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Review

Sexual and reproductive health service utilisation of adolescents and young people from migrant and refugee backgrounds in high-income settings: a qualitative evidence synthesis (QES)

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Abstract. Young people with migrant or refugee backgrounds from low- and middle-income countries settle in high-income countries and tend to underutilise sexual and reproductive health (SRH) services. This review aimed to explore perceptions and experiences of SRH services and the factors that shape their use among migrant youth. It focuses on qualitative studies that examine SRH service use among young migrants living in high-income countries. Seven peer-review databases and web-based grey literature were searched using pre-determined search criteria. The review includes 16 articles that met the inclusion criteria. The qualitative evidence synthesis (QES) method was used to synthesise findings. Thematic analysis resulted in five main themes and 11 sub-themes. Findings suggest that despite diversity of countries of origin and host countries, there were considerable similarities in their perceptions of and experiences with SRH services. Some young migrants reported experiences of discrimination by service providers. Cost of care was a deterrent to SRH service use in countries without universal healthcare coverage. Lack of information about SRH services, concerns about confidentiality, community stigma around sexually transmitted infections and premarital sex were key barriers to SRH service use. Health systems should integrate flexible service delivery options to address access barriers of SRH service use in young migrants. Engagement with parents and communities can help to destigmatise sexual health problems, including STIs. Host countries need to equip young migrants with the knowledge required to make informed SRH decisions and access relevant SRH services and resources.

Keywords: adolescents, health service use, migrants, qualitative evidence synthesis, refugees, sexual and reproductive health, sexually transmitted infections, young people.

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Introduction

Research indicates that adolescents and young people (aged 10–24 years) from refugee or migrant backgrounds (hereafter referred to as young migrants) underutilise sexual and reproductive health (SRH) services.[1–4] The use of SRH services by young migrants is important because of their overlapping experiences of transitioning to a new country and adulthood. Further, some young migrants and refugees are vulnerable to SRH risks, including unwanted pregnancies,[1] female genital mutilation[5] and histories of sexual and gender-based violence.[3]

Studies suggest that socio-cultural beliefs about sex and sexual health limit SRH service use in young migrants; many young migrants do not use SRH services due to shame and stigma attached to sex and sexual health.[3] Previous research also finds that young migrants from low- and middle-income countries (LMICs) may have limited sexual health literacy about sexually transmitted infections (STIs),[6] safe sex and contraception.[7,8] Studies across many locations report that some young migrants perceive and experience discrimination during their engagement with health services and professionals.[9] In addition, transitioning to a country of resettlement can be challenging for young migrants as it involves learning a new language, adjusting to a new culture[7,10] and navigating financial and legal issues.[11] Thus, diverse health beliefs, limited sexual health literacy, previous

experiences with health systems, and the broader challenges of resettlement can adversely affect the engagement of young migrants with SRH services.[4,11]

It is important to note here that young migrants and refugees often have significant resilience, capacity and strengths that enable them to access and navigate new cultures, systems and networks in resettlement countries. In foregrounding this resilience, the intention is not to promote individual resilience and therefore individual responsibility for addressing problems including SRH. Instead, we emphasise the importance of enabling environments and services that can provide access to resources that allow young migrants to build on their resilience[12]

Recent literature reviews have focused on the use of SRH services among migrant and/or refugee populations.[3,10,13–15] These reviews focus on 'health service utilisation of young migrants'[15], 'SRH use in overall migrant populations'[10,13,14,16,17] and SRH service use by culturally and linguistically diverse (CALD) young people in the context of a specific country, namely Australia.[3] The review that focuses on SRH service use among CALD young people in Australia found, for example, that many CALD young people remain hidden to and underserved by SRH services.[3] None of the reviews focuses specifically on young migrants and SRH service use across different countries of resettlement.

This review focuses on qualitative studies that examine SRH service use among young migrants who have resettled in high-income countries. The review provides insights into key challenges and opportunities for improving access and service use for young migrants. The review objectives are:

(1) to identify, appraise and synthesise the perceptions and experiences of young migrants regarding SRH services in high-income countries; and
(2) to identify factors that influence access to and use of SRH services in young migrants resettled in high-income countries.

Key definitions

SRH care encompasses a range of preventative and treatment services. We limited the scope of the study by focusing on research that addresses the following SRH care: (1) counselling, screening, diagnosis and treatment of STIs; (2) contraceptive services; and (3) elective abortions.

For the purpose of this study, we included facilities that deliver SRH services including sexual health clinics, general physicians/practitioners, family planning clinics, hospitals and adolescent-friendly centres or youth-friendly centres. We use the definition of the migrant as set out by the International Organization for Migration (IOM): 'a person who has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is'.[14] In this study, we refer to young migrants as individuals aged 10–24 years. We focus on young migrants from low- and middle-income countries (LMICs) resettled in high-income countries. LMICs are identified by the World Bank classification;[18] high-income countries are defined by the Organisation for Economic Co-operation and Development.[19]

Methods

We conducted a qualitative evidence synthesis (QES) review using the PRISMA guidelines (Fig. 1). The QES is a systematic approach synthesising multiple findings from qualitative studies to identify patterns in the data to develop a new interpretive model or framework.[20] This QES focused on SRH service use among young migrants residing in high-income countries at the time of data collection. The search for relevant publications was conducted using key search terms (Box 1). The detailed keyword search is presented in Appendix S1 (available as Supplementary material to this paper).

Inclusion criteria

Studies were included if they:

- focused on young migrants (aged 10–24 years) from LMICs living in high-income countries. In studies where young migrants were part of the wider research sample, we extracted qualitative data if the age of young migrant was provided.
- drew on the perceptions of parents/health professionals/key informants on SRH service use among young migrants.
- used qualitative methods to collect and analyse data, including focus group discussions, qualitative interviews, or participatory workshops.
- had any publication date (however, the search was updated until November 2018).

Reviews, commentaries or mixed-method studies that reported descriptive analysis from open-ended survey data were excluded from the analysis.

Screening

The search resulted in 2743 articles, from which 243 were excluded as duplicates. Three reviewers (HM, KC, SK) independently screened titles and abstracts based on the inclusion criterion. The screening identified 56 articles, of which 36 were eligible for a full-text review. From these 36 articles, 16 articles were included in the final analysis (see Fig. 1 for rationale).

Data extraction and quality assessment

The Critical Appraisal Skills Programme (CASP) tool was used for the quality-assessment of 16 articles. All articles were critically appraised for appropriateness of study design, ethical considerations and rigour in data collection and analysis. The overall quality assessment of 'high,' 'medium' or 'low' was based on an independent evaluation by three reviewers (HM, KC, SK) with discussion to achieve consensus in the case of discrepancies (see Appendix S2). We did not exclude any article based on quality assessment; however, the methodological quality contributed to the confidence assessments of the findings of each article.

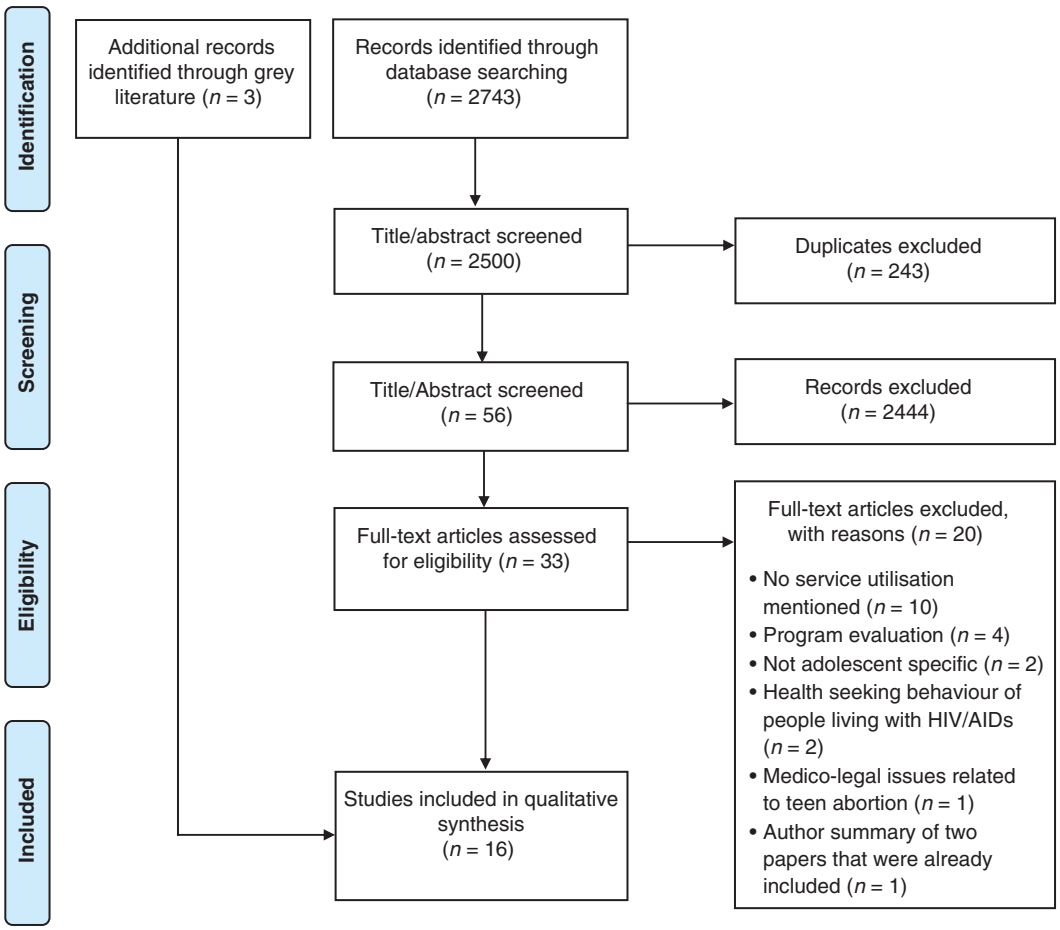

Fig. 1. PRISMA chart.

Box 1. Search strategies

- **The search terms**: (migrant* or immigrant* or refugee* or asylum seek* or culturally diverse or linguistically diverse or CALD or second generation) AND (sexual health or reproductive health or family planning or youth friendly or adult friendly) AND (young adj (women or men or male or males or female or females or girl or girls or boy or boys) AND ((STI or std or sexually transmitted or bacterial vaginosis or HIV or syphilis or chlamydia or blood borne viruses or bbv or bbvs or gonorrhoea or trichomoniasis or trichomonas) & (screen* or diagnos* or prevention)) AND (interview or focus group discussion or FGD or qualitative).
- **Databases:** CINAHL, Medline (Ovid), Embase, Family studies, PsycINFO, SocINDEX and grey literature (Open grey, Base (Bielefeld Academic Search), Australian Government Web Archive – National Library of Australia, TROVE/Pandora, POPLINE (US), PAIS International, APA-FT, APAIS-health, Burnet Institute, Victorian Refugee Health Network, Google).
- **Time:** There are no time limitations, however, the search was updated until November 2018.
- **Language:** There are no language restrictions.
- **Type of studies:** Primary qualitative studies.

Data synthesis

We used QSR NVivo 12.0 for data synthesis. Thematic analysis was used to identify, analyse and report themes across the included studies.[21] In the first stage, two authors (HM, KC) conducted line-by-line coding of data extraction forms to develop first-order themes and sub-themes. The sub-themes were broad enough to capture all themes emerging from the data. The two sets of coding structures were then compared and

developed into a comprehensive analytical framework based. All researchers provided input to the final thematic framework.

Assessing the confidence of the findings

Two authors (HM, KC) used the CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess the confidence in systematic review findings.[20] The CERQual approach enables assessment of the quality of the overall review findings across four dimensions: (1) methodological limitations; (2) relevance to the research question; (3) coherence; and (4) adequacy.[13] Confidence may be lowered if a finding is supported by results from only one or a few included studies or when the data supporting a finding are limited. The thematic analysis resulted in five main themes and 11 sub-themes. Out of the 11 sub-themes, six themes were assessed as having high-moderate quality evidence. Five sub-themes were graded as low-quality evidence because the theme was noted in only two to three studies (Table 1). Of two separate themes (without sub-themes), one was graded as low, and one was high quality.

Reporting

This QES review follows the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement guidelines. The ENTREQ statement consists of 21 items grouped into five main domains: (1) introduction; (2) methods and methodology; (3) literature search and selection; (4) appraisal; and (5) synthesis of findings.[35] The ENTREQ statement is a part of the QES guidelines to enhance transparency and quality of reporting.

Results

The 16 qualitative articles included in this review were conducted across six countries of resettlement: Australia (n = 8), the United States (US) (n = 3), Ireland (n = 1), Belgium (n = 1), Spain (n = 2) and Canada (n = 1). The review presents findings based on the views of young migrants from 31 countries of origin (see Appendix S2). As specified in the inclusion criteria, all articles discussed SRH service use among young migrants residing in high-income countries; ten discussed SRH service use, three discussed contraceptive and reproductive care services and four discussed the use of HIV screening services.

The findings are reported according to five primary themes (and 11 sub-themes) that emerged through the thematic analysis: (1) perceptions and experiences of young migrants on discrimination when using SRH services; (2) the effect of the stigma associated with sexual activity and STIs on young migrants' use of SRH services; (3) the challenges for health professionals in the delivery of SRH services to young migrants; (4) structural barriers that young migrants perceive and experience when using SRH services; and (5) enablers of SRH service use among young migrants.

Theme 1: perceptions and experiences of discrimination

Perceptions and experiences of discrimination by SRH service providers

Five studies documented that young migrants perceived that they were discriminated against by health professionals based on their cultural background.[9] Young migrants from some countries and regions (including countries in Africa and Latin America) were particularly likely to report experiences of discrimination. Three studies (conducted in Ireland, Belgium and Spain) reported that young migrants from African countries felt that they were being referred to STI screening by SRH service providers more frequently than were the general population of young people.[22–24] Young Hispanic women living in the US felt that health professionals treated them differently when providing contraceptive counselling than other young females and disregarded their preferences when suggesting contraceptives.[25] They reported that health providers overemphasised the need to control family size, even where they had no intention of starting a family at the time of visit.[25]

Perceptions about discriminatory policies

Three studies from Belgium, Ireland and Spain documented participants' expressions of frustration over perceived discriminatory policies that stereotype African migrants as HIV carriers.[22–24] For example, participants referred to policies of mandatory HIV testing for African refugees and asylum seekers who are seeking welfare benefits or certain services from financial institutions.[22] In one study, participants reported that a positive HIV result could lead to deportation from Belgium.[23] However, it is important to note that this perception was not aligned with policy in Belgium where a positive HIV diagnosis may facilitate accepting an asylum application based on medical grounds.[23]

Theme 2: stigma and SRH service use

The social stigma around premarital sex negatively influences SRH seeking behaviour among many young migrants.[11,26–28] In particular, young females across several studies voiced concerns that accessing specialised sexual health clinics for contraceptive counselling could put them at risk of being identified and stigmatised by community members who may attend the same services.[22,27,29] However, there were differences in young females' opinion based on their socio-cultural background. One study found that migrant Latin women and girls (aged 15–24 years) living in the metropolitan US valued contraception to prevent unintended pregnancies, with some indicating that their mothers actively encouraged them to seek SRH and contraceptive services.[25] Conversely, studies with young migrants from other regions (Asia, Africa, Middle East) found that females did not want to access SRH services because of the stigma surrounding premarital sex in their respective communities; study participants variously indicated that abstinence was expected to protect family honour and not bring shame to their families[22,27,29]

Table 1. CERQUAL Assessment of included studies (n = 16)

Third order	Second order (theme)	First order (sub-theme)	Relevant papers (n)	Confidence in evidence	Explanation of assessment of confidence in the evidence
SRH service use of migrant and refugee youth	Perceptions and experiences of discrimination	Experiences and perceptions of discrimination by SRH service providers	[9,22–25] (5 papers)	High	Studies had few methodological limitations (Sub)themes were found across different studies
		Perception about discriminatory policies	[22–24] (3 papers)	Low	Studies had few methodological limitations (Sub)themes found across studies, with a focus on HIV/AID testing
	Impact of stigma on SRH service use		[9,11,22–33] (14 papers)	High	Studies had few methodological limitations (Sub)themes found multiple times in different studies
	Health professionals' challenges to deliver SRH services		[8,31,34] (3 papers)	Low	Studies had some methodological limitations (Sub)themes found in all three studies
	Structural barriers	Cost	[8,22,23,28] (4 papers)	Moderate	Studies had few methodological limitations. (Sub)themes found in settings in North America and Europe
		Language barriers	[11,22,25,26,28,30,34] (7 papers)	High	Studies had some methodological limitations (Sub)themes found in several settings, particularly older participants or those who had very recently immigrated
		Clinic hours and waiting time	[22,28] (2 papers)	Low	Studies had few methodological limitations (Sub)themes found in two studies
		Lack of information or misleading information about sexual health services	[11,22,23,27,28] (5 papers)	High	Studies had few methodological limitations (Sub)themes were found multiple times in different contexts
	Positive influences on uptake of SRH services	Open conversations with health professionals	[26,32] (2 papers)	Low	Studies had some methodological limitations (Sub)themes appeared in three studies, all in Australia
		Reassurance for privacy and confidentiality	[25,28,31] (3 papers)	Low	Studies had few methodological limitations (Sub)themes found multiple times in different contexts
		Social support	[11,25] (2 papers)	Low	Studies had few methodological limitations (Sub)themes found in only two studies
		Quality sex education at the school level	[8,11,25,31] (4 papers)	Moderate	Studies had few methodological limitations (Sub)themes found in several settings
		Preferred attributes of health professionals	[11,22,26,29,32–34] (7 papers)	High	Studies had few methodological limitations (Sub)themes not reported with sufficient frequency or consistency to gain consensus, but some repeat findings about preference for younger doctors

Studies with young migrant males report some similar concerns about accessing voluntary HIV testing, particularly Latino and African migrants.[22,27,28] Studies with young Latin men who have resettled in the US report that many participants fear community members would judge their sexual activity as immoral if they knew they attended HIV screening.[28,30] Study participants with African and Latin backgrounds reported fear of being labelled HIV positive due to the stigma surrounding HIV in their communities.[22–24,28] The potential repercussions of being labelled HIV positive were said to include judgement from religious authorities,[22] sexual rejection by women[22–24,28] and social ostracism by the community.[23,24]

In many studies, young migrants stressed the importance of privacy and confidentiality when accessing SRH services.[23,25,26,29,31–33] There was high anxiety among young migrants about their parents or community finding out they had accessed sexual health services,[9,11,26–28] with some fearing that the General Practitioner (GP) or community members would report their attendance at SRH services to their parents. A study with migrant and refugee young people in Australia reported that these concerns restricted young people from accessing their regular GP to seek sexual health services, particularly if the doctor shared a similar cultural background.[26] The importance of privacy extended to front-office staff and how they handled appointments and communication of test results.[28]

Theme 3: health professional challenges to deliver SRH services

Three studies described the challenges that health professionals face in delivering SRH services to young migrants from the perspectives of key informants and health providers.[8,31,34] According to one service provider, some health professionals choose not to discuss a young person's sexual health needs because they are not confident in approaching the matter culturally sensitive way.[31] Some health professionals assumed that clients with migrant or refugee backgrounds were conservative and would not be comfortable discussing their sexual health.[34] Two studies suggested that the personal biases or beliefs of health professionals towards sexual health could affect service delivery for culturally diverse young people, including not prescribing abortion services or contraception to unmarried females.[8,31]

Theme 4: structural barriers

Cost

Young migrants frequently cited the cost of health care as an actual or perceived barrier to SRH service use.[8,22,23,28] In Ireland, residents with low-income are eligible for a medical card and are entitled to free primary and secondary care. People who are not eligible for the medical card pay 40 to 50 Euros to visit a general physician, with additional costs for any medical tests. Such healthcare expenses were noted as a significant barrier to service use for migrants who are not eligible for a medical card.[22] Moreover, in Canada, the cost of contraceptives was noted as a significant concern for young migrant women. Although some sexual health clinics offer contraceptives at subsidised rates, the exclusion of copper intrauterine device (IUD) and limited availability of the intrauterine system (IUS) in private health insurance inhibits young migrant women from accessing long-acting contraceptives.[8] Hence, the cost of SRH and contraceptive services acts as a barrier to service use for some young migrants. Importantly, however, some studies found that young people lacked information about the availability of free testing services or subsidised care.[23,28]

Language barriers

While two studies from Australia and the US found that language was not reported as a barrier to SRH service use among young migrants,[22,25,26,28,30,34] five studies identified language barriers.[22,28,30,34] Four studies described young migrants' difficulty understanding medical terminology used by general physicians.[11,22,28] Interpreter services were considered to bridge communication gaps between health providers and young migrant patients.[28,34] However, as one study from Ireland reported, interpreter services are not necessarily available at the places that young migrants might access for sexual and reproductive health.[22] Moreover, it is important to note that the use of interpreters may not be preferred by young migrants, especially if both interpreters and patients are from the same cultural background or are of different genders.[28]

Clinic hours and waiting times

Waiting times in health facilities and clinic hours were an impediment to SRH service use in two studies.[22,28] A study with immigrant Latin men in the rural US found that young migrants who are working, the overlap between their work hours and clinic operating hours limits their opportunity to access SRH services.[28] A study with African male immigrants living in Ireland found that long waiting times of up to 2–3 h were a disincentive to accessing SRH services.[22]

Lack of information on access to SRH services

In several studies, young migrants reported having limited knowledge about the availability and role of specialised SRH services. In five studies, young migrants were found to have incorrect information about SRH service provision and access in their current country of residence.[11,22,23,27,28] Some young male refugees living in Atlanta, US, believed they must be aged over 18 years to get condoms from a health centre.[11] Moreover, some young Bhutanese refugee females living in Philadelphia, US, believed that only people aged 18 years and older could independently access SRH services, that an older person must accompany a minor to SRH services, and that a boyfriend's permission was required to have an abortion.[27]

Theme 5: enablers of SRH service use

Preferred attributes of health professionals

The opinions of young migrants about their preferred SRH providers varied across socio-cultural groups and gender. In three studies, young female migrants reported a preference for female health providers for delivery of SRH services.[26,29,33] In another study, young males preferred male health providers to

discuss STI-related issues.[28] There were differing views on the preferred socio-cultural background of health professionals. In some studies, young females preferred to visit health providers from a different cultural background as they did not want to be exposed to cultural value judgements.[11,26,29,32,34] Conversely in three studies,[11,22,34] young migrants preferred health providers from a similar cultural background whom they felt would better understand their experiences and not be discriminatory.[22] Participants in a few studies indicated a preference for young SRH care providers equipped with current knowledge and accepting of the sexual decisions of young people.[26,29,33]

Open conversation with health professionals

Two studies suggested the openness of Western culture in their country of settlement (Australia) allowed young people to talk about sexual health and access information in a way that was not possible in their country of origin.[26,32] One study described the positive experiences of young Japanese females who could access sexual health services in Australia and appreciated open conversations with GPs about sexual health issues including STI transmission and testing.[32] In another Australian study, key informants and GPs emphasised the importance of initiating conversations around SRH with young migrants such that they are better able to make informed SRH choices.[26]

Reassurance for privacy and confidentiality

Given the concerns of young migrants about privacy and confidentiality (see above), it is essential that young people are confident that their personal information will not be disclosed to anyone except health care providers.[25] Three studies[25,28,31] recommended that health care providers address privacy and confidentiality at the beginning of an appointment. This reinforcement helps the young migrant establish trust with their health provider and seek appropriate and effective SRH services.

Social support

Wider social support networks influence SRH service access and use among young migrants. In one study, young Latin women living in the US indicated that open conversations with their parents helped them seek SRH services and make informed contraceptive choices.[25] In another study, some young refugee women living in Atlanta, US, expressed the wish that their parents better understood SRH services so they could attend consultations and provide support.[11] In addition, friends and schools were regarded as significant sources of information about SRH and provide some motivation for accessing SRH services.[11,25] For example, research on sexual health literacy among young refugees aged 18–24 years living in Atlanta, US, found that while participants had limited knowledge about sexual health, schools and peers were a primary source of information.

Quality sex education at school

Four studies highlighted the importance of school-based sexual health programs for migrant and refugee young people who may have limited or low sexual health literacy.[8,11,25,31] A study exploring contraceptive decision-making among Latin women in the US found that school-based sexual education initiatives could improve the knowledge about sexual health and SRH services in young migrants.[25] However, one study from Canada[8] found that the new migrants experience barriers to SRH service and contraception use, with one barrier being inconsistent and poor sexual health education in public schools.

Discussion

The QES explored young migrants' experiences and SRH services based on 16 qualitative studies from six high-income countries. Despite the diversity of countries of origin and host countries, there were some similarities in the perceptions and experiences of young migrants on SRH services. Findings suggest that young migrants: (1) variously perceive and/or experience discrimination when using SRH services; (2) are constrained by community stigma towards STI and sexual health; (3) have concerns about confidentiality and privacy when accessing SRH services; and (4) experience structural barriers to access SRH service. The discussion below focuses on four cross-cutting themes: (1) cultural competence of service providers; (2) structural barriers to SRH service use; (3) the role of wider community networks and education initiatives; and (4) the impact of socio-cultural values around sexual health, including the shame and stigma that can be attached to STIs.

Cultural competence of service providers

Wider research identified a lack of cultural competency among some health professionals and the need for culturally sensitive health and SRH services to improve the experience and use of services in migrant communities.[6,14,16,17] Improved cultural competency among relevant health professionals and service providers can come part way to: (1) addressing perceived and/or experienced discrimination towards migrant youth by service providers; (2) improving communication barriers linked to language and cultural differences; and (3) engaging sensitively with different community values and attitudes. We suggest that cultural competency be integrated within undergraduate and continuing education programs for doctors/physicians, nurses and other SRH providers. Here, cultural competency does not only mean respecting cultural values and beliefs, but also knowledge of cultural safety, cultural awareness and cultural sensitivity of health professionals.[31] The training should also enable health providers to introspect their personal biases concerning the sexual health of young migrants to discover dissimilar concepts (such as community stigma towards HIV testing or preference to specific contraceptive methods) in order for them to deliver culturally responsive care.[31,36]

The review findings suggest that young migrants would benefit from an open discussion with service providers on sexual health, and some authors recommend that service providers initiate the conversation.[26,32] For providers to approach the matter in a culturally appropriate way, Zhang *et al.*[16] suggested using a survey to inquire about a patient's

preference on sexual health discussion with health providers before the appointment. Given the stigma towards sexual health in many communities, service providers should reassure their young clients about the confidentiality of the information during the consultation and, if necessary, explain how their personal information is protected. This will build the confidence of young people in service providers, which could be instrumental for their long-term engagement with sexual health services.

Structural barriers to SRH service use

There are structural factors that constrain young migrants' access to and use of SRH services. Cost is a key barrier. In countries such as Ireland and the US, which do not offer universal health coverage, the cost of SRH service delivery (e.g. consultations, screening, treatment) and contraceptive resources (e.g. long-acting contraceptives for females) is a deterrent. Language can also be a barrier to SRH service use for some newly arrived migrant youth. While interpreting services are of significant value, they do not necessarily resolve language barriers where young migrants have concerns about privacy given their potentially shared community background. As noted by Brandenberger *et al.*,[17] a mismatch between patient and interpreter for sex, age or ethnic background can adversely affect the consultation. A pre-consultation survey can be used to ask young migrants' requirements and preferences for interpreter services to avoid a potential mismatch or related adverse outcome.[16]

Some of the structural barriers to SRH care (clinical hours, waiting time, confidentiality) identified in this review can be addressed using online sexual health consultation or telehealth; both have shown to address access barriers of SRH service use in young people.[15,37] Studies showed that online consultation for Chlamydia followed by home-based testing kits increased the screening rates of Chlamydia in marginalised youth[38] or those who lived in a remote location with limited sexual health services available to them.[39,40] Online testing can be offered to young migrants who do not wish to attend sexual health clinics for confidentiality concerns; however, considerable caution should be exercised while posting the testing kits as many young migrants live with their parents. The studies that found the helpful approach gave their young clients the options to use an alternate address (other than their home) and informed them that their results would not be disclosed to their parents, teachers or other community members.[39,40] The approach was found to address several access barriers, including cost, transport, confidentiality and could be offered to young migrants to see its viability.

In some high-income countries, confidential sexual health services are offered; however, they remain under utilised by young migrants because of a lack of awareness about these services. Availability of sexual health services alone cannot address the service utilisations until young migrants' knowledge about the health system is strengthened. This suggests a need to promoting information about 'sexual health services' and 'youth-friendly services' at health care sites (hospitals and clinics), with school-based nurses[41] and settlement services[2] that are regular visited by young migrants.

Role of wider community networks and education initiatives

Our review indicated that wider education services and social network shape young migrants' knowledge and attitudes towards the use of SRH services. School and community-based sexual health education were found to have a role to play in improving young migrants' knowledge of and access to SRH services, including youth-friendly services.[8,11,25,31] And in some contexts, parents (especially mothers) were found to be instrumental in encouraging young migrants to make informed contraceptive decisions and engage with SRH services,[25] although other young migrants feared the reactions of their parents and community if they found out they had accessed sexual health services.[9,11,23,26–28] Previous research have identified effective education and community-based initiatives that promote sexual health literacy and engagement with SRH services among migrant youth, including platforms that deliver digital stories as health literacy and service engagement tool,[42] and parent-based sexual risk reduction (e.g. 'Families Talking Together' (FTT) initiative) to reduce risky sexual behaviour in young migrants.[43,44] An evaluation of a culturally sensitive SRH education program in Sweden offered to refugee women and girls during the settlement phase found that it improved their sexual health literacy and confidence to navigate the health system.[45] Similar programs for young migrants and their families could be useful in other countries, ensuring sensitivity to the diversity of community values and contexts.

Impact of socio-cultural values around sexual health

Finally, the review confirms that stigma and shame around STIs (including HIV/AIDS) and premarital sex can have negative impacts on the use of SRH services by some migrant young people.[46] Many studies report that communities from migrant or refugee backgrounds can stigmatise people living with HIV and link their infection to immoral sexual behaviour.[23,28] Health system interventions should target community members, religious and faith leaders and multicultural organisations[23,47] to develop strategies that destigmatise sexual health problems and young migrants' use of sexual health services.

Limitations

The review compared SRH service use of young migrants from diverse backgrounds and regions, including Asia, Africa, Latin American, Middle East, Caribbean and Central Americas, living in high-income countries. While the recommendations are broadly relevant to high-income countries with young populations from diverse backgrounds, places of settlement and migrant populations are highly heterogeneous; as such, it is necessary to consider the relevance of the review findings to any context.

Some studies in this review included a broad age range of participants (e.g. aged 18–64 years). Given the inclusion criteria specified that studies must include young migrants within a given age range,[10–23] we were only able to include findings from these studies with a broad age range of participants where age was specifically provided and was 10–24 years (e.g. following a participant's quotes). This

means that some relevant qualitative data were not included because of missing information about participants' age. The CERQUAL assessment was important to guide our response to these methodological nuisances and provided the final analysis with rigour.

The host countries have different health systems. For example, Australia,[48] Canada,[49] Belgium[50] and Spain[51] offer universal primary healthcare for citizens; however, there are specific qualifications to these policies that can affect migrant access to healthcare services. For example, holders of certain temporary visas are ineligible for 'Medicare' in Australia. Ireland has means-tested medical care for people with low income to access free GP services and hospital services (if referred by the GP); those who are not eligible have to pay the fee for service or use health insurance.[52] The US does not offer a universal healthcare program but has multiple systems including Medicare for people over 65 years, state-run Medicaid for people on low incomes, employer health insurance, private health insurance and 'Obamacare' for those with no coverage.[53] In the US, both lawfully present and undocumented migrants are significantly more likely to be uninsured than US-born citizens.[54] Hence, access to SRH services by migrant youth must be understood within the context of relevant health systems; this can significantly influence experiences including, for example, structural factors that shape access such as cost of services.

Conclusion

Many young migrants have limited knowledge of sexual and reproductive health services in their host countries; as such, the availability of services does not guarantee service use by young migrants. Promoting knowledge and awareness of SRH services, especially youth-friendly services, is key to encouraging health service use. The capacity of health professionals to deliver culturally sensitive SRH care should be strengthened. Health systems should integrate flexible service delivery options to address access barriers of SRH service use in young migrants. Engagement with parents and communities can help to destigmatise sexual health problems, including STIs. Host countries need to equip young migrants with the knowledge required to make informed SRH decisions and access relevant SRH services and resources.

Conflicts of interest

The authors declare no conflicts of interest.

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