]; Johnsen (2020)[25]; Konje (2021)[25]
Opportunities to learn native language of the host country		Gele (2020)[21]	Degni (2014)[34]

concern was to be perceived as "problematic" patients causing providers to feel "fed up" and to ignore them. Not being able to express themselves correctly caused concern and frustration.[30]

Lack of Health Literacy

Women were often unfamiliar with medical terminology[23,35]; this shortcoming also affected the person who interpreted for them.[18,26] Even women who were confident in colloquial language found it difficult to understand what health professionals were explaining, perceiving a large gap between everyday language and medical terms.[20,35] Some declined routine pregnancy tests because they were not able to understand the information that was given to them.[30]

Lack of Interpreter

The lack of professional interpreters precluded women from attending cancer prevention programs,[23,27] family planning services,[18,32] STI services,[31] or maternity care.[25] Most of the host countries, including Sweden, Finland, Norway, Switzerland, and the United Kingdom, had professional interpreting services available, yet women were unaware of their existence and thus did not use them.[18,21,26,28,34] The lack of a professional interpreter meant women involved family members, acquaintances, or volunteers (ad hoc interpreters). This alternative was criticized for several reasons: dependence on the husband's availability[18,32]; the practitioners established the dialogue between themselves and the husband, leaving the woman aside[24]; the information could be modified or hidden, or their husbands' opinion would prevail over their own[18]; their openness was limited and their right to privacy violated[20,21,26,35]; fear of being monitored by the authorities in their country[35]; and not wanting to discuss their sex lives with anyone from their ethnic group present.[20] Others identified as problematic when children had to report shocking events, for example, a daughter had to inform her mother that the ultrasound showed a malformed fetus with no head.[19]

Nonverbal Language Barriers

Limitation in the Information Given by Health Care Providers

Women felt that health professionals did not make an effort to provide all the information needed to access SRH services, understand screening tests, choose contraceptives, or consent to treatment.[20,25,26,28,30,32] Communication with practitioners was a one-way transfer of information, not a dialogue.[28] Women were not encouraged to express their needs and felt that they annoyed the practitioners when they asked too many questions.[22,25,28,33] The contraceptive counseling received was said to be disappointing because it did not help them in their decision-making.[30,32]

Difficulties in Interpersonal Relationships With Practitioners

Feeling that they are treated professionally and respectfully was paramount to communicating effectively with practitioners.[19,22,25,33] Continuity of care, established mainly with primary care professionals, was related to trust and good communication.[25,26,28,30] On the contrary, hospital care providers were felt to be strangers, displaying rude behaviors, disinterest,[28] and a hostile attitude when women rejected their proposals.[34] Empathy appeared as a key communication factor. If women perceived that health care professionals showed interest, they felt listened to and cared for.[22,25,28]

Discrimination was perceived by women from different backgrounds.[22,26,28,30,34] They thought that having a foreign accent was associated with low socioeconomic and cultural status and negatively influenced care.[22] Some women felt prejudiced when a doctor, who had seen them several times, did not recognize them.[34] Mistrust was another factor that distorted communication.[19,20,33-35] Women with very traumatic life experiences were distrustful of strangers.[19,34]

Cultural Barriers

Cultural Constructions of Disease

Muslim women considered that their sexual practices protected them from STIs and cervical cancer, which led them to decline screening opportunities.[20,21,23,27,33] If an unmarried woman, who must be sexually inactive, is known in the community to have attended an SRH service, she may be stigmatized.[20] The fatalistic view of cancer, the fear of talking about it, and the shame of being diagnosed are reported by women from vastly different cultures.[23,27,29] This negative perception was associated with the conception of illness as "God's will."[23,28,30]

Cultural Dissonance and Confrontation (Racism)

The imposition of host country cultural values on SRH care was an important barrier to using health services.[19,20,23,25,28,30,34,35] Some clinical practices were in direct conflict with their cultural beliefs and values.[34] Women showed reluctance to come to consultations when they had experienced situations of misunderstanding by practitioners with some of their cultural practices such as female genital mutilation (FGM),[20,22,23] the decision not to use contraception,[21,34] or not consenting to cesarean birth.[25,34]

FGM was particularly conflictive and sensitive for women.[20,23,25,34] The possible expression of surprise, bewilderment, or rejection by some practitioners provoked embarrassment. Moreover, women feared the pain that gynecological practices might cause for circumcised virgin women.[20]

Health professionals often discouraged women from adhering to specific rituals and customs around childbirth, such as food preferences, child hygiene, performing an *adhan* (ritual in which the Muslim father recites a prayer in the ear of the newborn), or the choice of the people who will accompany the birth. Women experienced significant contradictions between the maternity care practiced by women of their ethnicity and the recommendations given to them by practitioners.[35]

Impact of Religious Beliefs on Health Attitudes and Behaviors

When the clinical practices conflicted with their religious beliefs, women rejected them.[19,25,30,34] They feared that if prenatal diagnostic tests detected any problems in the fetus, they would be pressured into deciding to abort.[25,29] Not all women who shared the same faith interpreted it in the same way.[21,27] For some women, their faith led them to adopt a fatalistic attitude that discouraged them from attending cancer screening, but for others, it gave them arguments to develop a proactive discourse that encouraged them to avoid the disease.[27] There was not a unanimous opinion among religious leaders on the use of contraceptives. Some thought that Allah would not punish families for having few children if they took good care of them.[20] Certain women decided to use contraception because it facilitated giving their children a good social and religious upbringing, whereas others rejected it.[34]

Cultural Construction of the Body, Female Sexuality, and Gender Relations

Disrobing or discussing gynecological problems with practitioners, especially if these were men, made women uncomfortable.[20,23,26] Although women preferred to be attended by professionals who were women,[27,29] the professional's competence and respectful attitude was more important than their gender.[19] An obligation to behave in accordance with their culture-based gender roles was reported. Women felt pressured by other women of their family and ethnicity to have many children, but the greatest strain was exerted by their own husbands, who did not accept contraception or abortion.[21]

Differences in SRH Care Between the Origin and Host Country

Women came from countries where preventive health was not usual. They only went to the doctor when they were sick. Clinical practices with which they were unfamiliar caused them incomprehension and fear.[20,23,25-27,30,32] The compulsory contraceptive experience of Chinese women, mostly using intrauterine devices, made them wary of hormonal methods because they believed these methods could interfere with their menstrual cycle and have undesirable side effects.[32]

Examinations that involved the use of instruments that had to be inserted into their vagina were rejected because they feared miscarriage or harm to their child.[30] Cesarean birth was regarded as an intervention that was done lightly without considering how important it was for them to be able to have more children.[25]

Cultural Competence Deficit of Health Professionals

From the common way of greeting in Europe (shaking hands), which involved unwanted physical contact with men,[26] to other situations with more serious repercussions, such as negligent and insensible treatment of FGM, the practitioner's lack of awareness on women's diverse cultural customs could lead to very traumatic experiences concerning SRH care.[19,22,29]

Communication Facilitators

The most requested facilitators for accessing and using SRH services identified by women were health education,[20,23,25,26,33,35] access to professional interpreters and translation of written information,[19,20,22-26,28,35] and increase of practitioners' cultural competence.[21,23-25,31,33,34]

Group health education programs should be delivered in their native language, by women with health training from their community,[21,23,26] and should include information about their health rights and how to navigate the health system.[35] It should take place where women could speak freely,[21] involving other older women in the community.[25] Religious leaders should be addressed to support health education programs and SRH campaigns.[21]

Individual, face-to-face, and preferably oral counseling were considered important.[23,25,26] Women were more likely to use health services when general practitioners recommended it personally.[23,26] Written information should be translated into their language in a simple and accessible way.[20,25,26] For women with limited language proficiency (LLP), a professional interpreter was essential,[21,24,25] and they preferred female interpreters[35] with extensive knowledge of medical terminology in both cultures.[23,26] Women called for greater cultural competence among health professionals, especially in dealing with highly sensitive issues such as FGM.[22,26,34]

Other identified facilitators were continuity of care, because it allowed the practitioner to get to know the person, with their history, experiences, hopes, and fears and gave the women the opportunity to express their wishes and make well-informed decisions[21,28,34]; choosing the practitioners with whom they felt most comfortable, from the same ethnic group and/or gender; and having more consultation time.[22,24-26,35] In only 2 studies was the opportunity to learn the language identified as a facilitator.[20,34]

DISCUSSION

This review sheds light on the communication barriers experienced by migrant women in accessing and using SRH services in Europe. The overarching themes and subthemes have identified the difficulties of intercultural communication from the perspective of language, both verbal and nonverbal, and culture. The 3 dimensions are intrinsically related, but the subthemes provide nuances that deepen the impact of each barrier independently and in interaction with each other. The facilitators, as stated by the women, refer to ensuring the availability of language support, through translation and interpretation into the women's language, to guarantee their right to receive SRH counseling, thus improving the communication skills of practitioners and their training in cultural competency.

In all high-income countries, there is a trend toward multiculturalism.[1] Studies conducted in the United States, Canada, or Australia[4,12,36] note that the difficulty in communication between health professionals and migrant women is universal. Common findings include communication difficulties as a key problem in migrant women's health care,[37] health care providers not being sufficiently prepared to provide culturally competent care,[38] and the power misbalance in the relationship between the professional and the woman ("professional dominance").[39] Racism[40] and preferential treatment bias favoring women of the same cultural group as professionals causes disparities in access to health care, treatment, and health outcomes for migrant women.[41,42] This explains why Somali women's communication barriers in Europe to access and use health services are similar to those faced in the United States.[39,43] Moreover, it is noteworthy that immigrant and nonimmigrant women residing in Europe or the United States seem to have very similar ideas about what they want from their health care, despite the diversity of women's countries and cultures of origin.[37] This suggests that the communication difficulties identified by migrant women and the possible help that could be offered to them would be useful for most immigrant women inside and outside Europe.

Verbal Language Barriers (Spoken and Written Language)

Limited Language Proficiency

The linguistic barrier can prevent migrant women from knowing how to navigate the health system as well as asking for help or consent to tests, which explains the lower access to and use of SRH services by migrant women compared with women living in a European country.[44,45] Difficulties are greater the shorter the length of stay and the more limited their language proficiency.[45,46] However, oral fluency is not the only language barrier. Doctors often use more complex language than their patients can understand, and the gap between colloquial language and medical terminology is even deeper in the migrant population.[37,47] On the other hand, health literacy has 2 components: health-related print literacy and health-related oral literacy; understanding the former and being able to comprehend and verbalize the latter are different skills and lead to different degrees of difficulty in communication. A study in the United States showed that the bilingual Mexican population was less health literate in English than native English speakers.[48] The difficulty increases with the coexistence of multiple languages or dialects in host countries.[49] For some women, this is exacerbated by low literacy in their own language.[44]

Lack of Linguistic Support

We found a lack of professional interpreters for migrant women to be provided with linguistic support. This same situation is described in the United States.[50] Evidence showed that when professional interpreters are replaced by ad hoc interpreters, the number of errors due to misinterpretation or omission of information increases, and health outcomes are worsened.[50] In addition, the presence of a family member may inhibit women and violate their right to privacy and confidentiality.[51] Another relevant aspect is the dependence on family members, mainly husbands, and the possible intentional or unintentional distortion of messages by ignoring embarrassing information or culturally conflicting issues.[52] Minors are also discouraged from acting as interpreters because they lack medical vocabulary and may feel embarrassed or overwhelmed.[53]

Nonverbal Language Barriers (Nonverbal Language and Communicative Context)

Lack of Information

Migrant women believe that in their encounters with health professionals, they do not receive all the information they need to understand and make decisions about their SRH. Women's perception of such "information theft" is consistent with other studies. For example, contraceptives were significantly less often discussed and prescribed to migrant women compared with native Dutch women.[54] Some doctors rely on their own interpretation skills, which are not always sufficient, or tend to avoid communication if they believe they will not be understood.[47] Poor communication and insufficient information provision impact women's lives and their ability to make appropriate care choices and give informed consent.[9]

Ineffective Communication

Most human communication occurs on a nonverbal level, through gestures, looks, posture, or silence.[55] This review showed that nonverbal language and the way they are treated are of utmost importance in communicating with women who have language barriers. Nonverbal language has the capacity to create trust or mistrust that directly impact health services' access and use. In the United States, medical mistrust has been associated with lower breast cancer screening rates among Arab American women.[56] Studies indicate that although respect for migrant's cultural beliefs and practices is important, it is more important for them to receive respectful care, focused on their individual communication needs, and better information about how to navigate the health care system.[37,57]

This integrative review corroborates that there are women from different cultures who feel more comfortable and speak more freely if they are seen by a woman when they consult for SRH issues.[58] This preference for women seems to have a cultural component, but it is not always the most important consideration; the competence and communication style of the practitioner may be decisive.[59] Female physicians more often show greater commitment to patient-centered communication, greater empathy, and a more socioemotional communication approach characterized by nonverbal communication and a higher expression of emotions, and their consultation times are also longer.[60] These caregiving characteristics are widely desired by migrant women in this review and underscore the importance of communicative style in effective communication.

Cultural Barriers

Racism

The provision of SRH care for women is more complex than other types of health care because it deals with highly sensitive issues, is heavily mediated by cultural and religious beliefs, and is intimately related to concepts of corporeality, gender, intimacy, and identity. This review identified racism as an important cause for decreased access to and use of SRH services.[9-13,61,62] Sometimes, discrepancies between the predominant culture of the host country and the minority culture of the immigrant women led to racist behaviors, especially when dealing with issues that are strongly criticized, rejected, and even punished in the host country, such as FGM. Women with FGM in high-income countries receive suboptimal care and report poor experiences of care,[63] whereas American and European gynecologists and midwives find it challenging to care for them.[43,64] These findings indicate that much is needed to improve interactions between these women and their health care providers. Implicit and explicit racial discrimination toward migrant populations is well documented in Europe[65] and has a negative impact on women's health.[66] This discrimination manifests as an attitude of suspicion toward migrants, as well as excessively paternalistic treatment where decisions are made for them.[67]

Stereotypes Toward Migrant Women

As this study described, not all immigrant women who share ethnicity or religion think and act in the same way about contraceptives or cancer screening. Cultural beliefs and practices are not static phenomena; there is considerable diversity in adherence to specific traditions or beliefs. To practice woman-centered and culturally competent care, it is not essential to have a thorough knowledge of each woman's culture, but it is necessary to ask about her SRH needs and preferences and try to accommodate them.[37,68,69]

The data from this review are consistent with the literature identifying the difficulty migrant women have in exercising their rights to autonomy and informed consent.[62,70] It is impossible for migrant women with LLP and no language

Table 3. Implications for Midwifery Practice

Implications
1. Midwives should offer migrant women the use of human resources (interpreters, mentors, cultural mediators) and materials (pictograms, images, models) available in the health service where they work. Interpreter type (professional or ad hoc) and gender should be chosen by the woman.
2. In verbal and written information (brochures, letters of invitation, written recommendations), midwives should use simple vocabulary free of technical terms, adapted to the languages of the community, and understood by women with no schooling.
3. Midwives must acknowledge and combat racism. If there is no evidence that a cultural practice violates human dignity or human rights, it should be respected and encouraged, including in the clinical setting.
4. Training in effective and intercultural communication should be part of undergraduate and graduate programs in midwifery.
5. Each woman is unique. Midwives should encourage women to express their needs, expectations, and concerns about health. Midwives should protect each woman's decisions about her health and body from outside interference or pressure.
6. All sexual and reproductive health programs, protocols, and clinical practice guidelines should incorporate the perspectives of women from ethnic minority groups in the population served.

support to understand the purpose of the tests or procedure, the alternatives, the benefits, and the risks involved. Furthermore, some women make their decisions subject to the will of their husbands or doctors and do not dispute the decisions made about them. In these cases, it is culturally inappropriate to speak of informed consent.[71] Yet, as shown in this review, many migrant women want to decide for themselves and desire information to take control of their care; if they are denied the necessary information, their rights are violated.[72]

Facilitators

The facilitators identified in this review confirm the existing literature on the subject.[9-11,13] A skillful interpreter builds bridges of communication, and an empathetic gaze breaks down linguistic and cultural barriers. Therefore, culturally competent practitioners and interpreters working together have been shown to be highly effective in communicating with women about cultural or religious practices which do not infringe on a person's human rights or health. This communication establishes a trusting relationship and encourages women to connect with health professionals when invited or needed.[62]

Strengths and Limitations

This review provides up-to-date systematic evidence through a comprehensive search conducted by a multidisciplinary team. It is strengthened by the inclusion of articles exploring different SRH services conducted in 7 European countries that include migrant women from a wide range of countries of origin. However, there is no consensus among the papers on the use of the term *migrant women*; some articles include first-generation women, whereas others include first- and second-generation women and women from ethnic minorities who were not migrants. The specific demographic characteristics of migrant women are not described in all studies. There is an overrepresentation of women from Somalia, meaning that some issues may be more relevant to this group. In contrast, other groups of migrant women in Europe may have been underrepresented. Nevertheless, the women's discourse in this review is fairly homogenous, and we also found no significant differences among host countries.

Most of the women provided information in their own language; there is the possibility of bias in the translation or interpretation of their words. The exclusion of grey literature may have excluded relevant findings, although they have not undergone the same quality control as peer-reviewed published studies. Finally, this review included only European studies; generalization of the results to other countries should be approached with caution. A deeper understanding of the barriers and facilitators specific to countries or ethnic communities is necessary to ensure local applicability.

Implications for Practice

The data from this review provide impetus to reevaluate the intercultural communication strategies of European health services and, by extension, in countries like the United States. The communication difficulties that migrant women encounter when accessing and using SRH services should be assessed with reliable and valid tools[73] in each health center and hospital and for providers such as midwives, nurses, and physicians. This must be pursued in order to identify women's communication barriers and to map what resources are available to health workers to overcome those barriers. A good assessment will provide efficient plans for improvement. Furthermore, investing in the dissemination of health promotion and disease prevention campaigns from a cross-cultural and inclusive perspective might bring SRH care closer to migrant women.

For midwifery, to know this information is essential to develop a midwifery model of woman-centered care (Table 3).

CONCLUSION

Migrant women in Europe report significant difficulties in accessing and using SRH services related to language deficits, interpersonal relationship problems, and cultural disagreements. Clinical practice guidelines and policies should support the availability of professional interpreters, the adaptation of health messages to the patient's comprehension level, continuity of care and empathy to increase women's trust in professionals, and the improvement of communication skills and the intercultural training of professionals. Future research should test the effectiveness of communication strategies to improve SRH care.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Appendix S1. Search Strategy
Appendix S2. Characteristics of Studies' Participants

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